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House of Representatives

The House met at 10 a.m. and was called to order by the Speaker pro tempore (Mrs. BIGGERT).

DESIGNATION OF THE SPEAKER PRO TEMPORE

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

WASHINGTON, DC,
October 7, 1999.

I hereby appoint the Honorable JUDY BIGGERT to act as Speaker pro tempore on this day.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

PRAYER

The Reverend Carl W. Rehling, St. James Parish, Lothian, Maryland, offered the following prayer:

Almighty and everliving God, Fountain of all wisdom, creator of all good knowledge, whose will is good and gracious and whose law is truth, so guide and bless the Representatives in this Congress assembled, that they may enact such laws as shall please You, to the glory of Your name and to the welfare of all people.

We ask that Your holy and life-giving spirit may so move every human heart, especially the hearts of those appointed by the people to lead us, that barriers which divide us may crumble, suspicions disappear, and hatreds cease; that our divisions being healed, we may live in a country and a world governed by Your justice and secure in Your peace. Amen.

THE JOURNAL

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

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

Ms. KILPATRICK. Madam 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.

Ms. KILPATRICK. Madam 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. Pursuant to clause 8, rule XX, further proceedings on this question will be postponed.

The point of no quorum is considered withdrawn.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from New York (Mr. GILMAN) come forward and lead the House in the Pledge of Allegiance.

Mr. GILMAN 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.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain 15 one-minutes on each side.

HEALTH CARE AND MISS NANNIE LACKEY

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

Mr. FLETCHER. Madam Speaker, as I was walking to work this morning and reflecting on the day's very important vote to ensure real patient protection, I was reminded of Miss Nannie Lackey and her 100th birthday.

As I got closer to the Capitol and the Longworth Building, I thought how rich her life was in health, friendship, love, and faith. See, Miss Lackey has voted in every election since women were first given the right to vote. She takes voting very seriously, and she hopes all of us will take equally seriously the votes we cast today.

So I would ask that my colleagues take a few minutes to reflect on the importance of providing the best health care possible in our next century.

I hope my colleagues will see, as I do, that increasing the cost and number of uninsured is not the answer to real health care reform, nor is it real patient protection.

I ask that my colleagues join me in supporting positive health care reform and support the Coburn-Shadegg coalition substitute.

DO NOT LET AMERICA DOWN; VOTE FOR NORWOOD-DINGELL SUBSTITUTE

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

Ms. KILPATRICK. Madam Speaker, today is the most important day in the life of this House of Representatives. Will the people of America be able to have quality health care or not? Will the people of America have the opportunity to have their doctors determine their health care, their length of stay, their type of procedure; or will they turn it over to the bureaucrats, the accountant whose main purpose is to watch the bottom line.

Madam Speaker, let us not take this lightly. Besides quality education, besides environment that is clean and safe, and decent housing, health care is the number one priority of American

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citizens. Let us not let them down. Vote for the Norwood-Dingell bill today, the most effective of all the proposals.

GOVERNOR OF NEW MEXICO'S CALL FOR DRUG LEGALIZATION

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

Mr. GILMAN. Madam Speaker, the Governor of New Mexico, Gary Johnson, has been calling for the legalization of mind-altering drugs. His rationale for throwing in the towel is his mistaken belief that we are losing the war on drugs.

Regrettably, under the Clinton administration, there has not been a balanced supply-and-demand-side fight against drugs. In fact, the war on drugs never truly began at its source in places like Colombia, since all of it was concentrated on treating the wounded here at home.

During the Reagan and Bush era, when we fought this battle against drugs on both the supply side and demand side simultaneously, we made real progress. Between 1985 and 1992, we reduced monthly cocaine use by nearly 80 percent. That is real progress.

In the city of Baltimore, we have learned firsthand the disastrous impact of a de facto legalization program and the lax attitude as has been proposed by Governor Johnson. The number of heroin addicts increased dramatically during a long laissez-faire period while population declined. Today, one in 17 citizens of Baltimore are heroin addicts. No one would agree that is any solution to the drug use problem. That is what Governor Johnson's legalization plan would bring to our Nation.

I urge the Governor to reconsider his stand.

WEST VIRGINIANS DESERVE PATIENTS' BILL OF RIGHTS

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

Mr. WISE. Madam Speaker, today, almost 200,000 people in West Virginia in HMOs and thousands more in managed care are watching Congress today. Today, this Congress has a chance to pass real health care reform.

If one's car is sick, one gets to choose one's mechanic. Do not my colleagues think people have the same rights when they are choosing their doctor?

This bill provides guaranteed access to emergency room care. It protects the doctor-patient relationship. It gives more rights to choose OB/GYNs and pediatricians. It has strong enforcement provisions against violation of patient rights. It holds HMOs and insurance companies accountable for their medical decisions. It has a real appeals process when an insurance company denies treatment.

From the Northern Panhandle, where 44 percent of all insured in Ohio County alone are in HMOs, to the growing 25 percent in the Kanawha Valley, to the thousands more across the State of West Virginia, there is a bill of rights for all citizens. Should there not be a bill of rights for patients in managed care?

I urge Congress to pass this today.

BIENNIAL BUDGET: AN IDEA WHOSE TIME HAS COME

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

Mr. STEARNS. Madam Speaker, in the next 3 weeks, we will see, perhaps, the best and worst of democracy in action; and that is why I have called for a biennial budget review process.

I have a bill, H.R. 493, I hope my colleagues will look at this. I am a firm believer that, by adopting such measure, we will remove this inherent politics every year that so often occurs during budget negotiations.

What I would like to see is the first session of Congress being dedicated to passing all of the 13 appropriations bills, then the second session of Congress would be dedicated to authorizing these bills, and then to look at oversight of the laws that we have passed.

Let us investigate and evaluate all these laws we pass every year. The current way of doing business often leads to a stalemate where politics prevails. This country deserves better.

IT IS NOT MANAGED CARE ANY MORE, IT IS MANAGED COSTS

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

Mr. TRAFICANT. Madam Speaker, America's the land of the free, but one cannot choose one's doctor. Freedom of speech; but doctors are gagged. Judicial review; HMOs are judge and jury.

Madam Speaker, health care in America has gone from the Constitution to HMOs. Beam me up. It is not managed care any more; it is managed costs. It is time for Congress to vote on behalf of the American people and pass the Patients' Bill of Rights, stone cold simple remedy today.

I yield back more medicine than ever in America and less health care.

IMPORTANCE OF INCREASING AWARENESS OF THYROID DISEASE

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

Ms. ROS-LEHTINEN. Madam Speaker, the women of our country form the backbone of strong, healthy families. However, it is American women who are often subject to debilitating and sometimes life-threatening diseases which subsequently deteriorate the stability of American households.

This week, I had the privilege of speaking to a remarkable woman who fights a valiant battle against a thyroid disorder known as Graves disease. This woman is none other than three-time Olympic track and field gold medalist Gail Devers. In spite of her illness, Gail will compete in the upcoming Olympics.

Approximately one in eight women will develop a similar thyroid disorder during her lifetime, and more than half of American women over 40 experience three or more common symptoms; yet, they fail to discuss them with their doctors.

To help raise awareness, Gail has joined forces with the American Women's Medical Association to launch a public, nationwide education campaign designed to increase awareness of thyroid disease.

Yesterday, the Congressional Prevention Coalition provided free thyroid screening, and I encourage all of our colleagues to embark on an educational campaign on the dangers of thyroid diseases.

BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT

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

Ms. SCHAKOWSKY. Madam Speaker, I rise today in support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999.

Enactment of this bill is the answer to the letter I received from a mother and a constituent in my district. She wrote, ''When my middle son was born, the insurance company wouldn't let my son stay in the hospital one extra day to finish the course of antibiotics. They sent him home with a shunt in his arm. The neonatologist has warned us that typically in babies so small the shunt comes out and then you have to start the antibiotics all over again orally and that they would upset the baby's symptom, causing severe intestinal distress and diarrhea, not good for a newborn. My son's shunt came out, and he screamed for 2 weeks.''

This baby deserved better. This bill assures that doctors, not insurance companies, decide how long newborns get to stay in the hospital when they are sick. Let us act now. Let us pass H.R. 2723.

GOVERNOR JESSE VENTURA SHOULD BE HONORED WITH NATIONAL DAY OF RECOGNITION

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

Mr. HEFLEY. Madam Speaker, I am here today to propose a national holiday in honor of the Governor in Minnesota, Jesse Ventura.

After all, he confounded the pundits, the pollsters, and the prognosticators by winning the highest office in the State at a time when most voters thought of him as ''Jesse the Body.''

He continues to confound everyone. Not too much notice was made when he indicated he would like to be re-incarnated as a large bra, but eyebrows did raise when he referred to members of the Armed Forces as Frankenstein monsters that cannot be controlled.

Then, of course, he outdid Oliver Stone by suggesting that President John Kennedy was killed by our own military-industrial complex in order to stimulate business.

Who can forget his plunge into theology? ''Organized religion is a sham and a crutch for weak-minded people who need strength in numbers,'' the Governor said.

□ 1015

So today I am proposing we name a day after Jesse Ventura, and the day I have chosen is April 1. That is right, April Fool's Day, because I can think of no one that so embodies the spirit of that day as the Governor of Minnesota.

AMERICANS SHOULD VOICE THEIR SUPPORT FOR NORWOOD-DINGELL BILL

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

Ms. JACKSON-LEE of Texas. Madam Speaker, yesterday I introduced into the RECORD the testimony from Dr. Thomas W. Self, an M.D. educated at Yale and UCLA, but an M.D. that has fallen victim to being terminated because his only grievance and error was spending too much time with patients.

Today, America's voices can be heard, and we ask that all Americans' voices be heard on a revolutionary idea, that is, that the patient and the physician are the two most important individuals who should assess the health condition of American patients on the precipice of the 21st century.

Today we have the opportunity to defeat poison pill bills that will do nothing but undermine the true essence of what we are trying to do. The Norwood-Dingell bill will emphasize the relationship of patient to physician. It will allow individuals to get into an emergency room, allow them to get the care that they need; it will allow women to have a relationship with their OB-GYN, and it will ensure that a patient can press their grievance when medical care is denied.

This is a day when patients will be able to determine that they are not commodities but that they are people. America should, today, let their voices be heard on the floor of the United States Congress that the Norwood-Dingell bill should pass.

TO DETERMINE CREDIBILITY, LOOK TO THE RECORD

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

Mr. PITTS. Madam Speaker, sometimes it is difficult for people to tell who is being straight with them and who is being misleading or disingenuous. One way to help decide who ought to be believed and who not is to look at the record and the credibility of those making various claims.

Take Social Security, for example. The record will show that the other party controlled this House for 40 years, along with its appropriations process, and not only failed to put aside one dime of the Social Security surplus; but 30 years ago they began the annual practice of raiding the Social Security Trust Fund to pay for things other than Social Security and left us with a huge Federal debt.

Just a few months ago, the other party turned their backs on the President's own Commission on Social Security because bipartisan Social Security reform would take away their ability to scare seniors on the issue in the next election process.

Republicans, on the other hand, have passed Social Security lockbox legislation that locks away 100 percent of Social Security taxes for Social Security and Medicare, and they have been reserving H.R. 1 even to this day for the President's proposal on Social Security reform.

So in judging credibility, look at the record, not just rhetoric.

VOTE AGAINST COBURN SUBSTITUTE AND FOR NORWOOD-DINGELL

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

Mr. TURNER. Madam Speaker, as a former member of a State legislature, both the House and Senate, I implore my colleagues today to support the Dingell-Norwood bill because it reserves in the States what for 2 centuries has been a clear right of every State in this Nation, and that is to control the medical malpractice laws of our country.

Why should we be able to sue a doctor for malpractice in State court but have to go to Federal Court to sue a managed care company? That is what the Coburn substitute does. That proposal is wrong; it does injustice to our State legislatures who work hard to be sure that we have malpractice protections for our citizens. It creates a new Federal cause of action that means individuals will have to go into Federal court.

If we read the Coburn substitute carefully, we will find out that it denies due process even after someone gets to Federal court, because the Coburn substitute says that when an individual gets to Federal court, it is the decision of the external review panel that governs and that individual has no right to challenge that once they get to Federal court.

I think it is a travesty of justice to support the Coburn substitute, and I urge the passage of the Norwood-Dingell bill.

WILDERNESS ISSUES IN THE WEST

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

Mr. HANSEN. Madam Speaker, one of the most contentious issues we have in the West is called wilderness. We find it very interesting, because whole industries have started because of this. They come in and have their attorneys and their accountants, and they come up and do all they can to get all our brethren to sign on to their bills, which everybody knows means nothing. We find it interesting because they start out with a small amount, and it just keeps going up.

Today, I am introducing a bill which will solve many of the problems of the great State of Utah, and I think this particular bill would be something that we could finally resolve this. This bill will call for 2.3 million acres of wilderness in the State of Utah.

But we have to be concerned about the local people there. For some reason, a lot of our people from the East think it is a throw-away vote to give away our western land. The people who live on the land, who make their living there, who recreate on the land should have a hand in this.

Today, I am very concerned about the Utah Test and Training Range. For those of us who sit on the military committees, we realize that the Utah Test and Training Range is the best training range the United States Air Force has. And if another bill goes through, we will find that we are killing the golden goose, and we will not be able to train our pilots. I will assure the military there will be nothing in this bill that will be detrimental to this.

Madam Speaker, I would hope that my colleagues could join us on this good piece of legislation and finally resolve an issue that has been very contentious to the West.

SUPPORT DEMOCRATS' PATIENTS' BILL OF RIGHTS

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

Mr. KLINK. Madam Speaker, back in 1994, the insurance companies of this country spent tens of millions of dollars having Harry and Louise tell us that we did not want the Government to control our health care, and they won. And as a result, now the insurance companies control our health care. Now managed care means if we need health care, we are going to have to learn to manage.

Beginning in early 1997, when I heard complaints from doctors and from patients, I held a series of health care forums across my district. Over 60 hours

of testimony, 1,500 people and horror stories beyond comprehension. I brought those stories and the results of that to the Democratic caucus. We began holding hearings here on the lawn right outside the Capitol. And from that came a series of health care proposals, because we learned that the American people had lost complete confidence in the health care system.

They were screaming for help and could not understand why we as Members of Congress let this go on so long. We had the best health care delivery system in the entire world, and we let it fall apart; and people could not understand why.

Now, today, we have a chance to fix that. We can stop the insurance companies from deciding what doctor we can go to, if we can go to a doctor, what hospital, what kind of treatment we can get. We can put health care back in the hands of doctors and patients by passing Norwood-Dingell.

NATIONAL 4–H WEEK

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

Mr. DEAL of Georgia. Madam Speaker, I rise today in honor of the National 4–H Club. October 3 through 9 is designated as National 4–H Week.

Across the country this week, the youth are marking the 97th year of this organization and are asking the question with the theme: Are you into it? The theme is embraced by more than 6.5 million young Americans who take part in 4–H educational programs. It is time to celebrate the diversity of 4–H activities and people, and to recognize the achievements of youth who strive to develop the four Hs: head, heart, hands, and health.

Founded in 1902 as an agricultural youth organization, 4–H is no longer just cows and plows. To keep up with the wide range of interests of today's youth, 4–H programs have diversified and include such things as designing web pages, participating in mock legislatures, community cleanups, and so forth. Since its beginning nearly 100 years ago in rural America, about 45 million Americans from all walks of life have been involved in 4–H.

Madam Speaker, I have authored a resolution in honor of the 4–H clubs of America as we congratulate their members.

SUPPORT NORWOOD-DINGELL PATIENTS' BILL OF RIGHTS

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

Mr. ALLEN. Madam Speaker, I rise in strong support of the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act.

This debate pits doctors and patients against the health insurance industry. The insurance industry has weighed into this debate to protect its pocketbooks, not its patients. In TV ads and on this floor, opponents of a patients' bill of rights have tried to demonize trial lawyers. But this debate is how to encourage HMOs to provide better care to their patients.

The substitutes to Norwood-Dingell preserve some or all of the legal immunity that the insurers now have even when their decisions kill or injure patients. If HMOs can be held liable for their own negligence, they will pay more attention to patients. They will be more careful. That is all. It is simple. That is what this debate is about. Pass the Dingell-Norwood Patients' Bill of Rights.

SUPPORT H.R. 3034, TO EXPAND FLEXIBLE SPENDING ACCOUNTS

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

Mr. ROYCE. Madam Speaker, flexible spending accounts allow employers and employees to contribute pretax money to accounts which they can then use to pay for out-of-pocket medical expenses and insurance costs and to pay for deductibles. But there is a problem in the Tax Code with the way in which these accounts work today, and that is there is a use it or lose it provision where it reverts back to the employer. So, typically, people put down $750 of pretax to use for these flexible spending accounts, and at the end of the year about $140 reverts back that they are not able to use.

My bill, House bill 3034, would allow this to be expanded, would allow this to be carried over into the following year so that that would not be lost. A lot more people would utilize this provision if they did not lose it.

Many employees would choose less expensive, high-deductible insurance policies and put the premium savings then in their flexible spending accounts if they knew they could roll that over into the following year. It also reinforces the doctor-patient relationship.

Madam Speaker, I urge support for H.R. 3034.

NORWOOD-DINGELL OFFERS BEST PROTECTIONS FOR AMERICAN FAMILIES

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

Ms. DELAURO. Madam Speaker, today we have a historic opportunity to pass HMO reform that will ensure that medical decisions are made by doctors and patients and not by insurance companies.

These are sensible patient protections that all parents should have for their families. But to pass them, we are being forced to cross a mine field. The Republican leadership has teamed up with the insurance industry to obstruct and weaken the Patients' Bill of Rights. The Republican leadership has set up a series of amendments that will undermine the basic provisions of this bill, a bipartisan bill. And I stress bipartisan.

The Patients' Bill of Rights simply ensures that medical decisions are being made by doctors and hospitals and that HMOs are accountable for damages caused by wrongful denials. These provisions are already working for families in California and in Texas; now every family deserves them.

I call on my colleagues to defeat the poison pill amendments, pass the Norwood-Dingell bill, the Patients' Bill of Rights, which today's New York Times says, and I quote, ''offers the best place to start in getting strong protections for millions of American families.''

SUPPORT A PATIENTS' BILL OF RIGHTS, NOT A LAWYER'S RIGHT TO BILL

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

Mr. HAYWORTH. Madam Speaker, I always enjoy hearing from my colleague from Connecticut, especially her description of a poison pill involving legislation. Madam Speaker, let me suggest to my colleagues the only poison pill is that which would seek to enrich and empower trial lawyers and courtrooms over clinics.

There is much we can agree on in truly a bipartisan fashion. I believe, as I think every Member of this House does, that when it comes to health care decisions, those decisions should not be made by an insurance company bureaucrat any more than they should be made by a Washington bureaucrat. The power should be in the hands of the patients.

The patients I know in the Sixth District of Arizona want to see a doctor, not a lawyer. They want access to a clinic, not a courtroom. And they do not want their estates to sue; they want to live long, productive lives and seek help. That is the essence of what happens today, not demonization of the insurance companies nor a poison pill of freedom for patients.

Let us have a true patients' bill of rights, not a lawyer's right to bill.

LOOK TO TEXAS FOR EXAMPLE OF MEANINGFUL MANAGED CARE REFORM

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

Mr. GREEN of Texas. Madam Speaker, my colleague from Arizona needs to come to Texas, and we will show him what has happened in the real world when we have really had a Patients' Bill of Rights and real effective reform.

We do not have a lot of lawsuits. In 2 years, in fact we have had three, maybe four.

□ 1030

What we have seen, though, is the external appeals process backed up with the right to go to the courthouse means that they settle those appeals.

In Texas, we are finding that over 50 percent of the appeals are being found in the patient's favor. In other words, the decision-maker, the insurance company, whoever made that decision was wrong over 50 percent of the time. And that is what is wrong with the current system.

I do not want lawyers to get rich. They want health care. The people want health care. That is what they are doing. And in Texas, with 2 years' experience, that is what is happening, strong external appeals backed up with a judicial review that they do not want to go to neither the insurance companies nor the patients.

We have that in the Norwood/Dingell bill, and that is why it is so important. Medical necessity, external appeals, access to specialists, emergency care, but also backed up with an accountability system.

If Wal-Mart can be sued for a slip-and-fall in State courts, why should their employees not be able to go to State courts?

TIME FOR CONGRESS TO QUIT PLAYING PARTISAN POLITICS WITH AMERICA'S SCHOOLCHILDREN

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

Mr. CHABOT. Madam Speaker, we have heard a lot of talk about health care here this morning. And health care is very important. Education is pretty important, too.

I think it is time for the President and his liberal Democratic friends here in the House to quit playing partisan politics with American schoolchildren and with their schools. They spend so much time distorting the Republican record on education spending that they fail to acknowledge that spending is not the only issue.

We all believe that education funding is important. The difference lies in how we want that money to be spent. Liberal Democrats want it to be spent on more big government programs. It does not matter to them if the programs work or not as long as they can make themselves believe that they are helping kids.

I would rather see education dollars go directly to the classroom where it can be spent by people who know other children's names. They could spend it on books or chalk or computer equipment or whatever else they need to teach their students. This is a whole lot better than spending it on reams of bureaucratic paperwork.

BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

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

Mr. LAMPSON. Madam Speaker, I rise today to challenge all of my colleagues, Democrats, Republicans, Independent, to pass legislation that would provide all Americans with the health care protections they need and deserve.

It concerns me that patients from my district are being denied the health coverage they need to lead productive lives. It seems that I cannot pick up the Beaumont Enterprise or Texas City Sun without reading about someone who was denied care because some insurance company decided that a procedure was not necessary. It has even happened to my own daughter, Stephanie.

It is one thing to keep costs down, but it cannot be done at the patient's expense. That is why I support the Bipartisan Consensus Managed Care Improvement Act of 1999.

I am confident that this bill will give residents of Hotel Beaumont, a senior citizens community in the heart of my hometown, the right to choose a specialist and see the same doctor throughout treatment.

It is time for us to put our money where our mouth is. Let us prove to the American people that this Congress can work together to address issues that they really care about. Let us pass H.R. 2723.

HEALTH CARE REFORM

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

Mr. HAYES. Madam Speaker, this morning I rise to simply say that the people in the 8th District of North Carolina care about access, they care about quality, they care about affordability. That is what we on our side of the aisle care about this morning. We want to provide that.

The language that some of my liberal friends use may be good politics, but it is bad medicine for the people in the 8th District. Support the bill that gives access, that gives affordability, and give quality to the people of America. Support Boehner. Support Shadegg/Coburn.

HEALTH CARE REFORM

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

Mr. SNYDER. Madam Speaker, as a family doctor in Arkansas for 20 years, I am well aware that doctors and nurses do not know everything about health policy. But one thing I do know is that, in a doctor's office in America today, arguments and shouting matches with insurance companies occur on a regular basis.

Let me tell my colleagues about one example. I saw a patient with depression; and as part of the treatment, I thought they needed counseling. How do I obtain counseling? I took the patient into a room, gave them an 800 number to their insurance company, and they had to call an anonymous voice on the phone who made the decision about whether they would get counseling and for how many sessions.

This is wrong. If anonymous voices working for insurance companies at the end of a phone make medical decisions, they should be held just as accountable under State law as doctors and nurses.

Pass Norwood-Dingell.

REPUBLICANS ENDING 30-YEAR RAID ON SOCIAL SECURITY

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

Mr. THUNE. Madam Speaker, Republicans here in the House are doing the right thing for seniors, the right thing for our children, and the right thing for every American who hopes to retire. We have walled off Social Security and placed it in a secure lockbox. We are ending the 30-year raid on Social Security.

Now we need our colleagues in the Senate to do the same thing: Take up the lockbox legislation, follow our lead, and do what is right for our parents, our children, and for the next generation of Americans.

The American people deserve to know who is serious about protecting and saving Social Security. We need the lockbox legislation passed in the Senate and signed into law by the President.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mrs. BIGGERT). The Chair must remind all Members not to suggest actions to be taken by the Senate.

MANAGED CARE REFORM: A MATTER OF VALUE, ETHICS AND PRIORITIES

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

Mr. STRICKLAND. Madam Speaker, the issue before the House today is a complex one, but the answer is fairly simple. We are being given a forced choice today. We can either choose to put medical care back into the hands of physicians and patients, or we can allow those medical decisions to remain in the hands of insurance bureaucrats.

All across America today, citizens are being harmed and I believe are losing their lives because we have allowed

the insurance companies and the HMOs to make medical decisions. This is a matter of value. It is a matter of ethics. It is a matter of priorities.

Who are we going to put first? Patients? And are we going to honor the sacred relationship between the physician and the patient, or are we going to continue to allow the HMOs and the insurance companies to put profits above patient welfare? It is a simple choice.

The American people are watching, and every one of us ought to be held accountable for what we do in this chamber today.

EUROPE JOB CREATION ALMOST ZERO

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

Mr. COOKSEY. Madam Speaker, the unemployment rate in most European countries is nearly three times the unemployment rate of the United States. While the U.S. economy is a job creating machine, in Europe job creation is almost zero. Older workers who lose their jobs cannot find new ones, and younger people looking for that first job often do so for years and often have to wait years before they could move out of the house.

Meanwhile, in the U.S., there is actually a job shortage in many areas of the country. I would be positively fascinated to know how my liberal colleagues might explain this situation.

I wonder if it would ever occur to them that low-tax countries such as the U.S., Hong Kong, Singapore have low unemployment rates, while high-tax countries such as France, Sweden, Germany, Italy, Spain and so many others are wallowing in economies with no economic growth.

The truth is European governments which are successful in implementing the policies of the Democratic party are successful in achieving dreadfully performing economies. It does make one wonder.

REPUBLICAN HEALTH CARE REFORM IS A RUSE

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

Mr. PASCRELL. Madam Speaker, I want to commend the gentleman from Michigan (Mr. DINGELL) and the gentleman from Georgia (Mr. NORWOOD), great Americans, for providing a great service to all of us on a managed care bill which I think will work. But there are Members of this House that are working against this consensus by introducing substitutes that in no way equal the comprehensive approach.

We have heard a great deal of hysteria in the past few weeks about how Norwood/Dingell will expose our small business owners and employers of all shapes and sizes to massive new litigation threats.

If my colleagues read the bill, and I would suggest that they read the bill, on page 99 it says very specifically in Section 302 that the bill ''does not authorize any cause of action against an employer, or other plan sponsor maintaining the group health plan, or against an employee of such an employer.''

It is a ruse. They have provided a ruse. Why do they not tell the American people the truth instead of standing out there with the money changers as they were yesterday as we walked here to do business?

AMERICANS HAVE A CHANCE TO HAVE A ACCOUNTABILITY AGAIN IN HEALTH ORGANIZATIONS

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

Mr. KUYKENDALL. Madam Speaker, today the American people are going to get a chance to have accountability put back in their health care organizations. There are a number of options before us, and at least three of those options are going to give the American public the ability to sue their health plan. They have not had that right in the past. That is an accountability they will have again over the medical profession for medical decisions.

What comes with that is a need to figure out how to protect this employer group that so many of us are dependent upon for our livelihood and health care insurance coverage. I think there are several options today that do a good job at that as well.

Those employers are not meant to be in the medical business, they are meant to be employers, manufacturers, and service providers. In this legislation today, I think we have a couple of options and the public will be well-served when they see the outcome. They will have accountability from their medical providers and their employers will remain sound and still be the conduit through which most people will get their medical coverage.

I would encourage the public to watch today. This debate will be both lengthy and strident. But at the end of the day, they will be better served.

SAFEWAY SHOULD RECOGNIZE ITS CORPORATE RESPONSIBILITY

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

Mr. LANTOS. Madam Speaker, I rise on behalf of the large group of senior, frail, and low-income citizens in my congressional district in the city of Pacifica. They have been shopping at Safeway for decades, but Safeway—in a display of corporate arrogance and irresponsibility—suddenly closed that store.

These folks have no automobiles. They are too frail and too old to walk two miles to another store. Safeway should have found a way to keep open this facility. But in an irresponsible act of corporate recklessness, it closed the store, and the seniors are left high and dry, trying to fend for themselves.

I call on Safeway—a multi-billion-dollar corporation—to change its course and recognize its corporate responsibility. It has the duty to serve the people who have kept it profitable for decades. It can't just walk out on them.

THE JOURNAL

The SPEAKER pro tempore. Pursuant to clause 8, rule XX, the pending business is the question of the Speaker's approval of the Journal.

The question is on the Speaker's approval of the Journal of the last day's proceedings.

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

Ms. DEGETTE. Madam 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 341, nays 73, not voting 19, as follows:

[Roll No. 486]

YEAS—341

Ackerman	Campbell	Emerson
Andrews	Canady	Engel
Archer	Cannon	Eshoo
Armey	Capps	Everett
Bachus	Cardin	Ewing
Baird	Carson	Farr
Baker	Castle	Fattah
Baldwin	Chabot	Fletcher
Ballenger	Chambliss	Foley
Barcia	Clayton	Forbes
Barrett (NE)	Coble	Fossella
Barrett (WI)	Coburn	Fowler
Bartlett	Collins	Frank (MA)
Barton	Combest	Franks (NJ)
Bass	Condit	Frelinghuysen
Bateman	Conyers	Gallegly
Becerra	Cook	Ganske
Bentsen	Cooksey	Gejdenson
Bereuter	Cox	Gekas
Berkley	Coyne	Gephardt
Berman	Cramer	Gilchrest
Berry	Cubin	Gillmor
Biggert	Cummings	Gilman
Bilirakis	Cunningham	Gonzalez
Bishop	Danner	Goode
Blagojevich	Davis (FL)	Goodlatte
Bliley	Davis (VA)	Goodling
Blumenauer	Deal	Gordon
Blunt	DeGette	Goss
Boehlert	Delahunt	Graham
Boehner	DeLauro	Granger
Bonilla	DeLay	Green (TX)
Bonior	DeMint	Green (WI)
Bono	Deutsch	Greenwood
Boswell	Diaz-Balart	Hall (OH)
Boucher	Dicks	Hall (TX)
Boyd	Dingell	Hansen
Brady (TX)	Dixon	Hastings (WA)
Brown (FL)	Doggett	Hayes
Brown (OH)	Dooley	Hayworth
Bryant	Doolittle	Herger
Burr	Doyle	Hill (IN)
Burton	Dreier	Hill (MT)
Buyer	Duncan	Hinchey
Callahan	Dunn	Hinojosa
Calvert	Edwards	Hobson
Camp	Ehlers	Hoeffel

Hoekstra	Millender-McDonald	Saxton
Holden	Schakowsky	Scott
Holt	Miller (FL)	Sensenbrenner
Horn	Miller, Gary	Serrano
Hostettler	Minge	Sessions
Houghton	Mink	Shadegg
Hoyer	Mollohan	Shaw
Hunter	Moore	Shays
Hyde	Moran (VA)	Sherman
Inslee	Morella	Sherwood
Isakson	Murtha	Shimkus
Istook	Myrick	Shows
Jackson (IL)	Nadler	Shuster
Jenkins	Napolitano	Simpson
John	Nethercutt	Sisisky
Johnson (CT)	Ney	Skeen
Johnson, Sam	Northup	Skelton
Jones (NC)	Norwood	Smith (MI)
Kanjorski	Nussle	Smith (NJ)
Kasich	Obey	Smith (TX)
Kelly	Olver	Smith (WA)
Kennedy	Ortiz	Snyder
Kildee	Ose	Souder
Kilpatrick	Oxley	Spence
Kind (WI)	Packard	Spratt
King (NY)	Pascrell	Stabenow
Kingston	Pastor	Stearns
Kleczka	Paul	Stump
Klink	Payne	Sununu
Knollenberg	Pease	Sweeney
Kolbe	Peterson (PA)	Talent
Kuykendall	Petri	Tancredo
LaHood	Phelps	Tauscher
Lampson	Pickering	Tauzin
Lantos	Pitts	Taylor (NC)
Larson	Pombo	Terry
Latham	Pomeroy	Thomas
LaTourette	Porter	Thornberry
Lazio	Portman	Thune
Leach	Price (NC)	Tiahrt
Levin	Pryce (OH)	Tierney
Lewis (CA)	Quinn	Toomey
Lewis (KY)	Radanovich	Towns
Lofgren	Rahall	Traficant
Lucas (KY)	Rangel	Turner
Lucas (OK)	Regula	Upton
Maloney (CT)	Reyes	Vitter
Maloney (NY)	Reynolds	Walden
Manzullo	Rivers	Walsh
Markey	Rodriguez	Watkins
Martinez	Roemer	Watt (NC)
Mascara	Rogan	Watts (OK)
Matsui	Rogers	Waxman
McCarthy (MO)	Rohrabacher	Weiner
McCarthy (NY)	Ros-Lehtinen	Weldon (FL)
McCrery	Rothman	Wexler
McHugh	Roukema	Weygand
McInnis	Roybal-Allard	Whitfield
McIntosh	Royce	Wicker
McIntyre	Rush	Wilson
McKeon	Ryan (WI)	Wise
McKinney	Ryun (KS)	Wolf
Meehan	Salmon	Woolsey
Meeks (NY)	Sanchez	Wu
Menendez	Sanders	Wynn
Metcalf	Sandlin	Young (FL)
Mica	Sanford	

NAYS—73

Aderholt	Hilleary	Peterson (MN)
Allen	Hilliard	Pickett
Baldacci	Hooley	Ramstad
Bilbray	Hulshof	Riley
Borski	Hutchinson	Sabo
Brady (PA)	Jackson-Lee (TX)	Schaffer
Capuano	Johnson, E. B.	Slaughter
Chenoweth-Hage	Jones (OH)	Stark
Clay	Kucinich	Stenholm
Clyburn	LaFalce	Strickland
Costello	Lee	Stupak
Crane	Lewis (GA)	Tanner
Crowley	Lipinski	Taylor (MS)
DeFazio	LoBiondo	Thompson (CA)
Dickey	Lowey	Thompson (MS)
English	Luther	Thurman
Etheridge	McDermott	Udall (CO)
Evans	McNulty	Udall (NM)
Filner	Meek (FL)	Velazquez
Frost	Miller, George	Vento
Gibbons	Moran (KS)	Visclosky
Gutierrez	Neal	Wamp
Gutknecht	Oberstar	Waters
Hastings (FL)	Pallone	Weller
Hefley		

NOT VOTING—19

Abercrombie	Davis (IL)	Jefferson
Barr	Ehrlich	Kaptur
Clement	Ford	Largent
Linder	Owens	Weldon (PA)
McCollum	Pelosi	Young (AK)
McGovern	Sawyer	
Moakley	Scarborough	

□ 1106

Ms. JACKSON-LEE of Texas and Mr. DICKEY changed their vote from ''yea'' to ''nay.''

So the Journal was approved.

The result of the vote was announced as above recorded.

BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

The SPEAKER pro tempore (Mrs. BIGGERT). Pursuant to House Resolution 323 and rule XXVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the further consideration of the bill, H.R. 2723.

□ 1107

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 further consideration of the bill (H.R. 2723) to amend Title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, with Mr. HASTINGS of Washington in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. When the Committee of the Whole rose on Wednesday, October 6, 1999, all time for general debate had expired.

Pursuant to the rule, the amendments printed in part A of House Report 106–366 are adopted and the bill, as amended, is considered read for amendment under the 5-minute rule.

The text of H.R. 2723, as amended, is as follows:

H.R. 2723

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Consensus Managed Care Improvement Act of 1999''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievances and Appeals

Sec. 101. Utilization review activities.
Sec. 102. Internal appeals procedures.
Sec. 103. External appeals procedures.
Sec. 104. Establishment of a grievance process.

Subtitle B—Access to Care

Sec. 111. Consumer choice option.
Sec. 112. Choice of health care professional.
Sec. 113. Access to emergency care.
Sec. 114. Access to specialty care.
Sec. 115. Access to obstetrical and gynecological care.
Sec. 116. Access to pediatric care.
Sec. 117. Continuity of care.
Sec. 118. Access to needed prescription drugs.
Sec. 119. Coverage for individuals participating in approved clinical trials.

Subtitle C—Access to Information

Sec. 121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

Sec. 131. Prohibition of interference with certain medical communications.
Sec. 132. Prohibition of discrimination against providers based on licensure.
Sec. 133. Prohibition against improper incentive arrangements.
Sec. 134. Payment of claims.
Sec. 135. Protection for patient advocacy.

Subtitle E—Definitions

Sec. 151. Definitions.
Sec. 152. Preemption; State flexibility; construction.
Sec. 153. Exclusions.
Sec. 154. Coverage of limited scope plans.
Sec. 155. Regulations.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

Sec. 201. Application to group health plans and group health insurance coverage.
Sec. 202. Application to individual health insurance coverage.

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

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 302. ERISA preemption not to apply to certain actions involving health insurance policyholders.

TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986

Sec. 401. Amendments to the Internal Revenue Code of 1986.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

Sec. 501. Effective dates.
Sec. 502. Coordination in implementation.

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

Sec. 601. Health care paperwork simplification.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievance and Appeals

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization

review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for an evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—

(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the case, and in no event later than the deadline specified in subparagraph (B).

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of receipt of the request for prior authorization.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a utilization review program—

(I) receives a request for a prior authorization,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than five business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for prior authorization.

(2) ONGOING CARE.—

(A) CONCURRENT REVIEW.—

(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

(4) FAILURE TO MEET DEADLINE.—In a case in which a group health plan or health insurance issuer fails to make a determination on a claim for benefit under paragraph (1), (2)(A), or (3) by the applicable deadline established under the respective paragraph, the failure shall be treated under this subtitle as a denial of the claim as of the date of the deadline.

(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 113, respectively.

(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the reasons for the denial (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 102; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

(1) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(2) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, means a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

SEC. 102. INTERNAL APPEALS PROCEDURES.

(a) RIGHT OF REVIEW.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

(A) shall provide adequate notice in writing to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied (within the meaning of section 101(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in a manner calculated to be understood by the participant, beneficiary, or enrollee; and

(B) shall afford such a participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity (of not less than 180 days) to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate

individual (with respect to such coverage) of the decision denying the claim.

(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in writing.

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual who—

(i) in a case involving medical judgment, shall be a physician or, in the case of limited scope coverage (as defined in subparagraph (B), shall be an appropriate specialist;

(ii) has been selected by the plan or issuer; and

(iii) did not make the initial denial in the internally appealable decision.

(B) LIMITED SCOPE COVERAGE DEFINED.—For purposes of subparagraph (A), the term ''limited scope coverage'' means a group health plan or health insurance coverage the only benefits under which are for benefits described in section 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)).

(2) TIME LIMITS FOR INTERNAL REVIEWS.—

(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of receipt of the request for internal review.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

(I) receives a request for internal review,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than five business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for review.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

(A) in which the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function; or

(B) described in section 101(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

(2) PROCESS.—Under such procedures—

(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 72 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

(d) WAIVER OF PROCESS.—A plan or issuer may waive its rights for an internal review under subsection (b). In such case the participant, beneficiary, or enrollee involved (and any designee or provider involved) shall be relieved of any obligation to complete the review involved and may, at the option of such participant, beneficiary, enrollee, designee, or provider, proceed directly to seek further appeal through any applicable external appeals process.

SEC. 103. EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent). The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term ''externally appealable decision'' means a denial of claim for benefits (as defined in section 101(f)(2))—

(i) that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental; or

(ii) in which the decision as to whether a benefit is covered involves a medical judgment.

(B) INCLUSION.—Such term also includes a failure to meet an applicable deadline for internal review under section 102.

(C) EXCLUSIONS.—Such term does not include—

(i) specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment; or

(ii) a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 102(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 102, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(4) FILING FEE REQUIREMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan or issuer may condition the use of an external appeal process upon payment to the plan or issuer of a filing fee that does not exceed $25.

(B) EXCEPTION FOR INDIGENCY.—The plan or issuer may not require payment of the filing fee in the case of an individual participant, beneficiary, or enrollee who certifies (in a form and manner specified in guidelines established by the Secretary of Health and Human Services) that the individual is indigent (as defined in such guidelines).

(C) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse or modify the denial of a claim for benefits which is the subject of the appeal.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Except as provided in subparagraph (D), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The applicable authority shall implement procedures—

(i) to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner, and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that all costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be construed as applying to the imposition of a filing fee under subsection (a)(4).

(D) STATE AUTHORITY WITH RESPECT QUALIFIED EXTERNAL APPEAL ENTITY FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in a manner determined by the State to assure an unbiased determination.

(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination. However, nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are specifically excluded under the plan or coverage.

(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the

plan's or issuer's decision is in accordance with the medical needs of the patient involved (as determined by the entity) taking into account, as of the time of the entity's determination, the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraph (D). If the entity determines the decision is in accordance with such needs, the entity shall affirm the decision and to the extent that the entity determines the decision is not in accordance with such needs, the entity shall reverse or modify the decision.

(C) CONSIDERATION OF PLAN OR COVERAGE DEFINITIONS.—In making such determination, the external appeal entity shall consider (but not be bound by) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms.

(D) EVIDENCE.—

(i) IN GENERAL.—An external appeal entity shall include, among the evidence taken into consideration—

(I) the decision made by the plan or issuer upon internal review under section 102 and any guidelines or standards used by the plan or issuer in reaching such decision;

(II) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed; and

(III) the opinion of the individual's treating physician or health care professional.

(ii) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

(I) The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

(II) The results of professional consensus conferences conducted or financed in whole or in part by one or more Government agencies.

(III) Practice and treatment guidelines prepared or financed in whole or in part by Government agencies.

(IV) Government-issued coverage and treatment policies.

(V) Community standard of care and generally accepted principles of professional medical practice.

(VI) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

(VII) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine—

(i) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

(ii) whether an externally appealable decision involves an expedited appeal; and

(iii) for purposes of initiating an external review, whether the internal review process has been completed.

(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to the external appeal entity to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity.

(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

(i) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 72 hours after the time) of requesting an external appeal of the decision;

(iii) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek further review by the courts (or other process) of the external appeal determination.

(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity reverses or modifies the denial of a claim for benefits, the plan or issuer shall—

(i) upon the receipt of the determination, authorize benefits in accordance with such determination;

(ii) take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

(iii) submit information to the entity documenting compliance with the entity's determination and this subparagraph.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term ''qualified external appeal entity'' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

(A) The entity meets the independence requirements of paragraph (3).

(B) The entity conducts external appeal activities through a panel of not fewer than three clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

(D) The entity meets such other requirements as the appropriate Secretary may impose.

(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1)—

(I) by the Secretary of Labor;

(II) under a process recognized or approved by the Secretary of Labor; or

(III) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization (certified under such subparagraph); or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements—

(I) by the applicable State authority (or under a process recognized or approved by such authority); or

(II) if the State has not established a certification and recertification process for such entities, by the Secretary of Health and Human Services, under a process recognized or approved by such Secretary, or to the extent provided in subparagraph (C)(ii), by a qualified private standard-setting organization (certified under such subparagraph).

(B) RECERTIFICATION PROCESS.—The appropriate Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a review of—

(i) the number of cases reviewed;

(ii) a summary of the disposition of those cases;

(iii) the length of time in making determinations on those cases;

(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

(v) such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted.

(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—

(i) FOR EXTERNAL REVIEWS UNDER GROUP HEALTH PLANS.—For purposes of subparagraph (A)(i)(III), the Secretary of Labor may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(i)(I).

(ii) FOR EXTERNAL REVIEWS OF HEALTH INSURANCE ISSUERS.—For purposes of subparagraph (A)(ii)(II), the Secretary of Health and Human Services may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(ii)(II).

(3) INDEPENDENCE REQUIREMENTS.—

(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

(i) the peer or entity does not have a familial, financial, or professional relationship with any related party;

(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

(iii) except as provided in paragraph (4), the plan and the issuer have no recourse against the peer or entity in connection with the external review; and

(iv) the peer or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

(B) RELATED PARTY.—For purposes of this paragraph, the term ''related party'' means—

(i) with respect to—

(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

(ii) the health care professional that provided the health care involved in the coverage decision;

(iii) the institution at which the health care involved in the coverage decision is provided;

(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision; or

(v) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—The determination by an external appeal entity under this section is binding on the plan and issuer involved in the determination.

(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(1) MONETARY PENALTIES.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(A) to cease and desist from the alleged action or failure to act; and

(B) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(3) ADDITIONAL CIVIL PENALTIES.—

(A) IN GENERAL.—In addition to any penalty imposed under paragraph (1) or (2), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(i) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity in violation of the terms of such a plan, coverage, or this title; or

(ii) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or plans or coverage.

(B) STANDARD OF PROOF AND AMOUNT OF PENALTY.—Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice and shall be in an amount not to exceed the lesser of—

(i) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice, or

(ii) $500,000.

(4) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in paragraph (3)(A) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

(2) GRIEVANCE DEFINED.—In this section, the term ''grievance'' means any question, complaint, or concern brought by a participant, beneficiary or enrollee that is not a claim for benefits (as defined in section 101(f)(1)).

(b) GRIEVANCE SYSTEM.—Such system shall include the following components with respect to individuals who are participants, beneficiaries, or enrollees:

(1) Written notification to all such individuals and providers of the telephone numbers and business addresses of the plan or issuer personnel responsible for resolution of grievances and appeals.

(2) A system to record and document, over a period of at least three previous years, all grievances and appeals made and their status.

(3) A process providing for timely processing and resolution of grievances.

(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

Grievances are not subject to appeal under the previous provisions of this subtitle.

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer or arrange to be offered to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such non-network coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)), and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with the guidelines established under section 1852(d)(2) of the Social Security Act), if the services are maintenance care or post-stabilization care covered under such guidelines.

SEC. 114. ACCESS TO SPECIALTY CARE.

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(C) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling, and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

SEC. 115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for coverage of gynecological care (including preventive women's health examinations) and pregnancy-related services provided by a participating health care professional, including a physician, who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(2) shall treat the ordering of other obstetrical or gynecological care by such a participating professional as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of pediatric care.

SEC. 117. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condition

(as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) DEFINITIONS.—For purposes of this section:

(A) ONGOING SPECIAL CONDITION.—The term ''ongoing special condition'' has the meaning given such term in section 114(b)(3), and also includes pregnancy.

(B) TERMINATION.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation, and

(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—If—

(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

If a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

(1) ensure participation of participating physicians and pharmacists in the development of the formulary;

(2) disclose to providers and, disclose upon request under section 121(c)(5) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(3) consistent with the standards for a utilization review program under section 101, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

(1) IN GENERAL.—Under this section a group health plan or health insurance issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

(2) PAYMENT RATE.—In the case of covered items and services provided by—

(A) a participating provider, the payment rate shall be at the agreed upon rate, or

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

(B) A cooperative group or center of the National Institutes of Health.

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) or (c) in printed form.

(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to enrollees, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c) in printed form.

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

(1) SERVICE AREA.—The service area of the plan or issuer.

(2) BENEFITS.—Benefits offered under the plan or coverage, including—

(A) covered benefits, including benefit limits and coverage exclusions;

(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

(C) the extent to which benefits may be obtained from nonparticipating providers;

(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

(3) ACCESS.—A description of the following:

(A) The number, mix, and distribution of providers under the plan or coverage.

(B) Out-of-network coverage (if any) provided by the plan or coverage.

(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

(F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 112(b)(2).

(H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals.

(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan or issuer for obtaining emergency services; and

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(8) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

(9) QUALITY ASSURANCE.—Any information made public by an accrediting organization in the process of accreditation of the plan or issuer or any additional quality indicators the plan or issuer makes available.

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) NOTICE OF REQUIREMENTS.—Notice of the requirements of this title.

(12) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 101, including under any drug formulary program under section 118.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) METHOD OF PHYSICIAN COMPENSATION.—A general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which a specified prospective or treating health care professional is (or would be) compensated in connection with the provision of health care under the plan or coverage.

(4) SPECIFIC INFORMATION ON CREDENTIALS OF PARTICIPATING PROVIDERS.—In the case of each participating provider, a description of the credentials of the provider.

(5) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

(6) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(b) CONSTRUCTION.—Subsection (a) shall not be construed—

(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

(2) to override any State licensure or scope-of-practice law; or

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section

1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

(B) the professional reasonably believes the information to be true;

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ''protected health care professional'' means an individual who is a licensed or certified health care professional and who—

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) ACTIVELY PRACTICING.—The term ''actively practicing'' means, with respect to a physician or other health care professional, such a physician or professional who provides professional services to individual patients on average at least two full days per week.

(2) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this title, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(3) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, an actively practicing physician (allopathic or osteopathic) or other actively practicing health care professional who holds a nonrestricted license, and who is appropriately credentialed in the same or similar specialty or subspecialty (as appropriate) as typically handles the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician (allopathic or osteopathic) may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

(4) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(5) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974 and in section 2791(a)(1) of the Public Health Service Act.

(6) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(8) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(9) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(10) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(11) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this title 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 or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title 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) 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 District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to provide items and services (including abortions) that are specifically excluded under the plan or coverage.

(b) EXCLUSION FROM ACCESS TO CARE MANAGED CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

(1) IN GENERAL.—The provisions of sections 111 through 117 shall not apply to a group health plan or health insurance coverage if the only coverage offered under the plan or coverage is fee-for-service coverage (as defined in paragraph (2)).

(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term ''fee-for-service coverage'' means coverage under a group health plan or health insurance coverage that—

(A) reimburses hospitals, health professionals, and other providers on the basis of a rate determined by the plan or issuer on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing coverage for any services.

SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

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

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 112 (relating to choice of providers).

''(B) Section 113 (relating to access to emergency care).

''(C) Section 114 (relating to access to specialty care).

''(D) Section 115 (relating to access to obstetrical and gynecological care).

''(E) Section 116 (relating to access to pediatric care).

''(F) Section 117(a)(1) (relating to continuity in case of termination of provider contract) and section 117(a)(2) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(G) Section 118 (relating to access to needed prescription drugs).

''(H) Section 119 (relating to coverage for individuals participating in approved clinical trials.)

''(I) Section 134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the internal appeals process and the grievance system required to be established under sections 102 and 104, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 103, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 131 (relating to prohibition of interference with certain medical communications).

''(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 133 (relating to prohibition against improper incentive arrangements).

''(D) Section 135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICYHOLDERS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsections:

''(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

''(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan as defined in section 733), or

''(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

''(B) LIMITATION ON PUNITIVE DAMAGES.—

''(i) IN GENERAL.—No person shall be liable for any punitive, exemplary, or similar damages in the case of a cause of action brought under subparagraph (A) if—

''(I) it relates to an externally appealable decision (as defined in subsection (a)(2) of section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999);

''(II) an external appeal with respect to such decision was completed under such section 103;

''(III) in the case such external appeal was initiated by the plan or issuer filing the request for the external appeal, the request was filed on a timely basis before the date the action was brought or, if later, within 30 days after the date the externally appealable decision was made; and

''(IV) the plan or issuer complied with the determination of the external appeal entity upon receipt of the determination of the external appeal entity.

The provisions of this clause supersede any State law or common law to the contrary.

''(ii) EXCEPTION.—Clause (i) shall not apply with respect to damages in the case of a cause of action for wrongful death if the applicable State law provides (or has been construed to provide) for damages in such a cause of action which are only punitive or exemplary in nature.

''(C) PERSONAL INJURY DEFINED.—For purposes of this subsection, the term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(2) EXCEPTION FOR GROUP HEALTH PLANS, EMPLOYERS, AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

''(i) any cause of action against a group health plan or an employer or other plan sponsor maintaining the plan (or against an employee of such a plan, employer, or sponsor acting within the scope of employment), or

''(ii) a right of recovery, indemnity, or contribution by a person against a group health plan or an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) against group health plan or an employer or other plan sponsor (or against an employee of such a plan, employer, or sponsor acting within the scope of employment) if—

''(i) such action is based on the exercise by the plan, employer, or sponsor (or employee) of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the exercise by the plan, employer, or sponsor (or employee) of such authority resulted in personal injury or wrongful death.

''(C) EXCEPTION.—The exercise of discretionary authority described in subparagraph (B)(i) shall not be construed to include—

''(i) the decision to include or exclude from the plan any specific benefit;

''(ii) any decision to provide extra-contractual benefits; or

''(iii) any decision not to consider the provision of a benefit while internal or external review is being conducted.

''(3) FUTILITY OF EXHAUSTION.—An individual bringing an action under this subsection is required to exhaust administrative processes under sections 102 and 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999, unless the injury to or death of such individual has occurred before the completion of such processes.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) permitting a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan involved;

''(B) as preempting a State law which requires an affidavit or certificate of merit in a civil action; or

''(C) permitting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as defined in section 733(c)), other than those described in section 733(c)(2)(A).

''(f) RULES OF CONSTRUCTION RELATING TO HEALTH CARE.—Nothing in this title shall be construed as—

''(1) permitting the application of State laws that are otherwise superseded by this title and that mandate the provision of specific benefits by a group health plan (as defined in section 733(a)) or a multiple employer welfare arrangement (as defined in section 3(40)), or

''(2) affecting any State law which regulates the practice of medicine or provision of medical care, or affecting any action based upon such a State law.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

SEC. 303. LIMITATIONS ON ACTIONS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) Except as provided in this subsection, no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 101, subtitle B, or subtitle D of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as incorporated under section 714).

''(2) An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of section 101, 113, 114, 115, 116, 117, 119, or 118(3) of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action, relief may only provide for the provision of (or payment of) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) Nothing in this subsection shall be construed as affecting any action brought by the Secretary.''.

TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to patient freedom of choice.'';

and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

''A group health plan shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, 303, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2001 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one 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 sections 201(a), 301, 303, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last 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) the general effective date.

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 Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury 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 such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) 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.

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Bipartisan Consensus Managed Care Improvement Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(C) CONTRACT AUTHORITY.—The Panel may contract with and compensate Government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection (a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

The CHAIRMAN. No further amendment is in order except those printed in part B of the report. Each amendment may be offered only in the order printed, may be offered only by a Member designated in the report, shall be considered read, debatable for the time specified in the report, equally divided and controlled by the proponent and an opponent, and shall not be subject to amendment.

The Chairman of the Committee of the Whole may postpone a request for a recorded vote on any amendment and may reduce to a minimum of 5 minutes the time for voting on any postponed question that immediately follows another vote, provided that the time for voting on the first question shall be a minimum of 15 minutes.

It is now in order to consider amendment No. 1 printed in part B of House Report 106–366.

AMENDMENT NO. 1 IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. BOEHNER

Mr. BOEHNER. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment No. 1 in the nature of a substitute offered by Mr. BOEHNER:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Access and Responsibility in Health Care Act of 1999''.

(b) TABLE OF CONTENTS.—The table of contents is as follows:

Sec. 1. Short title and table of contents.

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

Subtitle A—Patient Protections

Sec. 101. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.

Sec. 102. Required disclosure to network providers.

Sec. 103. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 111. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.-

Sec. 112. Effective date and related rules.

Subtitle C—Group Health Plan Review Standards

Sec. 121. Special rules for group health plans.

Sec. 122. Special rule for access to specialty care.

Sec. 123. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

Sec. 124. Effective date.

Subtitle E—Health Care Access, Affordability, and Quality Commission

Sec. 131. Establishment of commission.

Sec. 132. Effective date.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Sec. 201. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.

Sec. 202. Requiring health maintenance organizations to offer option of point-of-service coverage.

Sec. 203. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 211. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 212. Effective date and related rules.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Sec. 301. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 401. Federal reform of health care liability actions.

Sec. 402. Definitions.

Sec. 403. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 411. Statute of limitations.

Sec. 412. Calculation and payment of damages.

Sec. 413. Alternative dispute resolution.

Sec. 414. Reporting on fraud and abuse enforcement activities.

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

Subtitle A—Patient Protections

SEC. 101. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the sponsor of a group health plan or a health insurance issuer offering health insurance coverage in connection with the group health plan to engage in any practice that would violate its religious beliefs or moral convictions.

''(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) COVERAGE OF EMERGENCY SERVICES.—

''(A) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to emergency services (as defined in subparagraph (B)(ii)), or ambulance services, the plan or issuer shall cover emergency services (including emergency ambulance services as defined in subparagraph (B)(iii)) furnished under the plan or coverage—

''(i) without the need for any prior authorization determination;

''(ii) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

''(iii) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider; and

''(iv) without regard to any other term or condition of such plan or coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 701 and other than applicable cost sharing).

''(B) DEFINITIONS.—In this subsection:

''(i) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(I) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)); and

''(II) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(ii) EMERGENCY SERVICES.—The term 'emergency services' means—

''(I) with respect to an emergency medical condition described in clause (i)(I), a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd)) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in clause (i)) and also, within the capabilities of the staff and facilities at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(II) with respect to an emergency medical condition described in clause (i)(II), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(iii) EMERGENCY AMBULANCE SERVICES.—The term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in clause (i)) to a hospital for the receipt of emergency services (as defined in clause (ii)) in a case in which appropriate emergency medical screening examinations

are covered under the plan or coverage pursuant to paragraph (1)(A) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''(iv) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(v) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or under group health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(vi) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage offered by a health insurance issuer in connection with such a plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(c) PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) gynecological care (such as preventive women's health examinations); or

''(ii) obstetric care (such as pregnancy-related services),

provided by a participating health care professional who specializes in such care (or provides benefits consisting of payment for such care); and

''(B) requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a health care professional, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

''(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits; and

''(B) treats the ordering of other care of the same type, by the participating health care professional providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

''(3) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse midwife or nurse practitioner) who is licensed, accredited, or certified under State law to provide obstetric and gynecological health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform obstetric and gynecological health care services. Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(5) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(d) PATIENT RIGHT TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating health care professional who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating health care professional may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse practitioner) who is licensed, accredited, or certified under State law to provide pediatric health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform pediatric health care services. Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care so ordered.

''(4) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(e) CONTINUITY OF CARE.—

''(1) IN GENERAL.—

''(A) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, and a health care provider is terminated (as defined in subparagraph (D)(ii)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who, at the time of such termination, is a participant or beneficiary in the plan and is scheduled to undergo surgery (including an organ transplantation), is undergoing treatment for pregnancy, or is determined to be terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act) and is undergoing treatment for the terminal illness, the plan or issuer shall—

''(i) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this subsection; and

''(ii) subject to paragraph (3), permit the individual to elect to continue to be covered with respect to treatment by the provider for such surgery, pregnancy, or illness during a transitional period (provided under paragraph (2)).

''(B) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of subparagraph (A) (and the succeeding provisions of this subsection) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(C) TERMINATION DEFINED.—For purposes of this subsection, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(2) TRANSITIONAL PERIOD.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this paragraph shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

''(B) SCHEDULED SURGERY.—If surgery was scheduled for an individual before the date of the announcement of the termination of the provider status under paragraph (1)(A)(i), the transitional period under this paragraph with respect to the surgery shall extend beyond the period under subparagraph (A) and until the date of discharge of the individual after completion of the surgery.

''(C) PREGNANCY.—If—

''(i) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(ii) the provider was treating the pregnancy before date of the termination,

the transitional period under this paragraph with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(D) TERMINAL ILLNESS.—If—

''(i) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination, the transitional period under this paragraph shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under paragraph (1)(A)(i) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(A) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in paragraph (1)(B),

at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in paragraph (1)(A) had not been terminated.

''(B) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under subparagraph (A) and to provide to such plan or issuer necessary medical information related to the care provided.

''(C) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(D) The provider agrees to provide transitional care to all participants and beneficiaries who are eligible for and elect to have coverage of such care from such provider.

''(E) If the provider initiates the termination, the provider has notified the plan within 30 days prior to the effective date of the termination of—

''(i) whether the provider agrees to permissible terms and conditions (as set forth in this paragraph) required by the plan, and

''(ii) if the provider agrees to the terms and conditions, the specific plan beneficiaries and participants undergoing a course of treatment from the provider who the provider believes, at the time of the notification, would be eligible for transitional care under this subsection.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) require the coverage of benefits which would not have been covered if the provider involved remained a participating provider, or

''(B) prohibit a group health plan from conditioning a provider's participation on the provider's agreement to provide transitional care to all participants and beneficiaries eligible to obtain coverage of such care furnished by the provider as set forth under this subsection.

''(f) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.—

''(1) COVERAGE.—

''(A) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides coverage to a qualified individual (as defined in paragraph (2)), the plan or issuer—

''(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

''(ii) subject to paragraphs (2), (3), and (4), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(iii) may not discriminate against the individual on the basis of the participation of the participant or beneficiary in such trial.

''(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(A)(i) The individual has been diagnosed with cancer.

''(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer.

''(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(B) Either—

''(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon satisfaction by the individual of the conditions described in subparagraph (A); or

''(ii) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the satisfaction by the individual of the conditions described in subparagraph (A).

''(3) PAYMENT.—

''(A) IN GENERAL.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) shall provide for payment for routine patient costs described in paragraph (1)(B) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(B) ROUTINE PATIENT CARE COSTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'routine patient care costs' shall include the costs associated with the provision of items and services that—

''(I) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(II) are furnished according to the protocol of an approved clinical trial program.

''(ii) EXCLUSION.—For purposes of this paragraph, 'routine patient care costs' shall not include the costs associated with the provision of—

(I) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

(II) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(C) PAYMENT RATE.—For purposes of this subsection—

''(i) PARTICIPATING PROVIDERS.—In the case of covered items and services provided by a participating provider, the payment rate shall be at the agreed upon rate.

''(ii) NONPARTICIPATING PROVIDERS.—In the case of covered items and services provided by a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under clause (i).

''(4) APPROVED CLINICAL TRIAL DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

''(B) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's coverage with respect to clinical trials.

''(6) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(A) IN GENERAL.—For purposes of this subsection, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this subsection with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4.

''(7) STUDY AND REPORT.—

''(A) STUDY.—The Secretary shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(i) the cost of patient care in trials versus standard care;

''(ii) the cost effectiveness achieved in different sites of service;

''(iii) research outcomes;

''(iv) volume of research subjects available in different sites of service;

''(v) access to research sites and clinical trials by cancer patients;

''(vi) patient cost sharing or copayment costs realized in different sites of service;

''(vii) health outcomes experienced in different sites of service;

''(viii) long term health care services and costs experienced in different sites of service;

''(ix) morbidity and mortality experienced in different sites of service; and

''(x) patient satisfaction and preference of sites of service.

''(B) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains—

''(i) an assessment of any incremental cost to group health plans resulting from the provisions of this section;

''(ii) a projection of expenditures to such plans resulting from this section;

''(iii) an assessment of any impact on premiums resulting from this section; and

''(iv) recommendations regarding action on other diseases.''.

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

''Sec. 714. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.''.

SEC. 102. REQUIRED DISCLOSURE TO NETWORK PROVIDERS.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by section 101) is amended further by adding at the end the following new section:

"SEC. 715. REQUIRED DISCLOSURE TO NETWORK PROVIDERS.

''(a) IN GENERAL.—If a group health plan reimburses, through a contract or other arrangement, a health care provider at a discounted payment rate because the provider participates in a provider network, the plan shall disclose to the provider the following information before the provider furnishes covered items or services under the plan:

''(1) The identity of the plan sponsor or other entity that is to utilize the discounted payment rates in reimbursing network providers in that network.

''(2) The existence of any substantial benefit differentials established for the purpose of actively encouraging participants or beneficiaries under the plan to utilize the providers in that network.

''(3) The methods and materials by which providers in the network are identified to such participants or beneficiaries as part of the network.

''(b) PERMITTED MEANS OF DISCLOSURE.—Disclosure required under subsection (a) by a plan may be made—

''(1) by another entity under a contract or other arrangement between the plan and the entity; and

''(2) by making such information available in written format, in an electronic format, on the Internet, or on a proprietary computer network which is readily accessible to the network providers.

''(c) CONSTRUCTION.—Nothing in this section shall be construed to require, directly or indirectly, disclosure of specific fee arrangements or other reimbursement arrangements—

''(1) between (i) group health plans or provider networks and (ii) health care providers, or

''(2) among health care providers.

''(d) DEFINITIONS.—For purposes of this subsection:

''(1) BENEFIT DIFFERENTIAL.—The term 'benefit differential' means, with respect to a group health plan, differences in the case of any participant or beneficiary, in the financial responsibility for payment of coinsurance, copayments, deductibles, balance billing requirements, or any other charge, based upon whether a health care provider from whom covered items or services are obtained is a network provider.

''(2) DISCOUNTED PAYMENT RATE.—The term 'discounted payment rate' means, with respect to a provider, a payment rate that is below the charge imposed by the provider.

''(3) NETWORK PROVIDER.—The term 'network provider' means, with respect to a group health plan, a health care provider that furnishes health care items and services to participants or beneficiaries under the plan pursuant to a contract or other arrangement with a provider network in which the provider is participating.

''(4) PROVIDER NETWORK.—The term 'provider network' means, with respect to a group health plan offering health insurance coverage, an association of network providers through whom the plan provides, through contract or other arrangement, health care items and services to participants and beneficiaries.''.

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

''Sec. 715. Required disclosure to network providers.''.

SEC. 103. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this subtitle before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one 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 subtitle shall not apply with respect to plan years beginning before the later of—

(1) 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

(2) January 1, 2002.

For purposes of this subsection, 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 subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 111. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

''DISCLOSURE BY GROUP HEALTH PLANS

''SEC. 111. (a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program); and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes an investigational item or experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(3) NETWORK CHARACTERISTICS.—If the plan (or health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions;

''(B) internal review of coverage decisions; and

''(C) any external review of coverage decisions; and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION ON PLAN PERFORMANCE.—Any information required under subsection (a) shall include information concerning the number of external reviews under section 503 that have been completed during the prior plan year and the number of such reviews in which a recommendation is made for modification or reversal of an internal review decision under the plan.

''(f) INFORMATION INCLUDED WITH ADVERSE COVERAGE DECISIONS.—A group health plan shall provide to each participant and beneficiary, together with any notification of the participant or beneficiary of an adverse coverage decision, the following information:

''(1) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—A description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in the adverse coverage decision.

''(2) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR ON INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENTS.—If the adverse coverage decision is based on a determination relating to medical necessity or to an investigational item or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(g) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan may, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format—

''(i) the latest summary plan description, including the latest summary of material modifications, and

''(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

''(i) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(ii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iii) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

''(iv) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS.—

''(i) QUALIFICATIONS, PRIVILEGES, AND METHOD OF COMPENSATION.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(ii) COST OF PROCEDURES.—Any health care professional who recommends an elective procedure or treatment while treating a participant or beneficiary under a group health plan that requires a participant or beneficiary to share in the cost of treatment shall inform such participant or beneficiary of each cost associated with the procedure or treatment and an estimate of the magnitude of such costs.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(h) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(i) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations;

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants);

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification; or

''(4) by any other reasonable means of timely informing plan participants.

''(j) DEFINITIONS AND RELATED RULES.—

''(1) IN GENERAL.—For purposes of this section—

''(A) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 733(a)(1).

''(B) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

''(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(D) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).

''(2) APPLICABILITY ONLY IN CONNECTION WITH INCLUDED GROUP HEALTH PLAN BENEFITS.—

''(A) IN GENERAL.—The requirements of this section shall apply only in connection with included group health plan benefits.

''(B) INCLUDED GROUP HEALTH PLAN BENEFIT.—For purposes of subparagraph (A), the term 'included group health plan benefit' means a benefit which is not an excepted benefit (as defined in section 733(c)).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended by inserting before the period at the end the following: ''; and, in the case of a group health plan (as defined in section 112(j)(1)(A)) providing included group health plan benefits (as defined in section 111(j)(2)(B)), the information required to be included under section 111(a)''.

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

''Sec. 111. Disclosure by group health plans.
''Sec. 112. Repeal and effective date.''.

SEC. 112. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan

years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

Subtitle C—Group Health Plan Review Standards

SEC. 121. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.'';

(2) by inserting (after and below paragraph (2)) the following new flush-left sentence:

''This subsection does not apply in the case of included group health plan benefits (as defined in subsection (b)(10)(S)).''; and

(3) by adding at the end the following new subsection:

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) COVERAGE DETERMINATIONS.—Every group health plan shall, in the case of included group health plan benefits—

''(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to such benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the average participant;

''(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision;

''(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 90 days after receipt of the notice of the initial decision, for a full and fair review of the decision by an appropriate named fiduciary who did not make the initial decision; and

''(D) meet the additional requirements of this subsection, which shall apply solely with respect to such benefits.

''(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

''(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

''(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (10)(I) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO ACCELERATED NEED MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

''(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan before the end of the accelerated need decision period under paragraph (10)(K), in cases involving accelerated need medical care, following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision before the end of the accelerated need decision period under paragraph (10)(K) following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

''(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the requirements for medical appropriateness or necessity or would constitute provision of investigational items or experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to investigational items or experimental treatment or technology, shall be conducted by a physician who is selected by the plan and who did not make the initial denial.

''(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(A) IN GENERAL.—In any case in which a participant or beneficiary, who has received an adverse coverage decision which is not reversed upon review conducted pursuant to paragraph (1)(C) (including review under paragraph (2)(A)(ii) or (2)(B)(ii)) and who has not commenced review of the coverage decision under section 502, makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the requirements of subparagraphs (B), (C), (D) and (E) shall apply in the case of such adverse coverage decision, if the requirements of clause (i) or (ii) are met, subject to clause (iii).

''(i) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEM OR EXPERIMENTAL TREATMENT OR TECHNOLOGY.—The requirements of this clause are met if such coverage decision is based on a determination that provision of a particular item or service that would otherwise be covered is excluded from coverage because the provision of such item or service—

''(I) is not medically appropriate or necessary; or

''(II) would constitute provision of an investigational item or experimental treatment or technology.

''(ii) EXCLUSION OF ITEM OR SERVICE REQUIRING EVALUATION OF MEDICAL FACTS OR EVIDENCE.—The requirements of this clause are met if—

''(I) such coverage decision is based on a determination that a particular item or service is not covered under the terms of the plan because provision of such item or service is specifically or categorically excluded from coverage under the terms of the plan, and

''(II) an independent contract expert finds under subparagraph (C), in advance of any review of the decision under subparagraph (D), that such determination primarily requires the evaluation of medical facts or medical evidence by a health professional.

''(iii) MATTERS SPECIFICALLY NOT SUBJECT TO REVIEW.—The requirements of subparagraphs (B), (C), (D), and (E) shall not apply in the case of any adverse coverage decision if such decision is based on—

''(I) a determination of eligibility for benefits,

''(II) the application of explicit plan limits on the number, cost, or duration of any benefit, or

''(III) a limitation on the amount of any benefit payment or a requirement to make copayments under the terms of the plan.

Review under this paragraph shall not be available for any coverage decision that has previously undergone review under this paragraph.

''(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

''(i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or

''(ii) $25,

with such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in

part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert (or panel of such experts) under subparagraph (D)(ii)(IV) is to reverse or modify the coverage decision.

''(C) REQUEST TO INDEPENDENT CONTRACT EXPERT FOR DETERMINATION OF WHETHER COVERAGE DECISION REQUIRED EVALUATION OF MEDICAL FACTS OR EVIDENCE.—

''(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of subparagraph (A)(ii) are met (and review is not otherwise precluded under subparagraph (A)(iii)), the terms of the plan shall provide for a procedure for initial review by an independent contract expert selected in accordance with subparagraph (H) under which the expert will determine whether the coverage decision requires the evaluation of medical facts or evidence by a health professional. If the expert determines that the coverage decision requires such evaluation, reconsideration of such adverse decision shall proceed under this paragraph. If the expert determines that the coverage decision does not require such evaluation, the adverse decision shall remain the final decision of the plan.

''(ii) INDEPENDENT CONTRACT EXPERTS.—For purposes of this subparagraph, the term 'independent contract expert' means a professional—

''(I) who has appropriate credentials and has attained recognized expertise in the applicable area of contract interpretation;

''(II) who was not involved in the initial decision or any earlier review thereof; and

''(III) who is selected in accordance with subparagraph (H)(i) and meets the requirements of subparagraph (H)(iii).

''(D) RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of subparagraph (A)(i) are met or reconsideration proceeds under this paragraph pursuant to subparagraph (C), the terms of the plan shall provide for a procedure for such reconsideration in accordance with clause (ii).

''(ii) PROCEDURE FOR RECONSIDERATION.—The procedure required under clause (i) shall include the following—

''(I) An independent medical expert (or a panel of such experts, as determined necessary) will be selected in accordance with subparagraph (H) to reconsider any coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title.

''(II) The record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert (or panel) and maintained in a manner which will ensure confidentiality of such record.

''(III) Such expert (or panel) will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title. The expert (or panel) in its reconsideration will take into account the medical condition of the patient, the recommendation of the treating physician, the initial coverage decision (including the reasons for such decision) and the decision upon review conducted pursuant to paragraph (1)(C) (including review under paragraph (2)(A)(ii) or (2)(B)(ii)) , any guidelines adopted by the plan through a process involving medical practitioners and peer-reviewed medical literature identified as such under criteria established by the Food and Drug Administration, and any other valid, relevant, scientific or clinical evidence the expert (or panel) determines appropriate for its review. The expert (or panel) may consult the participant or beneficiary, the treating physician, the medical director of the plan, or any other party who, in the opinion of the expert (or panel), may have relevant information for consideration.

''(E) ISSUANCE OF BINDING FINAL DECISION.—Upon completion of the procedure for review under subparagraph (D), the independent medical expert (or panel of such experts) shall issue a written decision affirming, modifying, or reversing the initial review decision, setting forth the grounds for the decision. Such decision shall be the final decision of the plan and shall be binding on the plan. Such decision shall set forth specifically the determination of the expert (or panel) of the appropriate period for timely compliance by the plan with the decision. Such decision shall be issued concurrently to the participant or beneficiary, to the treating physician, and to the plan, shall constitute conclusive, written authorization for the provision of benefits under the plan in accordance with the decision, and shall be treated as terms of the plan for purposes of any action by the participant or beneficiary under section 502.

''(F) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph (including any review under subparagraph (C)) shall be completed before the end of the reconsideration period (as defined in paragraph (10)(L)) following the review filing date in connection with such review. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

''(G) INDEPENDENT MEDICAL EXPERTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

''(I) who is a physician or, if appropriate, another medical professional,

''(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

''(III) who was not involved in the initial decision or any earlier review thereof,

''(IV) who has no history of disciplinary action or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, health carrier, government, or regulatory body, and

''(V) who is selected in accordance with subparagraph (H)(i) and meets the requirements of subparagraph (H)(iii).

''(H) SELECTION OF EXPERTS.—

''(i) IN GENERAL.—An independent contract expert or independent medical expert (or each member of any panel of independent medical experts selected under subparagraph (D)(ii)) is selected in accordance with this clause if—

''(I) the expert is selected by an intermediary which itself meets the requirements of clauses (ii) and (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert;

''(II) the expert is selected by an appropriately credentialed panel of physicians meeting the requirements of clauses (ii) and (iii) established by a fully accredited teaching hospital meeting such requirements;

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of clauses (ii) and (iii);

''(IV) the expert is selected by an external review organization which meets the requirements of clauses (ii) and (iii) and is accredited by a private standard-setting organization meeting such requirements;

''(V) the expert is selected by a State agency which is established for the purpose of conducting independent external reviews and which meets the requirements of clauses (ii) and (iii); or

''(VI) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence, and the method of selection is devised to reasonably ensure that the expert selected meets the requirements of clauses (ii) and (iii).

''(ii) STANDARDS OF PERFORMANCE FOR INTERMEDIARIES.—The Secretary shall prescribe by regulation standards (in addition to the requirements of clause (iii)) which entities making selections under subclause (I), (II), (III), (IV), (V), or (VI) of clause (ii) must meet in order to be eligible for making such selections. Such standards shall include (but are not limited to)—

''(I) assurance that the entity will carry out specified duties in the course of exercising the entity's responsibilities under clause (i)(I),

''(II) assurance that applicable deadlines will be met in the exercise of such responsibilities, and

''(III) assurance that the entity meets appropriate indicators of solvency and fiscal integrity.

Each such entity shall provide to the Secretary, in such manner and at such times as the Secretary may prescribe, information relating the volume of claims with respect to which the entity has served under this subparagraph, the types of such claims, and such other information regarding such claims as the Secretary may determine appropriate.

''(iii) INDEPENDENCE REQUIREMENTS.—An independent contract expert or independent medical expert or another entity described in clause (i) meets the independence requirements of this clause if—

''(I) the expert or entity is not affiliated with any related party;

''(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity;

''(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review; and

''(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

''(iv) RELATED PARTY.—For purposes of clause (i)(I), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer);

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision;

''(III) the institution at which the medical care involved in the coverage decision is provided;

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision; or

''(V) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

''(v) AFFILIATED.—For purposes of clause (ii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(I) MISBEHAVIOR BY EXPERTS.—Any action by the expert or experts in applying for their selection under this paragraph or in the course of carrying out their duties under this paragraph which constitutes—

''(i) fraud or intentional misrepresentation by such expert or experts, or

''(ii) demonstrates failure to adhere to the standards for selection set forth in subparagraph (H)(iii),

shall be treated as a failure to meet the requirements of this paragraph and therefore as a cause of action which may be brought by a fiduciary under section 502(a)(3).

''(J) BENEFIT EXCLUSIONS MAINTAINED.—Nothing in this paragraph shall be construed as providing for or requiring the coverage of items or services for which benefits are specifically excluded under the group health plan or any health insurance coverage offered in connection with the plan.

''(5) PERMITTED ALTERNATIVES TO REQUIRED FORMS OF REVIEW.—

''(A) IN GENERAL.—In accordance with such regulations (if any) as may be prescribed by the Secretary for purposes of this paragraph, in the case of any initial coverage decision or any decision upon review thereof under paragraph (2)(A)(ii) or (2)(B)(ii), a group health plan may provide an alternative dispute resolution procedure meeting the requirements of subparagraph (B) for use in lieu of the procedures set forth under the preceding provisions of this subsection relating review of such decision. Such procedure may be provided in one form for all participants and beneficiaries or in a different form for each group of similarly situated participants and beneficiaries. Upon voluntary election of such procedure by the plan and by the aggrieved participant or beneficiary in connection with the decision, the plan may provide under such procedure (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) for waiver of the review of the decision under paragraph (3) or waiver of further review of the decision under paragraph (4) or section 502 or for election by such parties of an alternative means of external review (other than review under paragraph (4)).

''(B) REQUIREMENTS.—An alternative dispute resolution procedure meets the requirements of this subparagraph, in connection with any decision, if—

''(i) such procedure is utilized solely—

''(I) in accordance with the applicable terms of a bona fide collective bargaining agreement pursuant to which the plan (or the applicable portion thereof governed by the agreement) is established or maintained, or

''(II) upon election by both the aggrieved participant or beneficiary and the plan,

''(ii) the procedure incorporates any otherwise applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures); and

''(iii) the means of resolution of dispute allow for adequate presentation by each party of scientific and medical evidence supporting the position of such party.

''(6) REVIEW REQUIREMENTS.—In any review of a decision issued under this subsection—

''(A) the record shall be maintained for purposes of any further review in accordance with standards which shall be prescribed in regulations of the Secretary designed to facilitate such further review, and

''(B) any decision upon review which modifies or reverses a decision below shall specifically set forth a determination that the record upon review is sufficient to rebut a presumption in favor of the decision below.

''(7) COMPLIANCE WITH FIDUCIARY STANDARDS.—The issuance of a decision under a plan upon review in good faith compliance with the requirements of this subsection shall not be treated as a violation of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(8) LIMITATION ON APPLICABILITY OF SPECIAL RULES.—The provisions of this subsection shall not apply with respect to employee benefit plans that are not group health plans or with respect to benefits that are not included group health plan benefits (as defined in paragraph (10)(S)).

''(9) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

''(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

''(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

''(10) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by, or (if expressly authorized) on behalf of, a participant or beneficiary after such medical care has been provided.

''(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

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

''(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by, or (if expressly authorized) on behalf of, a participant or beneficiary before such medical care is provided.

''(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes accelerated need medical care.

''(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

''(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes accelerated need medical care.

''(H) ACCELERATED NEED MEDICAL CARE.—The term 'accelerated need medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that the participant or beneficiary is stabilized and—

''(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

''(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

''(II) serious impairment to bodily functions; or

''(III) serious dysfunction of any bodily organ or part; or

''(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

''(I) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such period as may be prescribed in regulations of the Secretary.

''(J) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of 30 days, or such period as may be prescribed in regulations of the Secretary.

''(K) ACCELERATED NEED DECISION PERIOD.—The term 'accelerated need decision period' means a period of 3 days, or such period as may be prescribed in regulations of the Secretary.

''(L) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such period as may be prescribed in regulations of the Secretary, except that, in the case of a decision involving accelerated need medical care, such term means the accelerated need decision period.

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

''(N) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or panel of such experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

''(O) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

''(P) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

''(Q) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

''(R) WRITTEN OR IN WRITING.—

''(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a

generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

''(ii) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.

''(S) INCLUDED GROUP HEALTH PLAN BENEFIT.—The term 'included group health plan benefit'' means a benefit under a group health plan which is not an excepted benefit (as defined in section 733(c)).''.

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A)(i) In the case of any failure to timely provide an included group health plan benefit (as defined in section 503(b)(10)(S)) to a participant or beneficiary, which occurs after the issuance of, and in violation of, a final decision rendered upon completion of external review (under section 503(b)(4)) of an adverse coverage decision by the plan relating to such benefit, any person acting in the capacity of a fiduciary of the plan so as to cause such failure may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

''(ii) Except as provided in clause (iii), such civil penalty shall be in an amount of up to $1,000 a day from the date that occurs on or after the date of the issuance of the decision under section 503(b)(4) and upon which the plan otherwise could have been reasonably expected to commence compliance with the decision until the date the failure to provide the benefit is corrected.

''(iii) In any case in which it is proven by clear and convincing evidence that the person referred to in clause (i) acted willfully and in bad faith, the daily penalty under clause (ii) shall be increased to an amount of up to $5,000 a day.

''(iv) In any case in which it is further proven by clear and convincing evidence that—

''(I) the plan is not in full compliance with the decision of the independent medical expert (or panel of such experts) under section 503(b)(4)(E)) within the appropriate period specified in such decision, and

''(II) the failure to be in full compliance was caused by the plan or by a health insurance issuer offering health insurance coverage in connection with the plan,

the plan shall pay the cost of all medical care which was not provided by reason of such failure to fully comply and which is otherwise obtained by the participant or beneficiary from any provider.

''(B) For purposes of subparagraph (A), the plan, and any health insurance issuer offering health insurance coverage in connection with the plan, shall be deemed to be in compliance with any decision of an independent medical expert (or panel of such experts) under section 503(b)(4) with respect to any participant or beneficiary upon transmission to such entity (or panel) and to such participant or beneficiary by the plan or issuer of timely notice of an authorization of coverage by the plan or issuer which is consistent with such decision.

''(C) In any action commenced under subsection (a) by a participant or beneficiary with respect to an included group health plan benefit in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act; and

''(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

''(D)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fiduciary of one or more group health plans (as defined in section 503(b)(9)) for—

''(I) any pattern or practice of repeated adverse coverage decisions in connection with included group health plan benefits in violation of the terms of the plan or plans or this title; or

''(II) any pattern or practice of repeated violations of the requirements of section 503 in connection with such benefits.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

''(ii) Such penalty shall be in an amount not to exceed the lesser of—

''(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice; or

''(II) $100,000.

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

''(E) For purposes of this paragraph, the term 'included group health plan benefit' has the meaning provided in section 503(b)(10)(S).

''(F) The preceding provisions of this paragraph shall not apply with respect to employee benefit plans that are not group health plans or with respect to benefits that are not included group health plan benefits (as defined in paragraph (10)(S)).''.

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking '', or (6)'' and inserting '', (6), or (7)''.

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking ''or'' at the end;

(2) in subsection (a)(9), by striking the period and inserting ''; or'';

(3) by adding at the end of subsection (a) the following new paragraph:

''(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).''.

(4) by adding at the end of subsection (b) the following new paragraph:

''(4) In the case of a group health plan, if exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by the participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action. This paragraph shall not apply with respect to benefits that are not included group health plan benefits (as defined in section 503(b)(10)(S)).''.

(d) ATTORNEY'S FEES.—Section 502(g) of such Act (29 U.S.C. 1132(g)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraph (2) or (3))''; and

(2) by adding at the end the following new paragraph:

''(3) In any action under this title by a participant or beneficiary in connection with an included group health plan benefit (as defined in section 503(b)(10)(S)) in which judgment in favor of the participant or beneficiary is awarded, the court shall allow a reasonable attorney's fee and costs of action to the participant or beneficiary.''.

(e) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(f) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking ''under subsection (a)(1)(B) of this section'' and inserting ''under subsection (a)(1)(A) for relief under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)''; and

(2) in the last sentence, by striking ''of actions under paragraphs (1)(B) and (7) of subsection (a) of this section'' and inserting ''of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)''.

SEC. 122. SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.

Section 503(b) of such Act (as added by the preceding provisions of this subtitle) is amended by adding at the end the following new paragraph:

''(11) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.—

''(A) IN GENERAL.—In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the accelerated need decision period.

''(B) SPECIALIST.—For purposes of this paragraph, the term 'specialist' means, with

respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a patient who is a child, appropriate pediatric expertise) to treat the condition.''.

SEC. 123. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

(c) DEFINITIONS.—For purposes of this section:

(1) The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term ''health care provider'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(5) The term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 124. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by sections 801 and 802 shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following 12 months after the date the Secretary of Labor issues all regulations necessary to carry out amendments made by this title. The amendments made by section 803 shall take effect on such January 1.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—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 title shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Health Care Access, Affordability, and Quality Commission

SEC. 131. ESTABLISHMENT OF COMMISSION.

Part 5 of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 518. HEALTH POLICY COMMISSION.

''(a) ESTABLISHMENT.—There is hereby established a commission to be known as the Health Care Access, Affordability, and Quality Commission (hereinafter in this Act referred to as the ''Commission'').

''(b) DUTIES OF COMMISSION.—The duties of the Commission shall be as follows:

''(1) STUDIES OF CRITICAL AREAS.—Based on information gathered by appropriate Federal agencies, advisory groups, and other appropriate sources for health care information, studies, and data, the Commission shall study and report on in each of the following areas:

''(A) Independent expert external review programs.

''(B) Consumer friendly information programs.

''(C) The extent to which the following affect patient quality and satisfaction:

''(i) health plan enrollees' attitudes based on surveys;

''(ii) outcomes measurements; and

''(iii) accreditation by private organizations.

''(D) Available systems to ensure the timely processing of claims.

''(2) ESTABLISHMENT OF FORM FOR REMITTANCE OF CLAIMS TO PROVIDERS.—Not later than 2 years after the date of the first meeting of the Commission, the Commission shall develop and transmit to the Secretary a proposed form for use by health insurance issuers (as defined in section 733(b)(2)) for the remittance of claims to health care providers. Effective for plan years beginning after 5 years after the date of the Comprehensive Access and Responsibility in Health Care Act of 1999, a health insurance issuer offering health insurance coverage in connection with a group health plan shall use such form for the remittance of all claims to providers.

''(3) EVALUATION OF HEALTH BENEFITS MANDATES.—At the request of the chairmen or ranking minority members of the appropriate committees of Congress, the Commission shall evaluate, taking into consideration the overall cost effect, availability of treatment, and the effect on the health of the general population, existing and proposed benefit requirements for group health plans.

''(4) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to policies under this section, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(5) AGENDA AND ADDITIONAL REVIEW.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics as may be requested by such chairmen and members and as the Commission deems appropriate.

''(6) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include—

''(i) physicians and other health professionals;

''(ii) representatives of employers, including multiemployer plans;

''(ii) representatives of insured employees;

''(iv) third-party payers; and

''(v) health services and health economics researchers with expertise in outcomes and effectiveness research and technology assessment.

''(B) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—Each member shall be appointed for a term of 3 years, except that the Comptroller shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(4) BASIC PAY.—

''(A) RATES OF PAY.—Except as provided in subparagraph (B), members shall each be paid at a rate equal to the rate of basic pay payable for level IV of the Executive Schedule for each day (including travel time) during which they are engaged in the actual performance of duties vested in the Commission.

''(B) PROHIBITION OF COMPENSATION OF FEDERAL EMPLOYEES.—Members of the Commission who are full-time officers or employees of the United States (or Members of Congress) may not receive additional pay, allowances, or benefits by reason of their service on the Commission.

''(5) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

''(6) CHAIRPERSON.—The Chairperson of the Commission shall be designated by the Comptroller at the time of the appointment. The term of office of the Chairperson shall be 3 years.

''(7) MEETINGS.—The Commission shall meet 4 times each year.

''(d) DIRECTOR AND STAFF OF COMMISSION.—

''(1) DIRECTOR.—The Commission shall have a Director who shall be appointed by the Chairperson. The Director shall be paid at a rate not to exceed the maximum rate of

basic pay payable for GS–13 of the General Schedule.

''(2) STAFF.—The Director may appoint 2 additional staff members.

''(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The Director and staff of the Commission shall be appointed subject to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid in accordance with the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates.

''(e) POWERS OF COMMISSION.—

''(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before it.

''(2) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

''(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this Act. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission.

''(4) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act.

''(6) CONTRACT AUTHORITY.—The Commission may contract with and compensate government and private agencies or persons for services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) REPORTS.—Beginning December 31, 2000, and each year thereafter, the Commission shall submit to the Congress an annual report detailing the following information:

''(1) Access to care, affordability to employers and employees, and quality of care under employer-sponsored health plans and recommendations for improving such access, affordability, and quality.

''(2) Any issues the Commission deems appropriate or any issues (such as the appropriateness and availability of particular medical treatment) that the chairmen or ranking members of the appropriate committees of Congress requested the Commission to evaluate.

''(g) DEFINITION OF APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section the term 'appropriate committees of Congress' means any committee in the Senate or House of Representatives having jurisdiction over the Employee Retirement Income Security Act of 1974.

''(h) TERMINATION.—Section 14(a)(2)(B) of the Federal Advisory Committee Act (5 U.S.C. App.; relating to the termination of advisory committees) shall not apply to the Commission.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for fiscal years 2000 through 2004 such sums as may be necessary to carry out this section.''.

SEC. 132. EFFECTIVE DATE.

This subtitle shall be effective 6 months after the date of the enactment of this Act.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 201. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the sponsor of a group health plan or a health insurance issuer offering health insurance coverage in connection with the group health plan to engage in any practice that would violate its religious beliefs or moral convictions.

''(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) COVERAGE OF EMERGENCY SERVICES.—

''(A) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to emergency services (as defined in subparagraph (B)(ii)), or ambulance services, the plan or issuer shall cover emergency services (including emergency ambulance services as defined in subparagraph (B)(iii)) furnished under the plan or coverage—

''(i) without the need for any prior authorization determination;

''(ii) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

''(iii) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider, the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider; and

''(iv) without regard to any other term or condition of such plan or coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 and other than applicable cost sharing).

''(B) DEFINITIONS.—In this subsection:

''(i) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(I) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)); and

''(II) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(ii) EMERGENCY SERVICES.—The term 'emergency services' means—

''(I) with respect to an emergency medical condition described in clause (i)(I), a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd)) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in clause (i)) and also, within the capabilities of the staff and facilities at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(II) with respect to an emergency medical condition described in clause (i)(II), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(iii) EMERGENCY AMBULANCE SERVICES.—The term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in clause (i)) to a hospital for the receipt of emergency services (as defined in clause (ii)) in a case in which appropriate emergency medical screening examinations are covered under the plan or coverage pursuant to paragraph (1)(A) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''(iv) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur

during the transfer of the individual from a facility.

''(v) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or under group health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(vi) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage offered by a health insurance issuer in connection with such a plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(c) PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) gynecological care (such as preventive women's health examinations); or

''(ii) obstetric care (such as pregnancy-related services),

provided by a participating health care professional who specializes in such care (or provides benefits consisting of payment for such care); and

''(B) requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a health care professional, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(1) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

''(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits; and

''(B) treats the ordering of other care of the same type, by the participating health care professional providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

''(3) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse midwife or nurse practitioner) who is licensed, accredited, or certified under State law to provide obstetric and gynecological health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform obstetric and gynecological health care services. Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(5) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(d) PATIENT RIGHT TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating health care professional who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating health care professional may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse practitioner) who is licensed, accredited, or certified under State law to provide pediatric health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform pediatric health care services. Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care so ordered.

''(4) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(e) CONTINUITY OF CARE.—

''(1) IN GENERAL.—

''(A) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, and a health care provider is terminated (as defined in subparagraph (D)(ii)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who, at the time of such termination, is a participant or beneficiary in the plan and is scheduled to undergo surgery (including an organ transplantation), is undergoing treatment for pregnancy, or is determined to be terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act) and is undergoing treatment for the terminal illness, the plan or issuer shall—

''(i) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this subsection; and

''(ii) subject to paragraph (3), permit the individual to elect to continue to be covered with respect to treatment by the provider for such surgery, pregnancy, or illness during a transitional period (provided under paragraph (2)).

''(B) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of subparagraph (A) (and the succeeding provisions of this subsection) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(C) TERMINATION DEFINED.—For purposes of this subsection, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(2) TRANSITIONAL PERIOD.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this paragraph shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

''(B) SCHEDULED SURGERY.—If surgery was scheduled for an individual before the date of the announcement of the termination of the provider status under paragraph (1)(A)(i), the transitional period under this paragraph with respect to the surgery shall extend beyond the period under subparagraph (A) and until the date of discharge of the individual after completion of the surgery.

''(C) PREGNANCY.—If—

''(i) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(ii) the provider was treating the pregnancy before date of the termination,

the transitional period under this paragraph with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(D) TERMINAL ILLNESS.—If—

''(i) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination,

the transitional period under this paragraph shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under paragraph (1)(A)(i) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(A) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in paragraph (1)(B), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in paragraph (1)(A) had not been terminated.

''(B) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under subparagraph (A) and to provide to such plan or issuer necessary medical information related to the care provided.

''(C) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization

and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(D) The provider agrees to provide transitional care to all participants and beneficiaries who are eligible for and elect to have coverage of such care from such provider.

''(E) If the provider initiates the termination, the provider has notified the plan within 30 days prior to the effective date of the termination of—

''(i) whether the provider agrees to permissible terms and conditions (as set forth in this paragraph) required by the plan, and

''(ii) if the provider agrees to the terms and conditions, the specific plan beneficiaries and participants undergoing a course of treatment from the provider who the provider believes, at the time of the notification, would be eligible for transitional care under this subsection.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) require the coverage of benefits which would not have been covered if the provider involved remained a participating provider, or

''(B) prohibit a group health plan from conditioning a provider's participation on the provider's agreement to provide transitional care to all participants and beneficiaries eligible to obtain coverage of such care furnished by the provider as set forth under this subsection.

''(f) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.—

''(1) COVERAGE.—

''(A) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage) provides coverage to a qualified individual (as defined in paragraph (2)), the plan or issuer—

''(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

''(ii) subject to paragraphs (2), (3), and (4), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(iii) may not discriminate against the individual on the basis of the participation of the participant or beneficiary in such trial.

''(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(A)(i) The individual has been diagnosed with cancer.

''(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer.

''(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(B) Either—

''(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon satisfaction by the individual of the conditions described in subparagraph (A); or

''(ii) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the satisfaction by the individual of the conditions described in subparagraph (A).

''(3) PAYMENT.—

''(A) IN GENERAL.—A group health plan (or a health insurance issuer offering health insurance coverage) shall provide for payment for routine patient costs described in paragraph (1)(B) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(B) ROUTINE PATIENT CARE COSTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'routine patient care costs' shall include the costs associated with the provision of items and services that—

''(I) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(II) are furnished according to the protocol of an approved clinical trial program.

''(ii) EXCLUSION.—For purposes of this paragraph, 'routine patient care costs' shall not include the costs associated with the provision of—

''(I) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(II) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(C) PAYMENT RATE.—For purposes of this subsection—

''(i) PARTICIPATING PROVIDERS.—In the case of covered items and services provided by a participating provider, the payment rate shall be at the agreed upon rate.

''(ii) NONPARTICIPATING PROVIDERS.—In the case of covered items and services provided by a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under clause (i).

''(4) APPROVED CLINICAL TRIAL DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

''(B) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's coverage with respect to clinical trials.

''(6) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(A) IN GENERAL.—For purposes of this subsection, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this subsection with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(7) STUDY AND REPORT.—

''(A) STUDY.—The Secretary shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(i) the cost of patient care in trials versus standard care;

''(ii) the cost effectiveness achieved in different sites of service;

''(iii) research outcomes;

''(iv) volume of research subjects available in different sites of service;

''(v) access to research sites and clinical trials by cancer patients;

''(vi) patient cost sharing or copayment costs realized in different sites of service;

''(vii) health outcomes experienced in different sites of service;

''(viii) long term health care services and costs experienced in different sites of service;

''(ix) morbidity and mortality experienced in different sites of service; and

''(x) patient satisfaction and preference of sites of service.

''(B) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains—

''(i) an assessment of any incremental cost to group health plans resulting from the provisions of this section;

''(ii) a projection of expenditures to such plans resulting from this section;

''(iii) an assessment of any impact on premiums resulting from this section; and

''(iv) recommendations regarding action on other diseases.''.

SEC. 202. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

''SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

''(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

''(1) is a health maintenance organization (as defined in section 2791(b)(3)); and

''(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

''(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the

group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

''(c) EXCEPTIONS.—

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

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

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

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

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

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently that once every 2 years.

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

''(5) SMALL ISSUERS.—Subsections (a) and (b) shall not apply in the case of a health insurance issuer with 25,000 or fewer covered lives.

''(d) APPLICABILITY.—The requirements of this section shall apply only in connection with included group health plan benefits.

''(e) DEFINITIONS.—For purposes of this section:

''(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' has the meaning given such term in section 2707(a)(2).

''(3) INCLUDED GROUP HEALTH PLAN BENEFIT.—The term 'included group health plan benefit' means a benefit which is not an excepted benefit (as defined in section 2791(c)).''.

SEC. 203. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one 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 title shall not apply with respect to plan years beginning before the later of—

(1) 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

(2) January 1, 2002.

For purposes of this subsection, 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 title shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 111. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A) is amended further by adding at the end the following new section:

''SEC. 2708. DISCLOSURE BY GROUP HEALTH PLANS.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the plan administrator on a timely basis with the information necessary to enable the administrator to provide participants and beneficiaries with information in a manner and to an extent consistent with the requirements of section 111 of the Employee Retirement Income Security Act of 1974. To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program); and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes an investigational item or experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(3) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary

care providers and with respect to specialists.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan of the type described in section 503 of the Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions;

''(B) internal review of coverage decisions; and

''(C) any external review of coverage decisions; and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION ON PLAN PERFORMANCE.—Any information required under subsection (a) shall include information concerning the number of external reviews of the type described in section 503 of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which a recommendation is made for modification or reversal of an internal review decision under the plan.

''(f) INFORMATION INCLUDED WITH ADVERSE COVERAGE DECISIONS.—A health insurance issuer offering health insurance coverage in connection with a group health plan shall provide to each participant and beneficiary, together with any notification of the participant or beneficiary of an adverse coverage decision, the following information:

''(1) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—A description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in the adverse coverage decision.

''(2) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR ON INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENTS.—If the adverse coverage decision is based on a determination relating to medical necessity or to an investigational item or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(g) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A health insurance issuer offering health insurance coverage in connection with a group health plan may, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format—

''(i) the latest summary plan description, including the latest summary of material modifications, and

''(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information otherwise required to be provided under this subsection, a health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the following information to a participant or beneficiary on request:

''(i) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(ii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iii) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

''(iv) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the health insurance issuer relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS.—

''(i) QUALIFICATIONS, PRIVILEGES, AND METHOD OF COMPENSATION.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(ii) COST OF PROCEDURES.—Any health care professional who recommends an elective procedure or treatment while treating a participant or beneficiary under a group health plan that requires a participant or beneficiary to share in the cost of treatment shall inform such participant or beneficiary of each cost associated with the procedure or treatment and an estimate of the magnitude of such costs.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(h) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a health insurance issuer offering health insurance coverage in connection with a group health plan shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(i) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under health insurance coverage offered by a health insurance issuer in connection with a group health plan that is used in the treatment of a chronic illness or disease, the issuer shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations;

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants);

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification; or

''(4) by any other reasonable means of timely informing plan participants.

''(j) DEFINITIONS AND RELATED RULES.—

''(1) IN GENERAL.—For purposes of this section—

''(A) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 733(a)(1).

''(B) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

''(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(D) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).

''(2) APPLICABILITY ONLY IN CONNECTION WITH INCLUDED GROUP HEALTH PLAN BENEFITS.—

''(A) IN GENERAL.—The requirements of this section shall apply only in connection with included group health plan benefits.

''(B) INCLUDED GROUP HEALTH PLAN BENEFIT.—For purposes of subparagraph (A), the term 'included group health plan benefit' means a benefit which is not an excepted benefit (as defined in section 2791(c)).''.

SEC. 212. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by section 211 shall apply with respect to plan

years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the issuer has sought to comply in good faith with such requirement.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

SEC. 301. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan, the plan with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the sponsor of a group health plan to engage in any practice that would violate its religious beliefs or moral convictions.

''(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) COVERAGE OF EMERGENCY SERVICES.—

''(A) IN GENERAL.—If a group health plan provides any benefits with respect to emergency services (as defined in subparagraph (B)(ii)), or ambulance services, the plan shall cover emergency services (including emergency ambulance services as defined in subparagraph (B)(iii)) furnished under the plan—

''(i) without the need for any prior authorization determination;

''(ii) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

''(iii) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider; and

''(iv) without regard to any other term or condition of such plan (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 701 and other than applicable cost sharing).

''(B) DEFINITIONS.—In this subsection:

''(i) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(I) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)); and

''(II) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(ii) EMERGENCY SERVICES.—The term 'emergency services' means—

''(I) with respect to an emergency medical condition described in clause (i)(I), a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd)) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in clause (i)) and also, within the capabilities of the staff and facilities at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(II) with respect to an emergency medical condition described in clause (i)(II), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(iii) EMERGENCY AMBULANCE SERVICES.—The term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in clause (i)) to a hospital for the receipt of emergency services (as defined in clause (ii)) in a case in which appropriate emergency medical screening examinations are covered under the plan pursuant to paragraph (1)(A) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''(iv) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(v) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that is not a participating health care provider with respect to such items and services.

''(vi) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan.

''(c) PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE.—

''(1) IN GENERAL.—In any case in which a group health plan—

''(A) provides benefits under the terms of the plan consisting of—

''(i) gynecological care (such as preventive women's health examinations); or

''(ii) obstetric care (such as pregnancy-related services),

provided by a participating health care professional who specializes in such care (or provides benefits consisting of payment for such care); and

''(B) requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a health care professional, then the plan shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan—

''(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits; and

''(B) treats the ordering of other care of the same type, by the participating health care professional providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

''(3) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse midwife or nurse practitioner) who is licensed, accredited, or certified under State law to provide obstetric and gynecological health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform obstetric and gynecological health care services. Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(5) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(d) PATIENT RIGHT TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan provides benefits consisting of routine pediatric care provided by a participating health care professional who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan shall provide that such a participating health care professional may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse practitioner) who is licensed, accredited, or certified under State law to provide pediatric health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform pediatric health care services. Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care so ordered.

''(4) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(e) CONTINUITY OF CARE.—

''(1) IN GENERAL.—

''(A) TERMINATION OF PROVIDER.—If a contract between a group health plan and a health care provider is terminated (as defined in subparagraph (D)(ii)), or benefits provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who, at the time of such termination, is a participant or beneficiary in the plan and is scheduled to undergo surgery (including an organ transplantation), is undergoing treatment for pregnancy, or is determined to be terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act) and is undergoing treatment for the terminal illness, the plan shall—

''(i) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this subsection; and

''(ii) subject to paragraph (3), permit the individual to elect to continue to be covered with respect to treatment by the provider for such surgery, pregnancy, or illness during a transitional period (provided under paragraph (2)).

''(B) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of subparagraph (A) (and the succeeding provisions of this subsection) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(C) TERMINATION DEFINED.—For purposes of this subsection, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(2) TRANSITIONAL PERIOD.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this paragraph shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

''(B) SCHEDULED SURGERY.—If surgery was scheduled for an individual before the date of the announcement of the termination of the provider status under paragraph (1)(A)(i), the transitional period under this paragraph with respect to the surgery or transplantation.

''(C) PREGNANCY.—If—

''(i) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(ii) the provider was treating the pregnancy before date of the termination,

the transitional period under this paragraph with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(D) TERMINAL ILLNESS.—If—

''(i) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination,

the transitional period under this paragraph shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan may condition coverage of continued treatment by a provider under paragraph (1)(A)(i) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(A) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in paragraph (1)(B), at the rates applicable under the replacement plan after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in paragraph (1)(A) had not been terminated.

''(B) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under subparagraph (A) and to provide to such plan necessary medical information related to the care provided.

''(C) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(D) The provider agrees to provide transitional care to all participants and beneficiaries who are eligible for and elect to have coverage of such care from such provider.

''(E) If the provider initiates the termination, the provider has notified the plan within 30 days prior to the effective date of the termination of—

''(i) whether the provider agrees to permissible terms and conditions (as set forth in this paragraph) required by the plan, and

''(ii) if the provider agrees to the terms and conditions, the specific plan beneficiaries and participants undergoing a course of treatment from the provider who the provider believes, at the time of the notification, would be eligible for transitional care under this subsection.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) require the coverage of benefits which would not have been covered if the provider involved remained a participating provider, or

''(B) prohibit a group health plan from conditioning a provider's participation on the provider's agreement to provide transitional care to all participants and beneficiaries eligible to obtain coverage of such care furnished by the provider as set forth under this subsection.

''(f) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.—

''(1) COVERAGE.—

''(A) IN GENERAL.—If a group health plan provides coverage to a qualified individual (as defined in paragraph (2)), the plan—

''(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

''(ii) subject to paragraphs (2), (3), and (4), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(iii) may not discriminate against the individual on the basis of the participation of the participant or beneficiary in such trial.

''(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(A)(i) The individual has been diagnosed with cancer.

''(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer.

''(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(B) Either—

''(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon satisfaction by the individual of the conditions described in subparagraph (A); or

''(ii) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the satisfaction

by the individual of the conditions described in subparagraph (A).

''(3) PAYMENT.—

''(A) IN GENERAL.—A group health plan shall provide for payment for routine patient costs described in paragraph (1)(B) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(B) ROUTINE PATIENT CARE COSTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'routine patient care costs' shall include the costs associated with the provision of items and services that—

''(I) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(II) are furnished according to the protocol of an approved clinical trial program.

''(ii) EXCLUSION.—For purposes of this paragraph, 'routine patient care costs' shall not include the costs associated with the provision of—

(I) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

(II) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(C) PAYMENT RATE.—For purposes of this subsection—

''(i) PARTICIPATING PROVIDERS.—In the case of covered items and services provided by a participating provider, the payment rate shall be at the agreed upon rate.

''(ii) NONPARTICIPATING PROVIDERS.—In the case of covered items and servicesprovided by a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under clause (i).

''(4) APPROVED CLINICAL TRIAL DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

''(B) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's coverage with respect to clinical trials.

''(6) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(A) IN GENERAL.—For purposes of this subsection, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this subsection with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(7) STUDY AND REPORT.—

''(A) STUDY.—The Secretary shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(i) the cost of patient care in trials versus standard care;

''(ii) the cost effectiveness achieved in different sites of service;

''(iii) research outcomes;

''(iv) volume of research subjects available in different sites of service;

''(v) access to research sites and clinical trials by cancer patients;

''(vi) patient cost sharing or copyament costs realized in different sites of service;

''(vii) health outcomes experienced in different sites of service;

''(viii) long term health care services and costs experienced in different sites of service;

''(ix) morbidity and mortality experienced in different sites of service; and

''(x) patient satisfaction and preference of sites of service.

''(B) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains—

''(i) an assessment of any incremental cost to group health plans resulting from the provisions of this section;

''(ii) a projection of expenditures to such plans resulting from this section;

''(iii) an assessment of any impact on premiums resulting from this section; and

''(iv) recommendations regarding action on other diseases.''.

SEC. 302. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this title, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one 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 title shall not apply with respect to plan years beginning before the later of—

(1) 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

(2) January 1, 2002.

For purposes of this subsection, 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 title shall not be treated as a termination of such collective bargaining agreement.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 401. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action;

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.); or

(3) an action in connection with benefits which are not included group health plan benefits (as defined in section 402(14)).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) 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.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 402. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means

any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate;

(B) a hospital or medical service plan contract;

(C) a health maintenance subscriber contract; or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against—

(A) a health care provider;

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit); or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) INCLUDED GROUP HEALTH PLAN BENEFIT.—The term 'included group health plan benefit' means a benefit under a group health plan which is not an excepted benefit (as defined in section 733(c) of the Employee Retirement Income Security Act of 1974).

(15) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(16) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(17) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(18) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce; or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(19) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(20) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 403. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court; and

(2) any health care liability claim subject to an alternative dispute resolution system,

that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 411. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 412. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 412(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm; or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages.

(3) LIMITATION ON PUNITIVE DAMAGES.—The total amount of punitive damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed the greater of—

(A) 2 times the amount of economic damages, or

(B) $250,000,

regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a

separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant; or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 413. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, noneconomic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

SEC. 414. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

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

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

(2) submit a report on such compliance to the Committee on Commerce, the Committee on the Judiciary, and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 2000, and every year thereafter for a period of 4 years ending February 1, 2003.

The CHAIRMAN. Pursuant to House Resolution 323, the gentleman from Ohio (Mr. BOEHNER) and the gentleman from Michigan (Mr. DINGELL) will each control 30 minutes.

The Chair recognizes the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, let us stop and ask ourselves a basic question: Just what is health care reform all about? Is it forcing HMOs to be more accountable? Is it expanding access for the 44 million who do not have health coverage? Is it limiting costs and making coverage more affordable?

The answer to all of these questions is yes. Health care reform is about all of these things, access, accountability, and affordability, and we cannot address one without affecting the others; and if we truly want to help patients, we certainly cannot address one at the expense of the other two.

Mr. Chairman, I have the utmost respect for my colleague the gentleman from Michigan (Mr. DINGELL) and my colleague the gentleman from Georgia (Mr. NORWOOD), and I know they believe they found the prescription for what is ailing our health system. But, in truth, I believe their bill is poison for our health care system today.

In an effort to make managed care more accountable, the Dingell-Norwood proposal would authorize lawsuits against health plans. The trouble is most health plans in America are employer-based. More than 124 million Americans get their health coverage through the workplace, a benefit employers can provide voluntarily, thanks to a law known as ERISA, which shields employers from unnecessary litigation. The system, for all its complexity, has saved countless American lives.

Under the Dingell-Norwood proposal though, that would change. Expanding lawsuits against employer-based health plans means expanding lawsuits against employers. If employers are exposed to lawsuits, they are going to stop providing coverage to their employees.

It means millions of American workers are going to lose their health insurance at the very time Congress should be working on expanding access to coverage.

The Dingell-Norwood bill has other flaws. The authors claim their bill is about giving control to doctors and patients, but it is also about giving control to the Federal Government.

Under their proposal, the Department of Labor, the Department of Health and Human Services, the IRS, and likely the States, would all have a hand in regulating Americans' health benefits. Granting the bureaucracy these new powers is another quiet step toward the government-run health care system Americans overwhelmingly rejected in 1993 and 1994. They were right to reject it then, and they would be right in rejecting it now.

Their proposal has a third gaping flaw, and it concerns something that is not even in the bill at all, and that is medical malpractice reform. Our opponents often cite the experience in Texas and what they have done with their HMO liability reform bill, and in fact there have not been a flood of frivolous lawsuits and exploding costs. But what our colleagues never mention is that Texas passed a sweeping medical malpractice and tort reform law 2 years before they passed their HMO liability. Why should this Congress not do the same?

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Mr. Chairman, Americans want health care reform. But legislation that exposes employers to lawsuits jeopardizes the benefits to 124 million American lives who get their coverage from their workplace. It expands the reach of big government and slams the door of medical tort reform, and I am not sure that that is what Americans really want when they think about health care reform today.

Fortunately, there is an alternative. My substitute, the CARE Act, would punish bad HMOs without punishing

the uninsured. We named it the CARE Act because patients want access to care, not access to court. But that does not mean that managed care companies get a free ride. Instead of lawsuits, the CARE Act would guarantee patients the protection of a strong, enforceable and legally binding appeals process.

If you or your family is denied care, you can automatically appeal to independent physicians who are familiar with your case and conditions and are completely independent from the HMO. Assuming the physicians rule in your favor, you get the care; there is no delay, period. You have the right to that care and can get it immediately. And if your plan refuses to do what the doctors order, the plan is subject up to $5,000 per day until you get the care, with no caps.

Now, Mr. Chairman, if we really want to get tough on HMOs that wrongly deny care, I do not think it gets much tougher than that. But here is the best part. Under our CARE Act, HMOs are punished for the wrongful denials before a patient is harmed, instead of after the fact when it is too late. Instead of waiting until a tragic mistake is made, it ensures that patients get the care they need when they need it, and is that not really what managed care reform is all about?

External review gives patients a better option. It also gives us as Members of Congress the chance to be consistent. How can 286 Members of Congress vote to cap Y2K liability for high-tech companies, and then change course and vote for expanded lawsuits in health care? How can three-fourths of the House vote to override the President's veto of securities litigation reform and then turn around and vote to support new lawsuits against employers? How can Members vote for medical malpractice reform six times in the last 5 years in this House that shields providers from lawsuits and then reverse themselves and support expanded liability in health care?

The CARE Act is not just an alternative to lawsuits, Mr. Chairman, it is a better idea altogether.

So I ask my colleagues, for the sake of the 124 million Americans in employer-based health care, give this plan a chance. And for the sake of the 44 million Americans who have no health insurance, give this option a chance. For the sake of our kids and our grandkids whose quality of life will depend on the health care system of the 21st century, give this option a chance.

I urge my colleagues to join me in voting to give patients care, not court. Let us not jeopardize the health insurance benefits our constituents enjoy today from their employers.

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

Mr. DINGELL. Mr. Chairman, I yield myself 2 minutes.

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

Mr. DINGELL. Mr. Chairman, this is a wonderful amendment, but unfortunately, it is a sham and an optical illusion, and very frankly, a fraud. The benefits look good, but there is no way that one can obtain them. Every other alternative to the Norwood-Dingell-Ganske bill that we will consider at least pretends to give you the ability to hold the health insurance companies accountable when they make a medical decision that hurts you. This one does not even keep up the pretense.

The bill is not a serious effort. If you buy insurance, the bill does not help you; and if you have a chronic or serious medical condition requiring regular treatment by a specialist, the bill does not help you. If you believe you should get care when it is medically necessary, this bill does not help you.

For the rhetoric that we are about to hear about lawyers taking over health care and the health care profession, this bill would hand the lawyer, and not the doctor, the power to decide when one needs medical evaluation.

These are just a few of the flaws contained in the Boehner substitute. I urge my colleagues to reject it. I say that with all respect for my good friend, the author of this unfortunate proposal.

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

Mr. BOEHNER. Mr. Chairman, I yield 3 minutes to the gentleman from Virginia (Mr. BLILEY), the chairman of the Committee on Commerce.

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

Mr. BLILEY. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, we need care, not courts. The Boehner bill does that. It allows for binding external review; and if the plan does not accept that, if the external review rules in favor of the patient and the care, then the fine of $1,000 a day takes place until they do comply, and there is no cap. It also enables the patient to go to any health care provider that they see fit at that time and be treated. Is that not far better than waiting and going to court and maybe 3 years down the road you get a verdict in your favor. In the meantime, what are you doing about the care that you need in order maybe to live? It is good for your heirs, but it is not very good for you.

If people say, well, there will not be many lawsuits, read last week's Wall Street Journal. The same plaintiff lawyers who took on the tobacco companies and are taking on the gun manufacturers are lining up for the biggest pot since tobacco, the HMOs. And when they sue, they will not just sue the HMO, they will sue everybody in sight, including the employer. And employers, many of them, are not going to put up with that. What they will do will be to put the money in the worker's envelope and say, you are on your own. Unfortunately, many of them, you know how young people are, they think they are eternal, they will not buy insurance. They would rather have an automobile or something else, or take a trip, and that $44 million uninsured number will go up dramatically.

We increased our uninsured last year by 1 million at a time when we have virtual full employment. So, we need to pass the Boehner bill to make sure that patients get care and not courts.

Mr. Chairman, I rise today in strong support of the Boehner substitute to H.R. 2723.

Managed care is an essential component of our health care delivery system today. The notion of managing care grew out of a concern over a decade ago that health care costs were escalating, and something needed to be done to get control over these skyrocketing annual cost increases. In response to these concerns, insurers began to contract with health care providers to arrange to have a broad network of health professionals available to provide benefits. Health professionals accept reduced fees in exchange for access to a high volume of patients; and plan enrollees pay lower premiums in exchange for seeing one of the health professionals in the network. In addition, plans have quality assurance and utilization review programs to ensure that patients continue to receive cost-efficient quality health care.

This private sector response to the increase in health care spending in the 1980's succeeded in reigning in health care spending, while maintaining and yes, even improving the quality of care for millions of Americans. Many health care professionals believe that the techniques used by managed care companies, such as promoting wellness, the strong emphasis on preventive care, and the ability to ''manage one's care,'' have been valuable contributions to improving the health of America.

The pendulum which started on the side of high health costs, with no control on utilization, has swung towards lower costs and increased scrutiny of the types of services health professionals are performing. We are here today, to decide how far that pendulum has swung. I agree that many of the provisions in all of the bills we are discussing today are reasonable—ensuring that doctors are not limited in the treatment options they can share with their patients; guaranteeing women direct access to their OB/GYN provider, and ensuring that children can have their pediatrician serve as their primary care provider, are just some of the common sense protections that I think we all support.

I also support providing as much information as possible that the patient would find useful in evaluating their health care options. That is why I submitted an amendment which would have required physicians to disclose malpractice judgments or criminal convictions issued against them. If this amendment were law today, a consumer would be able to use the Internet to thoroughly research the background of any physician licensed to practice medicine in the United States. I was disappointed when this amendment was not made in order.

There are two provisions in the Boehner substitute that I would like to bring to everyone's attention, because I feel they are positive steps towards ensuring quality without compromising on accountability. The first is

the responsible and common sense way in which a plan is held accountable once an independent medical expert has determined what the course of treatment for a patient should be. If the plan does not arrange to provide the care in accordance with what an independent medical expert has determined to be appropriate care, the plan will be fined $1,000 per day until the plan complies with the independent expert's opinion. More importantly for the patient, he or she can see any provider at any facility he or she chooses, and the plan has to pay for it. This is a commonsense approach towards ensuring the patient gets the care he or she has paid for, and holds the plan accountable for providing that care in a timely manner. Care, not courts—that is what patients want when they seek medical attention.

The second provision I would like to mention, which prior to this year had been strongly supported by the AMA, is medical malpractice reform. The Boehner substitute would reform the guidelines governing health care lawsuits by, among other things, limiting ''non-economic damages to $250,000, but deferring to states if they feel a higher or lower amount is appropriate. Health care expenditures should be directed towards improving the health of America's patients; not towards lining the pockets of trial lawyers—too often the case today. These reforms would keep more dollars going to patient care and less to the trial lawyers.

I am extremely concerned about the terms of the debate we are having today. One million Americans lost their health insurance coverage in just this past year alone. That is the crisis in health care in America today. If we legislators want to alter the way in which health care is delivered through private markets in this country, we owe it to the American people, to those who sent us here to do the people's work, to at a minimum, abide by the Hippocratic oath that health professionals are obligated to follow every day, which states ''First, Do No Harm.''

I am disappointed that the debate has focused more on trial lawyers, than on how we can create incentives for the private insurance market to offer more affordable health insurance for all Americans.

Those favoring increasing the role of trial lawyers in our health care delivery system point to Texas as an example of what happens when a state allowed state court action against a health plan, and yet only a handful of suits have been filed. This does not tell the whole picture. Just this week in an article printed in the New York Times by Dave Morehead, a doctor with the Scott and White Health Plan in Texas, Dr. Morehead states, ''Lawsuits cost companies money, but so does the mere threat of a lawsuits.'' He points out that as a result of the recent legislation passed in Texas, the physicians participating in the Scott and White Health Plan have changed the way they practice medicine. Preauthorization requirements which are utilized as a means to ensure that patients receive a course of treatment that is safe and effective, thus reducing the risk of complications which often result from some procedures, have been discontinued for fear of litigation resulting from any delay in treatment. He adds that 25 to 35 percent of tests and treatments do not contribute to better health. Dr. Morehead sums up his experience in Texas by concluding 'Our experience shows that the right to sue doesn't help patients get better care. It just drives costs up, for us and for them.''

How many times do we have to come to the well this session on a highly politicized issue and find the trial lawyers actively campaigning for more litigation. First it was tobacco, then guns, now health care. If lawyers are going to start getting in the business of practicing medicine, perhaps we should require them to go to medical school. I am sure the physician community would welcome them, as ironically they too are advocating for more lawyer involvement in the delivery of health care in this country today. On the other hand, this might give the public more comfort. Since lawyers and judges will be making clinical decisions as a result of some of these bills, perhaps we should require them to at least have some medical training.

America has the greatest health care in the world. The fact that 16.3 percent of our fellow citizens cannot afford it is deeply troubling. That the plight of these 44.3 million Americans has been lost on helping the trial attorneys is tragic. I hope members will think of the 44.3 million of Americans who do not have any health insurance as they consider what legislation to vote for today. Do patients deserve care or courts? I vote for care and that is why I am supporting the Boehner substitute, and encourage my colleagues to do the same.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, a fundamental flaw, a fundamental flaw in the bill that passed the Senate and in the Boehner bill is that it does not address the issue of medical necessity. The problem in the ERISA plan, and that is under ERISA law, a health plan can define medical necessity in any way they want to. The gentleman's bill does nothing to change that, he would agree with me on that.

Let me cite an example of why that could be a problem. Let us say that a health plan sets up its definition for getting psychiatric care, saying that somebody has to try to commit suicide three times before one can qualify. That may sound absurd, but let us just say that the plan does that.

A little boy goes out, a teenager, tries to commit suicide once, tries to commit suicide twice, and finally on the third time, commits suicide. Now, under the Boehner bill, that plan followed its own criteria. Guess what? Under the Boehner bill and under the bill that passed the Senate, there is no recourse, because ERISA says that the health plan can define medical necessity in any way they want to, no matter how unreasonable the criteria are or seem to be by an independent panel, review panel. They still, under ERISA law, cannot change the fact that a health plan could define medical necessity as the cheapest, least expensive care.

We could take a little boy with a cleft palate, a health plan could say all we are going to provide treatment for that is a plastic obturator, a piece of plastic stuck up into that hole. If that is the way the plan's employer has defined medical necessity, there is no recourse, even if it does not fit any prescribed standards of care.

That is such a fundamental problem that is not addressed in the Boehner bill and that was not addressed in the Senate bill, and on that alone we should vote no on the Boehner bill.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Chairman, I rise in opposition to the Boehner substitute.

The key questions here are who decides who gets care and on what basis. The Boehner substitute says the managed care plan decides who gets care on any basis they find economically viable.

When a Member of our family, when someone we love has to see an oncologist or a cardiologist or a speech therapist, the reason we are here today is that too many people have been told no, that that is not something that is appropriate under their plan. The underlying Norwood-Dingell bill says that decisions about who will get that care will be made by qualified, independent medical professionals. The Boehner bill says the plan will decide, and when the plan decides on the basis of its own economic motivation, its own definition of what is best for the plan, no one is held accountable.

The Boehner substitute fails the two most critical tests that are before us today in protecting the rights of patients. When it comes to the issue of whether decision-makers are held accountable, the Boehner substitute says, they are not held accountable in the same way that delicatessens and fast food restaurants and homebuilders and everyone else in America is held accountable.

When it comes to the issue of the standard on that decision, the Boehner bill says the plan sets the standard. We say the medical professionals acting in consultation with the families should set that standard.

Reject the Boehner substitute; stand for the Norwood-Dingell bill.

Mr. BOEHNER. Mr. Chairman, I yield 2½ minutes to the gentleman from Missouri (Mr. TALENT), the chairman of the Committee on Small Business.

Mr. TALENT. Mr. Chairman, we have a problem in America with health care today. We addressed one of the problems yesterday, trying to help the uninsured.

The other problem is people who have insurance and cannot be certain that they will get the coverage they have been promised when they get sick. So their insurance is fine, and then when they get sick, they are concerned that their HMO may turn them down for coverage, and they have a right to be concerned, and we need to address that, and the Boehner bill does that.

The idea is to provide people with the care that they need when their physician prescribes it before they become seriously ill or die. The key to that is the external review process that is in this bill, and what it says, quite simply, is this: your physician, let us say, prescribes for you a cardiac cath. The plan turns it down and says no, you only need beta blockers. You can appeal immediately to an independent panel of specialists, cardiologists in that field who are fully vested with the authority to reverse the HMO's decision. They have to take into account all of the evidence that is given, including the protocols that the plan wants to follow, but they are vested under this bill with the authority to reverse the decision of the HMO. I read that language this morning.

It is frustrating how we all seem to agree we want the same thing here, and then we are arguing about what the bills actually say. The bill vests the authority in the independent reviewers to reverse decisions of the plan with regard to medical necessity.

Now, why is that better than open-ended liability against employers and plans as is provided in Norwood-Dingell? Because that will take billions and billions of dollars out of treatment rooms and put it into courtrooms. That will take billions and billions of dollars out of care and put it into legal fees and defensive medicine and everything that we have been struggling with for years and years and years with regard to providers and physicians.

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Mr. Chairman, it does not have to be all or nothing at all. It does not have to be the world we have now where the plans are unrestricted, where you cannot control what they do, or where we open this thing up to lawsuits against every employer in the country who has a group health plan and all the plans in unrestricted fashions. We can have a good, measured response that makes sure people get the care they need when their physician prescribes it without big government, without thousands and thousands of lawsuits that will draw money out of treatment rooms and put it in the courtrooms. I think the gentleman has a good idea. I am going to support his bill.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Chairman, children are not just little adults. They have different health and developmental needs than adults, and they often require age-appropriate pediatric expertise to understand, diagnose, and treat their health problems. They deserve health care providers that have training and expertise in their conditions. H.R. 2723, the Dingell-Norwood bill, contains provisions that allow children to have access to pediatricians, access to pediatric specialty care, access to emergency care, continuity of care, appeals to pediatric experts, and pediatric quality assurance provisions.

The Boehner substitute, however, as we can see from this chart, fails to measure up in every single comparison. Children are far too often put at risk by being inappropriately referred to certain adult specialists who are not trained in children's health needs. Who is affected? Children like Kaitlynn Bogan of West Alexandria, Ohio, whose health plan would not refer her to a pediatric gastrologist and who continued to react with blood curdling screams until the Bogan family mortgaged their home and went outside the plan to a pediatric specialist who corrected her problem.

Carley Christie of Palo Alto, California, who was inappropriately referred to an adult specialist for a Wilms' tumor who performed a needle biopsy which punctured the tumor and essentially tripled the duration of Christie's chemotherapy. The family, finally on their own and at their own expense, again elected to have the surgery performed by a qualified pediatric specialist.

Mr. Chairman, the American public strongly supports allowing families like these to get access to the critical pediatric care they need. In fact, 86 percent of Americans have expressed their support for the Dingell-Norwood plan that would ensure children get access to pediatric specialists like pediatric heart specialists and surgeons and to hospitals that specialize in treating children. As adults, we have a responsibility to our kids. I urge my colleagues to reject this amendment and to support the Dingell-Norwood plan.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the gentleman from Utah (Mr. COOK).

Mr. COOK. Mr. Chairman, I rise in support of the bipartisan patient protection plan offered by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL). I want to commend the leadership of the House for allowing what I think has been a very fair and an open debate. Quality health care is one of the most important issues facing our constituents.

Now, each of these proposals, all of the bills that are being debated today, have some very good ideas in them. However, I have concluded that the Norwood-Dingell approach is the best. If Americans have the right to sue for a damaged fence or an unsafe toy, they should have the right to sue if their health or life has been endangered or lost. This is a constitutional right.

Doctors already face liability. But too often their decisions are forced upon them by an insurance plan. It is only fair, it is only American that the insurance plans be held to the same accountability. The State is the appropriate venue for these cases. States already license the doctors. They license the health plans. And we all know that the Federal courts are already overwhelmed with criminal cases.

I cannot understand why those of us that believe in the importance of States rights are so eager to try to throw some of these cases into the Federal system. The doctor-patient relationship has been damaged in this country, and I believe that the Norwood-Dingell bill is going to help restore that relationship and hopefully will put doctors and patients back in control of what I think ought to be a private health care system.

Mr. BOEHNER. Mr. Chairman, I am happy to yield 2½ minutes to the gentleman from North Carolina (Mr. BALLENGER), chairman of the Subcommittee on Workforce Protections of the Committee on Education and the Workforce.

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

Mr. BALLENGER. Mr. Chairman, first of all I thank the gentleman for yielding me this time. I think it is important to realize what small businesses will do when they are faced with health care liability provided by the Norwood-Dingell bill.

Let me show Members what increased liability will do to my own small company in North Carolina. We have 200 employees. We self-insure. Our health insurance expenses last year were a total of $700,000. Of this cost, the company voluntarily paid $550,000, or $2,750 per employee. For additional coverage, the employees collectively paid $150,000, or $750 per employee. Now, the $2,750 per employee expense covered by my company is a voluntary fringe benefit.

Why would any company voluntarily give a fringe benefit that would expose them to the possibility of being sued? We can say that litigation is not likely but small business owners cannot afford to take that chance. With the specter of liability looming, it would make good business sense to give the employee a pay increase of $1.375 per hour, that is $2,750 spread over a year, give them $1.375 and advise each of them to get their own health insurance. This would leave my company free of liability. I guarantee that it would cost each employee substantially more to purchase insurance individually, and many employees would not use their wage increases for health insurance.

As Members can see, the liability provisions of Norwood-Dingell will lead to a greater number of uninsured nationwide. Unlike the liability-ridden Norwood-Dingell bill, the Boehner substitute will ensure patients' rights without exposing employers to lawsuits for voluntarily providing health care to their employees. A strong, binding, independent external review process for health plans, with a fine of $5,000 a day for plans who refuse to adhere to the decision of the panel of doctors, will provide accountability to the millions of Americans in employer-based care.

Do not jeopardize the employer-based health care system. Let the small businesses and employers continue to provide health care benefits to the American workforce. I urge my colleagues to vote for the Boehner substitute and the 150 million people who have insurance coverage right now.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Michigan (Ms. STABENOW).

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

Ms. STABENOW. Mr. Chairman, I am very pleased to be a cosponsor of the Norwood-Dingell-Ganske legislation. I want to particularly thank the gentleman from Michigan (Mr. DINGELL) for his leadership in this area.

I rise to strongly oppose the Boehner substitute. I want to take just a moment to share the story of Jessica Luker. Jessica died 3 weeks ago. She had an emergency operation on May 11. Her family found out on May 12 that they had suddenly become part of an HMO as of May 1. The HMO would not cover the emergency surgery. They would not allow her to continue with her doctor of 14 years, her neurologist who had been caring for her and her disability. Jessica died while her family was fighting the HMO that would not allow her to get the kind of care that she needed.

It is not right in this country when a family that is struggling to care for their dying daughter also has to fight their insurance carrier. The Boehner substitute would do nothing to help Jessica's family or her situation. I urge a ''no'' vote on the Boehner substitute and a ''yes'' vote on a real patients' bill of rights.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from New York (Mr. FORBES).

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

Mr. FORBES. I thank the gentleman for yielding me the time.

Mr. Chairman, I rise today and ask that we pass a comprehensive patients' bill of rights and reject the Boehner and other substitutes that would only delay what this Nation needs. It needs accountability with our HMOs; we need consumer protections; and we need to put the doctors and health care professionals back in charge.

I am reminded of a family up in the north fork of Long Island, New York. Mae woke up in the middle of the night. Her husband was gagging and choking in blood. He was lying in a pool of blood. She did not call 911. Why? Because when she called it a month earlier, 911 arrived and when she got home from the hospital with her husband, the bills came in and they were not paid because a clerk said at the HMO that it was not deemed an emergency.

So this time she calls the 24-hour hotline for the HMO. They have the privately contracted ambulance come from somewhere up the island half an hour after her husband stopped breathing. The privately contracted ambulance arrives and, of course, unfortunately her husband was dead. These kinds of incidents require that we move as a Congress to get a comprehensive patients' bill of rights. I urge passage of Dingell-Norwood and rejection of all the substitutes.

Mr. BOEHNER. Mr. Chairman, I yield myself 15 seconds. The last 2 examples that were presented on the floor by the other side would be protected under the Boehner substitute today. The accountability procedures in our bill guarantee access to care. The only real difference between these two bills is that we do not allow lawsuits filed to drive employers into bankruptcy.

Mr. Chairman, I yield 2 minutes to the gentleman from Michigan (Mr. KNOLLENBERG).

Mr. KNOLLENBERG. Mr. Chairman, I thank the gentleman for yielding me this time. I rise in strong support of the substitute offered by the gentleman from Ohio.

Mr. Chairman, I urge my colleagues to remember the important principle behind the creation of the Employee Retirement Income Security Act of 1974, better known as ERISA. In response to a number of flagrant abuses to benefit plans, it was decided that protecting the interests of employers as well as the beneficiaries was of the utmost importance. Because of this sentiment, ERISA abides by the predominant view that employees should be afforded the opportunity to quality care.

These provisions apply to nearly 150 million employees, 80 percent of our Nation's workers, who otherwise may not have obtained the necessary access to the vital coverage that they require. Because plans would be subject to the same benefit laws across the States, costs are kept down because government regulations which traditionally drive costs up are eliminated.

Look at the numbers. We have heard them before. Some 44 million Americans do not have health insurance. That means one out of six do not have health coverage. The other proposals that we are considering today, that we have been listening to, would significantly raise premiums, some by over 4 percent. The nonpartisan CBO, Congressional Budget Office, concludes every percentage point in premiums that are increased translates into 400,000 people losing their coverage.

Common sense tells us that what we should be doing is to consider ways to provide coverage for all Americans, not forcing people out of their health coverage. Make no mistake about it, the chief beneficiaries of preempting ERISA would be the trial attorneys. Consumers and employers would be left to pick up the bill for increased and often frivolous litigation.

This Congress must ensure the patient's right to care, not the lawyer's right to bill. The alternatives offered today do nothing to help sick people get better. That is what this debate should be about. That is why I support the Boehner substitute, and I believe all Members should.

Mr. BROWN of Ohio. Mr. Chairman, I ask unanimous consent to claim the time of the gentleman from Michigan (Mr. DINGELL).

The CHAIRMAN. Without objection, the gentleman from Ohio will control the time in opposition.

There was no objection.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentleman from Georgia (Mr. NORWOOD), the sponsor of the underlying Norwood-Dingell bill.

Mr. NORWOOD. Mr. Chairman, I think it would be sort of nice and fun if I took a minute and responded to my good friend the gentleman from North Carolina (Mr. BALLENGER). He said that he is a business owner, a small business owner, and he does not want his business sued, he does not want to be sued. I could not agree with that more. Of course we do not want to do that. That is why we really do not do that. The gentleman from North Carolina has discretionary authority over his small company. He is the CEO, he is the owner, he is the President.

□ 1145

But he is also the congressman. He is in Washington. He is not making medical necessity decisions for his employees at all. It is that third-party administrator that he hired to decide whether those patients get to be hospitalized or whether they get that surgery or whether they get that operation. That is who we are talking about. That is who we are putting under the gun, that third-party administrator.

Our bill says over and over again, it protects the gentleman from North Carolina, but it does go after that third-party administrator in a very tailored way. All it says, one thing, if one denies a benefit that is a benefit in the plan, that was a benefit the gentleman from North Carolina thought his people ought to have, and one denies it arbitrarily, and one kills somebody, one has to be responsible for those decisions.

What are they going to do? They are going to carry malpractice insurance like the rest of the world has to. What is that going to cost? Fifteen to 20 cents a month per patient. But it gives those people that are patients, that work for the gentleman from North Carolina the feeling, the encouragement they actually will have decisions made by their doctors, not by that clerk that may be living in Missouri. That is what it is all about.

I have told the gentleman from North Carolina over and over again, we are not going to sue him. We do not want to sue him. We do not want to sue small businesses. That is why we wrote the bill. Page 99, look at it. We protect the gentleman from North Carolina. But his third-party administrator must be careful.

Mr. BOEHNER. Mr. Chairman, I yield myself 1 minute.

Now, the gentleman from Georgia (Mr. NORWOOD), my dear friend who believes passionately on this issue, and I congratulate him for the 5 years he spent moving this issue along, but we have a very serious disagreement here, because not only are my colleagues exposing health plans and employers to liability, they are jeopardizing the health coverage for millions of Americans because, in the end, it is the health plan and the employer that is going to pay the bill.

Now, under our system today, the employers provide coverage for 125 million people. If my colleagues raise the cost to them and expose them to liability, guess who is in danger? Their employees are. That is not what we want to do.

Now, the gentleman says, well, employers are shielded. The fact is, under ERISA, employers have to provide a fiduciary responsibility. They have to use discretion on behalf and for the benefit of every employee in the plan. We cannot create a wall that says we are going to punish health plans without hurting employers and their employees.

Mr. Chairman, I am happy to yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Chairman, I wish to speak in favor of the Boehner amendment today. I believe that this amendment achieves the necessary balance between protection of individuals enrolled in managed care plans and keeping their care affordable and accessible for employers and their employees.

The last thing we want to do is drive up the number of uninsured Americans today. Too many costly mandates and too many costly lawsuits will result in just that.

I firmly believe that real patient protections are ensuring greater access to care, more affordable care, and the highest quality care. According to the Census Bureau, we have 44 million Americans who are uninsured today. The last thing we want to do is drive that number up. We want to get that number down, not up.

We must approach managed care legislation in the same way we approach other mandates we have voted on. We need to consider its effect on the individuals in this country and on their ability to access quality health care.

I have heard from hundreds of employers and their representatives from my district, the First District of Wisconsin, who are extremely nervous about this action that we are taking here today. They are nervous, not because they may be required to provide more benefits, that is a fine thing, but they are nervous because they may be facing a whole new array of lawsuits simply because they choose to offer health care for their employees.

I urge Congress to consider those businesses and the people they employ in this debate today. Anything we do to drive up their costs to expose them to a whole new feeding frenzy of lawsuits will drive up the number of uninsured.

We must strive to protect the rights of individuals in managed care, make sure that they are not wrongfully denied care, but make sure that health care remains affordable and accessible.

The Boehner amendment strikes that balance. It contains strong measures to review health care decisions. It requires an internal review, external review that has teeth and enforcement measures. More importantly, we need to make sure that the relationship in health care is between patients and their doctors, not patients and the HMOs and patients and their trial lawyers.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Wisconsin (Mr. KIND).

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

Mr. KIND. Mr. Chairman, I thank the gentleman from Ohio for yielding me this time.

Mr. Chairman, I rise today as a supporter of Norwood-Dingell and in strong opposition to the Boehner substitute.

This debate is really a very simple debate. Do my colleagues think that medically necessary, important health care decisions should be placed in the hands of doctors in consultation with their patients or should health plan administrators sitting in their offices hundreds of miles away be making these life-and-death decisions. And there are life and death decisions being made.

For me, the debate is about a young family in western Wisconsin who, 2 years ago, were informed that their 10-year-old little girl had an inoperable brain tumor, and they wanted this particular form of treatment that the doctor was recommending.

The health plan administrator says, ''We will cover that as long as it is an AMA-approved treatment.'' The problem, when they talked to the AMA, is that there was no such thing as an ''AMA-approved'' treatment. So they denied coverage.

As a father of 2 young boys myself, I can think of no greater fear than a parent facing the prospect of losing a child.

They then did what any parents would do under the circumstances. They went into debt. They borrowed. They took a second mortgage out in order to finance the treatment. They ended up with over $100,000 of debt. That young girl eventually died last year. It should not be this way.

Under the Norwood-Dingell bill, administration of a health plan will no longer be able to hide behind the shield of ERISA protection but instead will be subject to an internal and external review process and held responsible for negligent medical decisions.

No longer should parents be faced with the draconian decision of having to mortgage their families' life away or face the prospect of losing a child. Let's put medical decisions back in the hands of doctors and their patients, not insurance companies.

I urge my colleagues to support the Norwood-Dingell bill and oppose the Boehner and other substitutes.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Chairman, do my colleagues realize that the only people in our society that are exempted from our laws and exempted from being sued are foreign diplomats and HMO bureaucrats? They are the only ones in our society that are held above the law.

My colleagues read about where that foreign diplomat ran over that young girl in Washington, D.C., never had to be held liable until the Georgian government said that he had to be held liable. Guess what? The same blanket immunity that those foreign diplomats have these HMO bureaucrats have.

Now, the thing that is going on here is these HMO bureaucrats forget medical malpractice. That is when a doctor makes a bad decision. We are having people who have no medical education whatsoever, never went to medical school, they are the ones making medical decisions. That is criminal.

If my colleagues think medical malpractice is criminal, try having someone who has no medical experience whatsoever making a medical decision. That is criminal. Those two instances, this Boehner bill will not cover; and that is why we ought to reject the Boehner substitute.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Louisiana (Mr. JEFFERSON).

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

Mr. JEFFERSON. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, who would have ever thought just a few short years ago that we would earnestly debate here in this Congress whether a child needing medical attention could see a pediatrician or whether a woman could engage an OB/GYN for her primary care or whether a cancer patient could follow the advice of a family physician and see a cancer specialist?

It seems obvious that people should be able to make these choices for themselves and for their families. What is more odd is that the choices and the access, which we seek today through the passage of the Dingell-Norwood Patients' Bills of Rights, are choices that our people used to have.

In this sense, Dingell-Norwood is not declarative of new rights for patients, but is restorative of old ones.

But the trouble with restoring old choices, the other side says, is the new costs involved that make health care choices unaffordable.

But are we to assume that every level of every profit center in every

HMO plan is reasonable, that every expense incurred by every HMO plan is warranted, or that greater patient choice will not usher in greater competition among HMO plans that will work to drive plan costs down? I think not. Besides, this has not been the experience of States which have undertaken HMO reform.

The three amendments offered by my Republican colleagues make these vital decisions for consumers. I urge Members to reject the tempered approach of the Boehner-Coburn amendments and embrace the bold approach of Dingell-Norwood.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Pennsylvania (Mr. HOEFFEL).

Mr. HOEFFEL. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, I rise in opposition to the Boehner amendment and in strong support of the Norwood-Dingell underlying legislation. The gentleman from Iowa (Mr. GANSKE) got it entirely correct when he identified, as others have, that the key here is the question of medical necessity.

The Boehner substitute would continue to allow insurance company bureaucrats to determine what is medically necessary. That has got to stop. We must allow medical doctors once again to make the decisions that affect the quality of their patients' care. We must allow them to determine medical necessity, not the insurance bureaucrats.

Like our doctors who have complained to me in huge numbers, the Montgomery County, Pennsylvania Medical Society to a person tells me that they spend far too much time fighting with insurance companies, and that is time taken away from patient care.

Let us oppose the Boehner substitute and pass Norwood-Dingell.

Mr. Chairman, I rise in opposition to the Boehner substitute and in support of the base bill, the Bipartisan Consensus Managed Care Improvement Act.

I am a cosponsor of H.R. 2723 because it would allow Americans to be treated as patients, not as numbers that affect the bottom line.

HMO encroachments on the quality of health care are real.

One of my constituents, Dr. Peter Lantos of Erdenheim, PA, described to me that when he needed prostate surgery, his HMO was unwilling to provide a list of specialists, making it difficult to make an intelligent choice. He was told to go to a specific hospital, not the one he preferred.

After fighting many layers of bureaucracy, Dr. Lantos prevailed. However, he lost what could have been critical time, although as a doctor he knew how to fight the system. What about the average person who does not? They would have lost even more valuable time.

H.R. 2723 would: strengthen doctor and patient control over medical decisions by allowing doctors, rather than accountants, to define ''medical necessity''; protect patients by guaranteeing access to specialists, out-of-network doctors, out-of-network emergency rooms, and non-formulary drugs. It also increases choice by guaranteeing patients a point-of service plan option; prohibit gag rules on doctors, so they may discuss all treatment options with their patients; and hold HMO's accountable by establishing an external review process and allowing liability suits in state courts.

The Boehner substitute does not correct medical necessity, does not hold health plans liable, and waters down patient protections. It is not serious reform.

We spend millions of dollars training our doctors, and billions developing drugs, treatments and equipment to treat America's patients. Then we turn all of that knowledge and innovation and investment over to a bean counter from a business school. Something is wrong.

The most important part of a good bedside manner used to be the infusion of hope that everything would be done to fix what ails the patient. That has been replaced by a glance at the HMO manual and a shrug of the shoulder.

Doctors now take time they could spend with patients to argue with insurance companies.

America's patients deserve medical care that will make them well quicker and keep them well longer. They need more than a placebo, but sadly, that is all this bill is.

I urge my colleagues not to be fooled by this or the other two poison pill substitutes. Let's have a clean vote on Dingell-Norwood, clean up the Senate bill in conference, and send managed care reform to the American people before the holidays.

Mr. BOEHNER. Mr. Chairman, I yield myself 15 seconds.

Mr. Chairman, under our proposal, an internal review is required, as we have under existing law. Only a doctor can deny care at the internal review level. Then if it is denied, a patient has the ability to go to an external review where an independent medical doctor will determine whether, in fact, that care can be given.

Mr. Chairman, I am happy to yield 3 minutes to the gentlewoman from Kentucky (Mrs. NORTHUP).

Mrs. NORTHUP. Mr. Chairman, as we debate this substitute, I am reminded of what Kentucky did in the General Assembly in 1994. They passed a bill much like the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) have proposed in this session and the last session of Congress, one that is highly regulatory, one that they convinced the public will give them more medicine at a lower cost. Of course none of this happened.

In fact, the highly regulatory procedures that were enacted by the Kentucky General Assembly is pointed to by every other one of the other 49 States as the disaster that anybody with any understanding of insurance and the cost of medicine would have understood.

The fact is 45 insurance companies out of 47 have left Kentucky. There are only two that are selling insurance in Kentucky today. The fact is the prices have skyrocketed. Just this year, businesses are telling me again of their increases at 38 percent and 50 percent.

We have an increasing number of workers today that are choosing not to take their company's health insurance because even their share of the premium at 10 or 25 percent is more than they want to pay.

Who is deciding not to take insurance? It is the healthy young workers, the workers we need in the health insurance system. Because insurance in all cases is one of those products where all of the people pay in, the healthy pay in, so that the people that get sick, that the costs are taken care of. When we begin to have the healthy young workers not buy insurance, what it does is create this spiral that continues. Health insurance goes up and up, outpricing most people that want health insurance.

It is terribly counterproductive for us to siphon off medical money, medical money that comes to the medical community from insurance and use it for legal services. We need to create a system where every dollar of medical money, money gotten through medical insurance, is spent on medical services and medical miracles.

We can do that if we ensure that insurance companies live up to their responsibility through an appeals process, appeals process within the plan, an appeals process outside of the plan, and not through siphoning off huge numbers of dollars and go back to the system of excessive medical tests that drove the costs so high originally by allowing lawsuits, more lawsuits than what we have now.

So I support the substitute of the gentleman from Ohio (Mr. BOEHNER), and I ask the rest of the Members to consider supporting it, too.

□ 1200

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentlewoman from California (Mrs. CAPPS), a member of the Subcommittee on Health and Environment.

Mrs. CAPPS. Mr. Chairman, I rise in strong opposition to the Boehner amendment. This substitute will not protect patients. This bill does not provide for independent and timely appeals when patients are harmed by HMO decisions. This amendment leaves in place what is wrong with the current system. HMO bureaucrats, not doctors, will determine what treatment is medically necessary. In comparison, the bipartisan Norwood-Dingell bill provides a core set of meaningful protections for patients. Finally, the Boehner amendment will not allow patients to sue their HMOs for negligent care.

The consensus bill includes a strong independent review panel procedure. And as a last resort, patients must have the ability to sue HMOs for harmful medical decisions. No other industry has such special legal protections. The HMO industry should not have them either.

I urge my colleagues to oppose the Boehner amendment.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Ohio (Mr. STRICKLAND), also a member of the Subcommittee on Health and Environment.

Mr. STRICKLAND. Mr. Chairman, I am angry today. I am angry because the constituents that I represent from southern Ohio are being denied their rightful medical care under today's system. I am angry because the health care insurance lobbyists are lining our walkways as we walk to this chamber. I am angry because hundreds of thousands of dollars have been poured into influencing the decisions of Members in this chamber in the last few days and weeks. I am angry because I believe Americans, moms and dads and children, are being injured and are losing their lives today because we have not had the courage to stand up and do the right thing for the American people.

I hope the American people are watching us today. I hope they take note of our votes today, because we have a forced choice. We can either support patients or we can support insurance companies. It is as simple as that. This substitute is a nonhelpful bill. We need to support the Norwood-Dingell bill and give the American citizens true protections in their health care coverage.

Mr. BROWN of Ohio. Mr. Chairman, I yield such time as she may consume to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

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

Mrs. CHRISTENSEN. Mr. Chairman, I rise in opposition to this amendment.

Mr. Chairman, I rise in opposition to the Boehner amendment, and ask my colleagues to vote against it. This is a poison pill amendment which would gut many of the provisions that are needed to implement true managed care reform.

The American people have told us time and time again, and in many ways, that they want the way that managed care delivers health care changed. They don't want it changed just for some, but for all. To half step change, as this amendment would do, would be more of a disservice than a service.

For example, Mr. Chairman, the Boehner substitute would half step the accountability provisions in the Dingell-Norwood bill by providing for an external appeal provision. The problem with this proposal and why it fall far short, is because the external reviewers in the Boehner substitute will use the HMO's plan definition of medical necessity and not the insured's physician.

If such a set-up could work there would be no need for the Norwood-Dingell.

It is precisely to get away from having the plan's definition of medical necessity be the determining factor and not the patient and his doctor's definition why we need the Norwood-Dingell bill.

Vote against the Boehner substitute and vote for a clean Norwood-Dingell bill.

Mr. BROWN of Ohio. Mr. Chairman, I yield 3 minutes to the gentleman from Michigan (Mr. BONIOR), the Democratic whip.

Mr. BONIOR. Mr. Chairman, I thank the gentleman for yielding me this time.

I recently met a woman from Marysville, Michigan. Her young daughter had only one kidney left and was in a fight for her life against diabetes. She desperately needed to see a specialist, but her HMO was worried about the cost, not getting this little girl the treatment that she needed. They were worried about how much it might affect their bottom line.

So what happened? They sent her to a general practitioner. That doctor could not help her. Her mother begged for a specialist. The HMO said, again, no, you have to go see somebody on the staff. So they sent her to another staff doctor. No answers. They still would not yield, the HMOs. This went on week after week after week. This girl got sicker and sicker and sicker, and ultimately the HMO refused to see her 10 different times before they sent her to a specialist. Ten times before a specialist.

She survived, but there are others who have not survived. This is what happens when insurance companies make medical decisions instead of doctors and patients. And that is why we are trying to come up with a bill today that will address this problem. Over 300 health organizations, the AMA, the cardiologists, Families USA, consumer and health groups have endorsed the Dingell-Norwood bill and are opposed to the Boehner substitute, which we are on now, the Shadegg-Coburn substitute, and the others that we will face.

They know that the insurance companies are out of control, these groups. Just look at the numbers. Eighty-three percent of the doctors surveyed say managed care has cut time that they spent with their patients. Eighty-six percent of the doctors say that managed care has reduced their access to specialists, in the example I gave previously. Almost 90 percent of the docs report that HMOs actually reject medical recommendations they make for their patients. And it goes on and on and on.

There is no accountability in the substitute that we are addressing here today. No recourse if an individual is turned down; nothing to give an individual the right to fight and to petition in a way that is going to hold the HMOs and the insurance companies accountable.

Vote against the substitute, vote against Coburn-Shadegg, vote against the substitute that follows that changes the course of direction in our courts, and vote for the bill that the American people are yearning for, waiting for, the bill authored by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL), as well as the gentleman from Iowa (Mr. GANSKE). It is the bill that will set us on the course to correct all of these abuses, all of these horror stories.

It is the doctors and the patients versus the insurance companies in this country. It could not be more clear.

Mr. BOEHNER. Mr. Chairman, I yield 1 minute to the gentleman from South Carolina (Mr. DEMINT).

Mr. DEMINT. Mr. Chairman, I rise in strong support of the Boehner substitute.

As an employer myself for 15 years, I am angry too that folks would stand up today and punish small employers as well as any size employers who try to provide health insurance for their employees.

I am angry at this idea that we can take health insurance out of the hands of employers and put it in the hands of the trial lawyers and expect to get better health care.

I am angry that yesterday I was in this room and this same group who is arguing for more liability today would try to keep individuals from owning their own health insurance so they could protect themselves by making their own health care decisions.

And I am angry today that now they are back making it harder for employers to buy that health insurance for individuals who cannot buy it for themselves.

I am angry because there is no one here suggesting where they are going to go when they cannot buy it for themselves, yet we do not want employers to buy it any more. Because the question is not whether people will have good health care, it is whether the health care system will be run by attorneys or will be run by physicians.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Tennessee (Mr. TANNER).

Mr. TANNER. Mr. Chairman, I thank the gentleman for yielding me this time, and I would like to engage in a colloquy with the gentleman from Michigan (Mr. DINGELL) and the gentleman from Georgia (Mr. NORWOOD) about the underlying intent of the bill.

Is it the intent of the sponsors to permit claims to be brought against independent insurance agents who work with employers in helping to select a plan?

Mr. DINGELL. Mr. Chairman, will the gentleman yield?

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

Mr. DINGELL. The answer to the gentleman's question is no. If an independent insurance agent assists with the selection of or purchase of a plan, but is not involved in the medical care decisions, it is not our intent to permit a claim to be brought against the insurance agent, and under our proposal it cannot.

Mr. TANNER. Reclaiming my time, Mr. Chairman, I thank the gentleman.

It is an important clarifying position, and I wanted to make sure that the omission of specific legislative language in section 302 could not be interpreted to permit a claim against an independent insurance agent if that agent is not involved in the making of any actual medical care decisions.

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. TANNER. I yield to the gentleman from Georgia.

Mr. NORWOOD. I would say to the gentleman, Mr. Chairman, that I hope my son is watching this colloquy. He is an insurance agent.

But the gentleman is absolutely correct in his assumption.

Mr. DINGELL. Mr. Chairman, if an independent insurance agent assists with the selection or purchase of a plan but is not involved in the medical care decisions, it is not our intent to permit a claim to be brought against that insurance agent.

Independent insurance agents do not make medical decisions and therefore should not be liable for harm caused by a decision made by a group health plan. However, Section 302 dictates that claims may be brought against an employer or its employees, if the employer or employee participates in any way in the making of decisions on health care claims.

The omission of specific legislative language could not be interpreted to permit a claim against an independent insurance agent if the independent insurance agent is not involved in the making of any actual medical care decisions.

If this bill proceeds to conference, we would seek clarification that independent insurance agents are not to be held liable for medical and care decisions made by others. It is the intent of the legislation to limit liability only to those who make medical care decisions.

It is not our intent that independent insurance agents could be held liable.

Independent insurance agents who work with or on behalf of an employer in helping the employer to select a plan should be subject to the same liability parameters as the employer.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentlewoman from North Carolina (Mrs. CLAYTON).

Mrs. CLAYTON. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, some would have us believe that this debate is about courts and lawyers. This is not about courts; it is about care. It is not about lawyers but about doctors having the right to provide that care.

I am against the Boehner substitute because it omits the needed enforcement of protection for patients and their doctors in providing that care. Similarly, I am against any substitution that caps damages, like the Coburn substitute. Likewise, I am against the Houghton-Graham substitute because it also strikes out the enforcement and compliance provided by the Norwood-Dingell bill on H.R. 2723.

When a person goes to the doctor, they are not interested in who they can sue. They are interested in who can cure them. But more importantly, Mr. Chairman, this debate is about care for all, rather than care for some. Some would have us believe that the tax package will result in all America's being covered and healthy. But such an approach to managed care reform will not result in greater coverage; it will only result in benefiting the wealthy, the healthy, or those who are financially well off.

This is a misguided concern, Mr. Chairman, because in North Carolina 28.6 percent of children under the age of 19, who are at or below 200 percent of the poverty level, are without health insurance. Rural communities are disproportionately without care. Some 44.3 million people are uninsured in 1998, despite a good economy. Last year 1.7 million more people were uninsured than the previous year in households making below $50,000.

Mr. Chairman, we should support the Norwood-Dingell bill. It is about care, it is about opportunity, it is about accountability.

Mr. BOEHNER. Mr. Chairman, I yield 1 minute to the gentlewoman from Ohio (Ms. PRYCE), an esteemed member of the Republican leadership in the House.

Ms. PRYCE of Ohio. Mr. Chairman, I thank my good friend from Ohio for yielding me this time, and I rise in support of the Boehner substitute.

Mr. Chairman, since his markup, the gentleman from Ohio has continued to work to improve upon his proposals. Specifically, he deserves credit as the first one to add strong cancer clinical trials language to his proposal. This language gives cancer patients access to all trials approved by the FDA or sponsored by federally approved entities, as well as those sanctioned by the Department of Defense, NIH, and Veterans Affairs.

We simply must increase participation in clinical trials if our researchers are going to make strides in their search for new treatments and a cure for this horrid disease. This language has the support of some 40 cancer organizations, and it is not in the Dingell-Norwood bill.

In addition to cancer patients, the Boehner substitute offers all patients basic protections. The amendment bans gag rules, ensures emergency room coverage, provides direct access to OB-GYNs and pediatricians, and offers continuity of care. These are the common sense reforms that we all agree on.

I encourage all of my colleagues to support the Boehner amendment.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Wisconsin (Mr. BARRETT), a member of the Subcommittee on Health and Environment.

Mr. BARRETT of Wisconsin. Mr. Chairman, we have heard a lot this morning about lawsuits, and I want to talk a little bit about the lawsuits in Texas, because Texas has a law similar to the law that we are trying to pass. There have been less than a handful, less than five. Three of them involved persons who were denied access to a cancer specialist; and, as a result, their health deteriorated dramatically over that time period.

The fourth one, the one that struck me the most, was an individual who was in the hospital and his physician said that this patient should not be sent home because of his severe depression. The HMO bureaucrat demanded that the patient be sent home. The patient went home, swallowed a bottle of antifreeze and killed himself because of the decision of the bureaucrat.

Mr. Chairman, this piece of legislation, or this amendment, would deny access to the courts for that individual. I think that that would be wrong. I think that that is a situation where, clearly, the medical decision was not made by the physician. The decision was made by the HMO. And in order for us to move that decision-making process back to the physician, we have to have access to the courts.

Mr. Chairman, this is not going to create a wave of lawsuits, but it is going to protect those individuals who are denied medical care.

Mr. BOEHNER. Mr. Chairman, I yield myself such time as I may consume to say that the example just given would never happen under the Boehner proposal, nor would it happen under the Dingell-Norwood proposal, and the gentleman well knows that.

Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. ARMEY), the majority leader.

Mr. ARMEY. Mr. Chairman, I thank the gentleman for yielding me this time.

Let me begin my remarks, Mr. Chairman, by pointing out that this is a serious business we are about today, and I am proud it is being taken as seriously as it is by this body.

I would also like to thank those Members of this body who yesterday cast a vote that provided some equity and opportunity not only to the 44 million Americans that are today doing without insurance, but to the millions of additional Americans who buy their own insurance.

□ 1215

It is about time that we remove barriers to insurability from these people and treated them fairly under the law. I am proud that we passed those provisions last night.

But with respect to the offers we see contested here, I want to tell my colleagues I am speaking on behalf of the Boehner bill precisely because the gentleman from Ohio (Mr. BOEHNER) in crafting this bill kept his eye on the ball. He asked himself the question, who is this about? And the answer was, wholly and without compromise, the well-being of the patient and the patient's family.

Mr. Chairman, we have all been there ourselves and we have certainly seen our constituents there. They have someone they love, maybe it is mom or dad, maybe it is their child, maybe it is their spouse, someone they love, relying on their insurance coverage and a sense of security they have drawn from that, at a moment of medical stress; and they are scared. They are terrified, Mr. Chairman, that dad is not getting the right care, that their baby is not getting the right procedures. They

have doubts. They have concerns. They have worries. And they are frantic with fear.

Mr. Chairman, not only does the patient but the patient's family deserves to have an answer now from medical professionals. Now I must know. If dad is not getting the right treatment, what can we do to change it?

The gentleman from Ohio (Mr. BOEHNER) responds to that. He says the patient's well-being and that peace of mind of the family comes before the doctors, comes before the trial lawyers, comes before the health care provider, comes before everything. And that is what he provides, an immediate, comprehensive, compelling review by medical professionals that says, we give the right necessary treatment and we give it now.

How could anybody turn away from that and say instead to that distressed mother or father or husband or daughter, no, we would rather give you our promise that 6 months from now or maybe a year we will get you on the docket and we will let the lawyers and the judges decide what should have been the care that that precious baby got 6 months or a year ago?

No, that is not good enough, Mr. Chairman. That is not a good enough answer for my children. It is not a good enough answer for the parents. We must do what the Boehner bill says we should do, give that family that answer now and get the care to the parents now. It is about health care. It is about danger. It is about a chance to get a good recovery with the right care and get it now.

Let the trial lawyers and, for that matter, let the doctors take their turn. But today let us all vote for Boehner and let us put patients and the patients' families ahead of everybody else as this bill does.

The CHAIRMAN. The Chair would remind the Members that the gentleman from Ohio (Mr. BOEHNER) on the majority side has 3¾ minutes remaining, and the gentleman from Ohio (Mr. BROWN) on the minority side has 3¾ minutes remaining and the right to close.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to my friend the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Chairman, let me read a letter from my constituents Gary and Marlene Rappaport from Orange, Connecticut.

As parents whose 25-year-old daughter Rebecca died after delay in receiving a bone marrow transplant because of repeated denials from her insurance provider, we are writing in strong support of the Norwood-Dingell bill. As Rebecca wrote in her journal dated March 28, 1997, ''I would like my family to continue my pursuit of litigation, suing for gross negligence resulting in severe physical damage, physical pain and inestimable emotional suffering. My medical record, history, and physicians support my case. Should an award be given in my absence, I would like a significant portion donated to cancer research.

Rebecca had a full life ahead of her. She did not get that chance. Her parents are left with an unimaginable heartache, the loss of a beloved daughter, and nowhere to turn to address wrongful denial.

Vote against the Boehner substitute. It fails to cover all privately insured Americans, does not provide for independent or timely appeals of decisions. It does not provide for access to specialty care. And most of all, it does not allow patients to hold their health plans accountable.

The only bill that does that today is Dingell-Norwood. Do it. Pass Dingell-Norwood. Do it for the Rappaports and do it for families like them who are in pain and who are begging for our help here on the floor of this House today.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, I am here once again to ask my colleagues to reject all of the substitute amendments that are now being considered and vote for a clean Norwood-Dingell-Ganske bill.

I realize that I have not been here very long. But in the almost 3 years that I have been in Congress, this bill, H.R. 2723, represents the best example of bipartisan cooperation that I have ever seen.

What makes this compromise so special is that it was done in direct response to the concerns that have been brought to us by the people we serve, not out of our political interests but in the interests of all Americans.

The Goss-Coburn-Shadegg substitute puts an unnecessary albatross on the back of our attempts to have real managed care reform. Its purpose could not be anything other than to fatally poison a good bill, making it eligible for a sure veto, thus killing any chance for the American people to get the relief they so desperately seek.

I ask my colleagues to stand with the American people and against the HMO industry. Vote ''no'' on the Goss-Coburn-Shadegg amendment.

Mr. BOEHNER. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, what this debate really comes down to, I think, is whether we are going to have accountability through litigation and lawyers or are we going to have accountability through doctors.

To ensure accountability in health care decisions, I think my proposal vests its power in independent doctors to make the right medical decisions.

I think the Dingell-Norwood proposal believes lawyers are the best authority when it comes to medical treatment. They believe that employers who voluntarily provide health care insurance to their employees ought to be subject to open-ended liability if someone believes they have been treated unfairly.

This reminds me of the incredible logic of trial attorneys suing doctors for malpractice when they attempted to render medical care to injured or ill individuals on an emergency basis. What happened? Doctors and other health care professionals began to stand by and did not apply their knowledge and skills to help fellow human beings for fear of being sued by some enterprising trial lawyer.

Across this country, States and local governments had to pass good samaritan laws in order to protect doctors and nurses from doing the right thing in the first place.

Well, let me assure my colleagues, if we move forward on court liability for employers, today's employers are going to become the doctors and nurses of the 1970s. They will stand by and no longer offer health insurance to their employees. Instead of having 44 million Americans with no health care coverage, we will have tens of millions added to that list.

Now, let us put in place a binding external appeal that will ensure that patients get their care when they need it. As the Washington Post stated earlier this week: ''Our first instinct would be to try the appeals system first and broaden access to the courts only if the appeals process turned out after a number of years to not work.''

My colleagues, we have an opportunity today to do something that is responsible, responsible for our health care system by bringing more accountability to managed care without driving up costs and without creating more uninsured. It is a delicate balance that we walk between bringing more accountability without driving up the cost and driving down access to our system. We have a great system in America where employers are provided health care for 125 million American lives in a shared arrangement in most cases.

Unfortunately, the Norwood-Dingell bill today, in my view, will jeopardize the health insurance benefits that millions of Americans get. Do we really want to take that big step off of this cliff without a parachute? Do we really want to take the chance that millions of Americans are going to lose their insurance because we want to open this up to litigation and entreat the trial bar to another new field that they can go out and operate in?

I do not think that is what the American people want us to do. They want us to take a responsible approach. They want us to take an approach that will ensure they get the care without driving up cost and without jeopardizing the number one benefit that they appreciate from their employers.

Vote for the Boehner proposal.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, this substitute undoes the good bipartisan work that the gentleman from Michigan (Mr. DINGELL), the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Iowa (Mr. GANSKE) did to craft this very positive strong legislation.

Similar legislation is working in Texas where insurance companies are

held accountable when they make medical decisions.

The Boehner substitute, however, is not a serious legislative effort. It does not hold insurance companies accountable when they make medical decisions that harm people. For all the discussion and all the talk, Mr. Chairman, about lawyers taking over the health care profession, the Boehner substitute would hand the lawyer, not the doctor, the power to decide whether a case needs a medical evaluation.

Mr. Chairman, the majority of Members support the Norwood-Dingell-Ganske bill. Vote ''no'' on the Boehner substitute.

Mr. CLAY. Mr. Chairman, the Boehner substitute fails to provide enrollees with what they want most from their health plan—accountability. Under the Boehner substitute, all court actions would be subject to caps on noneconomic and punitive damages of $250,000. The Boehner substitute does not ensure that employees are adequately redressed when they have been injured. Therefore, health plans still retain an incentive to deny claims in order to cut costs. Every other business is subject to liability when they make negligent decisions, why should health plans be any different?

The Boehner substitute creates a health care access affordability, and quality commission. This proposed commission would establish model guidelines, evaluate the cost impact of proposed mandates, comment on secretarial reports, and conduct additional reviews requested by Members of Congress. However, what this proposed commission really does is create a new Federal bureaucracy that duplicates many functions that are ongoing, both within the Department of Labor and other parts of the Federal Government.

The Boehner substitute also contains a ''conscience clause'' that significantly weakens the anti-gag protection. This clause allows plans to limit or deny any coverage that is inconsistent with its moral or religious convictions. This provision essentially allows plans to gag their providers from discussing any issues to which the plan is morally opposed. Plans would be able to devise new strategies to deny care, under the guise of moral opposition. This is why I support the Bipartisan Managed Care Improvement Act, H.R. 2723. It represents a reasonable, bipartisan compromise that protects patients. This is not the case with the substitute before us. I urge my colleagues to vote ''no'' on the Boehner substitute.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from Ohio (Mr. BOEHNER).

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. BOEHNER. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 145, noes 284, not voting 5, as follows:

[Roll No 487]

AYES—145

Aderholt	Goodling	Paul
Archer	Goss	Pease
Armey	Granger	Peterson (PA)
Baker	Green (WI)	Petri
Ballenger	Gutknecht	Pickering
Barrett (NE)	Hansen	Pitts
Bartlett	Hastert	Pombo
Barton	Hastings (WA)	Portman
Bereuter	Hayes	Pryce (OH)
Biggert	Hayworth	Radanovich
Bilirakis	Hefley	Ramstad
Bliley	Herger	Regula
Blunt	Hill (MT)	Riley
Boehner	Hilleary	Rogers
Bonilla	Hobson	Rohrabacher
Brady (TX)	Hoekstra	Royce
Bryant	Hostettler	Ryan (WI)
Burr	Houghton	Ryun (KS)
Callahan	Hulshof	Salmon
Calvert	Hyde	Sensenbrenner
Camp	Jenkins	Sherwood
Cannon	Johnson, Sam	Shimkus
Chabot	Jones (NC)	Shuster
Chambliss	Kasich	Simpson
Coble	Kingston	Smith (MI)
Collins	Knollenberg	Smith (TX)
Cox	Kolbe	Stump
Crane	LaHood	Sununu
Cubin	Latham	Talent
Cunningham	Lewis (KY)	Tancredo
Deal	Linder	Tauzin
DeLay	Lucas (KY)	Taylor (NC)
DeMint	Lucas (OK)	Terry
Dickey	Manzullo	Thomas
Doolittle	McCrery	Thune
Dreier	McInnis	Tiahrt
Dunn	McIntosh	Toomey
Ehlers	McKeon	Upton
Ehrlich	Mica	Walden
Everett	Miller (FL)	Watkins
Ewing	Miller, Gary	Watts (OK)
Fletcher	Myrick	Weldon (FL)
Fossella	Nethercutt	Weldon (PA)
Fowler	Ney	Weller
Gekas	Northup	Whitfield
Gibbons	Nussle	Wicker
Gillmor	Ose	Young (AK)
Goode	Oxley	
Goodlatte	Packard	

NOES—284

Abercrombie	Clyburn	Frost
Ackerman	Coburn	Gallegly
Allen	Combest	Ganske
Andrews	Condit	Gejdenson
Bachus	Conyers	Gephardt
Baird	Cook	Gilchrest
Baldacci	Cooksey	Gilman
Baldwin	Costello	Gonzalez
Barcia	Coyne	Gordon
Barr	Cramer	Graham
Barrett (WI)	Crowley	Green (TX)
Bass	Cummings	Greenwood
Bateman	Danner	Gutierrez
Becerra	Davis (FL)	Hall (OH)
Bentsen	Davis (IL)	Hall (TX)
Berkley	Davis (VA)	Hastings (FL)
Berman	DeFazio	Hill (IN)
Berry	DeGette	Hilliard
Bilbray	Delahunt	Hinchey
Bishop	DeLauro	Hinojosa
Blagojevich	Deutsch	Hoeffel
Blumenauer	Diaz-Balart	Holden
Boehlert	Dicks	Holt
Bonior	Dingell	Hooley
Bono	Dixon	Horn
Borski	Doggett	Hoyer
Boswell	Dooley	Hunter
Boucher	Doyle	Hutchinson
Boyd	Duncan	Inslee
Brady (PA)	Edwards	Isakson
Brown (FL)	Emerson	Istook
Brown (OH)	Engel	Jackson (IL)
Burton	English	Jackson-Lee (TX)
Buyer	Eshoo	
Campbell	Etheridge	Jefferson
Canady	Evans	John
Capps	Farr	Johnson, E. B.
Capuano	Fattah	Jones (OH)
Cardin	Filner	Kanjorski
Carson	Foley	Kelly
Castle	Forbes	Kennedy
Chenoweth-Hage	Ford	Kildee
Clay	Frank (MA)	Kilpatrick
Clayton	Franks (NJ)	Kind (WI)
Clement	Frelinghuysen	King (NY)
Kleczka	Nadler	Sisisky
Klink	Napolitano	Skeen
Kucinich	Neal	Skelton
Kuykendall	Norwood	Slaughter
LaFalce	Oberstar	Smith (NJ)
Lampson	Obey	Smith (WA)
Lantos	Olver	Snyder
Largent	Ortiz	Souder
LaTourette	Owens	Spence
Lazio	Pallone	Spratt
Leach	Pascrell	Stabenow
Lee	Pastor	Stark
Levin	Payne	Stearns
Lewis (CA)	Pelosi	Stenholm
Lewis (GA)	Peterson (MN)	Strickland
Lipinski	Phelps	Stupak
LoBiondo	Pickett	Sweeney
Lofgren	Pomeroy	Tanner
Lowey	Porter	Tauscher
Luther	Price (NC)	Taylor (MS)
Maloney (CT)	Quinn	Thompson (CA)
Maloney (NY)	Rahall	Thompson (MS)
Markey	Rangel	Thornberry
Martinez	Reyes	Thurman
Mascara	Reynolds	Tierney
Matsui	Rivers	Towns
McCarthy (MO)	Rodriguez	Traficant
McCarthy (NY)	Roemer	Turner
McCollum	Rogan	Udall (CO)
McDermott	Ros-Lehtinen	Udall (NM)
McGovern	Rothman	Velázquez
McHugh	Roukema	Vento
McIntyre	Roybal-Allard	Visclosky
McKinney	Rush	Vitter
McNulty	Sabo	Walsh
Meehan	Sanchez	Wamp
Meek (FL)	Sanders	Waters
Meeks (NY)	Sandlin	Watt (NC)
Menendez	Sanford	Waxman
Millender-McDonald	Sawyer	Weiner
	Saxton	Wexler
Miller, George	Schaffer	Weygand
Minge	Schakowsky	Wilson
Mink	Scott	Wise
Moakley	Serrano	Wolf
Mollohan	Sessions	Woolsey
Moore	Shadegg	Wu
Moran (KS)	Shaw	Wynn
Moran (VA)	Shays	Young (FL)
Morella	Sherman	
Murtha	Shows	

NOT VOTING—5

Johnson (CT)	Larson	Scarborough
Kaptur	Metcalf	

☐ 1246

Ms. RIVERS and Mr. KUYKENDALL changed their vote from ''aye'' to ''no.''

Mr. BARRETT of Nebraska changed his vote from ''no'' to ''aye.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

Stated against:

Mr. LARSON. Mr. Chairman, on rollcall No. 487, I was inadvertently detained. Had I been present, I would have voted ''no.''

The CHAIRMAN. It is now in order to consider amendment No. 2 printed in part B of House Report 106–366.

AMENDMENT NO. 2 IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. GOSS

Mr. GOSS. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment No. 2 in the nature of a substitute offered by Mr. GOSS:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Quality and Choice Act of 1999''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I— AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Sec. 101. Application to group health plans and group health insurance coverage.
Sec. 102. Application to individual health insurance coverage.
Sec. 103. Improving managed care.
''TITLE XXVIII—IMPROVING MANAGED CARE
''Subtitle A—Grievance and Appeals
''Sec. 2801. Utilization review activities.
''Sec. 2802. Internal appeals procedures.
''Sec. 2803. External appeals procedures.
''Sec. 2804. Establishment of a grievance process.
''Subtitle B—Access to Care
''Sec. 2811. Consumer choice option.
''Sec. 2812. Choice of health care professional.
''Sec. 2813. Access to emergency care.
''Sec. 2814. Access to specialty care.
''Sec. 2815. Access to obstetrical and gynecological care.
''Sec. 2816. Access to pediatric care.
''Sec. 2817. Continuity of care.
''Sec. 2818. Network adequacy.
''Sec. 2819. Access to experimental or investigational prescription drugs.
''Sec. 2820. Coverage for individuals participating in approved cancer clinical trials.
''Subtitle C—Access to Information
''Sec. 2821. Patient access to information.
''Subtitle D—Protecting the Doctor-Patient Relationship
''Sec. 2831. Prohibition of interference with certain medical communications.
''Sec. 2832. Prohibition of discrimination against providers based on licensure.
''Sec. 2833. Prohibition against improper incentive arrangements.
''Sec. 2834. Payment of clean claims.
''Subtitle E—Definitions
''Sec. 2841. Definitions.
''Sec. 2842. Rule of construction.
''Sec. 2843. Exclusions.
''Sec. 2844. Coverage of limited scope plans.
''Sec. 2845. Regulations.
''Sec. 2846. Limitation on application of provisions relating to group health plans..

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

Sec. 201. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 202. Improving managed care.
''PART 8—IMPROVING MANAGED CARE
''SUBPART A—GRIEVANCE AND APPEALS
''Sec. 801. Utilization review activities.
''Sec. 802. Internal appeals procedures.
''Sec. 803. External appeals procedures.
''Sec. 804. Establishment of a grievance process.
''SUBPART B—ACCESS TO CARE
''Sec. 812. Choice of health care professional.
''Sec. 813. Access to emergency care.
''Sec. 814. Access to specialty care.
''Sec. 815. Access to obstetrical and gynecological care.
''Sec. 816. Access to pediatric care.
''Sec. 817. Continuity of care.
''Sec. 818. Network adequacy.
''Sec. 819. Access to experimental or investigational prescription drugs.
''Sec. 820. Coverage for individuals participating in approved cancer clinical trials.
''SUBPART C—ACCESS TO INFORMATION
''Sec. 821. Patient access to information.
''SUBPART D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
''Sec. 831. Prohibition of interference with certain medical communications.
''Sec. 832. Prohibition of discrimination against providers based on licensure.
''Sec. 833. Prohibition against improper incentive arrangements.
''Sec. 834. Payment of clean claims.
''SUBPART E—DEFINITIONS
''Sec. 841. Definitions.
''Sec. 842. Rule of construction.
''Sec. 843. Exclusions.
''Sec. 844. Coverage of limited scope plans.
''Sec. 845. Regulations.
Sec. 203. Availability of court remedies.
Sec. 204. Availability of binding arbitration.

TITLE III— AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Sec. 301. Application to group health plans under the Internal Revenue Code of 1986.
Sec. 302. Improving managed care.
''CHAPTER 101—IMPROVING MANAGED CARE
''SUBCHAPTER A—GRIEVANCE AND APPEALS.
''Sec. 9901. Utilization review activities.
''Sec. 9902. Internal appeals procedures.
''Sec. 9903. External appeals procedures.
''Sec. 9904. Establishment of a grievance process.
''SUBCHAPTER B—ACCESS TO CARE
''Sec. 9912. Choice of health care professional.
''Sec. 9913. Access to emergency care.
''Sec. 9914. Access to specialty care.
''Sec. 9915. Access to obstetrical and gynecological care.
''Sec. 9916. Access to pediatric care.
''Sec. 9917. Continuity of care.
''Sec. 9918. Network adequacy.
''Sec. 9919. Access to experimental or investigational prescription drugs.
''Sec. 9920. Coverage for individuals participating in approved cancer clinical trials.
''SUBCHAPTER C—ACCESS TO INFORMATION
''Sec. 9921. Patient access to information.
''SUBCHAPTER D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
''Sec. 9931. Prohibition of interference with certain medical communications.
''Sec. 9932. Prohibition of discrimination against providers based on licensure.
''Sec. 9933. Prohibition against improper incentive arrangements.
''Sec. 9934. Payment of clean claims.
''SUBCHAPTER E—DEFINITIONS
''Sec. 9941. Definitions.
''Sec. 9942. Exclusions.
''Sec. 9943. Coverage of limited scope plans.
''Sec. 9944. Regulations.

TITLE IV—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

Sec. 401. Effective dates.
Sec. 402. Coordination in implementation.

TITLE V—OTHER PROVISIONS

Subtitle A—Protection of Information

Sec. 501. Protection for certain information.

Subtitle B—Other Matters

Sec. 511. Health care paperwork simplification.

TITLE I— AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 101. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title XXVIII, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 (as in effect on the date of the enactment of the Health Care Quality and Choice Act of 1999) with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

SEC. 102. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title XXVIII with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

SEC. 103. IMPROVING MANAGED CARE.

The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—IMPROVING MANAGED CARE

''Subtitle A—Grievance and Appeals

''SEC. 2801. UTILIZATION REVIEW ACTIVITIES.

''(a) COMPLIANCE WITH REQUIREMENTS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

''(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization

review program that meets the requirements of this section.

''(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms 'utilization review' and 'utilization review activities' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

''(b) WRITTEN POLICIES AND CRITERIA.—

''(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

''(2) USE OF WRITTEN CRITERIA.—

''(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate practicing physicians, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

''(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

''(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for periodic evaluation at reasonable intervals of the clinical appropriateness of a sample of denials of claims for benefits.

''(c) CONDUCT OF PROGRAM ACTIVITIES.—

''(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by appropriate physician specialists who shall be selected by the plan or issuer and who shall oversee review decisions.

''(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

''(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

''(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits. This subparagraph shall not preclude any capitation arrangements between plans and providers.

''(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

''(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

''(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

''(d) DEADLINE FOR DETERMINATIONS.—

''(1) PRIOR AUTHORIZATION SERVICES.—

''(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, no later than the deadline specified in subparagraph (B). The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided.

''(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a utilization review program—

''(I) receives a request for a prior authorization,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 2 business days after notification,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of the request for prior authorization.

''(2) ONGOING CARE.—

''(A) CONCURRENT REVIEW.—

''(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed or electronic form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

''(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

''(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

''(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

''(4) FAILURE TO MEET DEADLINE.—In a case in which a group health plan or health insurance issuer fails to make a determination on a claim for benefit under paragraph (1), (2)(A), or (3) by the applicable deadline established under the respective paragraph, the failure shall be treated under this subtitle as a denial of the claim as of the date of the deadline.

''(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, POST-STABILIZATION CARE, AND EMERGENCY AMBULANCE SERVICES.—For waiver of prior authorization requirements in certain cases involving emergency services, maintenance care and post-stabilization care, and emergency ambulance services, see subsections (a)(1), (b), and (c)(1) of section 113, respectively.

''(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

''(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed or electronic form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

''(A) the reasons for the denial (including the clinical rationale);

''(B) instructions on how to initiate an appeal under section 102; and

''(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

''(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

''(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

''(1) CLAIM FOR BENEFITS.—The term 'claim for benefits' means any request for coverage (including authorization of coverage), or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

''(2) DENIAL OF CLAIM FOR BENEFITS.—The term 'denial' means, with respect to a claim for benefits, a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide or pay for benefits (including items and services) required to be provided or paid for under this title.

''SEC. 2802. INTERNAL APPEALS PROCEDURES.

''(a) RIGHT OF REVIEW.—

''(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

''(A) shall provide adequate notice in written or electronic form to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied ''(within the meaning of section 2801(f)(2)), setting forth the specific reasons

for such denial of claim for benefits and rights to any further review or appeal, written in layman's terms to be understood by the participant, beneficiary, or enrollee; and

''(B) shall afford such a participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity of not less than 180 days to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to such coverage) of the decision denying the claim.

''(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in written or electronic form.

''(b) INTERNAL REVIEW PROCESS.—

''(1) CONDUCT OF REVIEW.—

''(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual (who shall be a physician in a case involving medical judgment) who has been selected by the plan or issuer and who did not make the initial denial in the internally appealable decision, except that in the case of limited scope coverage (as defined in subparagraph (B)) an appropriate specialist shall review the decision.

''(B) LIMITED SCOPE COVERAGE DEFINED.—For purposes of subparagraph (A), the term 'limited scope coverage' means a group health plan or health insurance coverage the only benefits under which are for benefits described in section 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)).

''(2) TIME LIMITS FOR INTERNAL REVIEWS.—

''(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed or electronic form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided. The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

''(I) receives a request for internal review,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 48 hours after notification,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of request for review

''(c) EXPEDITED REVIEW PROCESS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

''(A) in which, as determined by the plan or issuer or as certified in writing by a treating physician, the application of the normal timeframe for making the determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such individual's ability to regain maximum function; or

''(B) described in section 2801(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

''(2) PROCESS.—Under such procedures—

''(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

''(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

''(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

''(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 48 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

''(d) WAIVER OF PROCESS.—A plan or issuer may waive its rights for an internal review under subsection (b). In such case the participant, beneficiary, or enrollee involved (and any designee or provider involved) shall be relieved of any obligation to complete the review involved and may, at the option of such participant, beneficiary, enrollee, designee, or provider, proceed directly to seek further appeal through any applicable external appeals process.

''SEC. 2803. EXTERNAL APPEALS PROCEDURES.

''(a) RIGHT TO EXTERNAL APPEAL.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made (within a reasonable period not to exceed 365 days) either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent).

''(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'externally appealable decision' means a denial of claim for benefits (as defined in section 2801(f)(2)), if—

''(i) the item or service involved is covered under the plan or coverage,

''(ii) the amount involved exceeds $100, increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from such index for September 2000, and

''(iii) the requirements of subparagraph (B) are met with respect to such denial.

Such term also includes a failure to meet an applicable deadline for internal review under section 2802 or such standards as are established pursuant to section 2818.

''(B) REQUIREMENTS.—For purposes of subparagraph (A)(iii), the requirements of this subparagraph are met with respect to a denial of a claim for benefits if—

''(i) the denial is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or

''(ii) in such denial, the decision as to whether an item or service is covered involves a medical judgment.

''(C) EXCLUSIONS.—The term 'externally appealable decision' does not include—

''(i) specific exclusions or express limitations on the amount, duration, or scope of coverage; or

''(ii) a decision regarding eligibility for any benefits.

''(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 2802(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 2802, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

''(4) FILING FEE REQUIREMENT.—

''(A) IN GENERAL.—A plan or issuer may condition the use of an external appeal process upon payment in advance to the plan or issuer of a $25 filing fee.

''(B) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse the denial of a claim for benefits which is the subject of the appeal.

''(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

''(1) USE OF QUALIFIED EXTERNAL APPEAL ENTITY.—

''(A) IN GENERAL.—The external appeal process under this section of a plan or issuer shall be conducted between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)). Nothing in this subsection shall be construed as requiring that such procedures provide for the selection for any plan of more than one such entity.

''(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The Secretary shall implement procedures to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner.

''(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of this paragraph shall be consistent with the standards the Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. All costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be

construed as applying to the imposition of a filing fee under subsection (a)(4).

''(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the Secretary that include at least the following:

''(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination described in subparagraph (B) based on evidence described in subparagraphs (C) and (D).

''(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's or issuer's decision is appropriate for the medical condition of the patient involved (as determined by the entity) taking into account as of the time of the entity's determination the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraphs (C) and (D). If the entity determines the decision is appropriate for such condition, the entity shall affirm the decision and to the extent that the entity determines the decision is not appropriate for such condition, the entity shall reverse the decision. Nothing in this subparagraph shall be construed as providing for coverage of items or services not provided or covered by the plan or issuer.

''(C) REQUIRED CONSIDERATION OF CERTAIN MATTERS.—In making such determination, the external appeal entity shall consider, but not be bound by—

''(i) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms;

''(ii) the decision made by the plan or issuer upon internal review under section 2802 and any guidelines or standards used by the plan or issuer in reaching such decision; and

''(iii) the opinion of the individual's treating physician or health care professional.

The entity also shall consider any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed. The entity also shall consider the results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

''(D) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

''(i) The results of professional consensus conferences.

''(ii) Practice and treatment policies.

''(iii) Community standard of care.

''(iv) Generally accepted principles of professional medical practice consistent with the best practice of medicine.

''(v) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

''(vi) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

''(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—

''(i) IN GENERAL.—A qualified external appeal entity shall determine—

''(I) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

''(II) whether an externally appealable decision involves an expedited appeal;

''(III) for purposes of initiating an external review, whether the internal review process has been completed; and

''(IV) whether the item or services is covered under the plan or coverage.

''(ii) CONSTRUCTION.—Nothing in a determination by a qualified external appeal entity under this section shall be construed as authorizing, or providing for, coverage of items and services for which benefits are not provided under the plan or coverage.

''(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

''(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide to the external appeal entity timely access to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity. The provider involved shall provide to the external appeal entity timely access to information relevant to the matter of the externally appealable decision, as determined by the entity.

''(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

''(i) be made orally or in written or electronic form and, if it is made orally, shall be supplied to the parties in written or electronic form as soon as possible;

''(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 48 hours after the time) of requesting an external appeal of the decision;

''(iii) state, in layperson's language, the scientific rationale for such determination as well as the basis for such determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

''(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek binding arbitration or further review by the courts (or other process) of the external appeal determination.

''(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity determines that a denial of a claim for benefits was not reasonable and reverses the denial, the plan or issuer—

''(i) shall (upon the receipt of the determination) authorize the provision or payment for benefits in accordance with such determination;

''(ii) shall take such actions as may be necessary to provide or pay for benefits (including items or services) in a timely manner consistent with such determination; and

''(iii) shall submit information to the entity documenting compliance with the entity's determination and this subparagraph.

''(J) CONSTRUCTION.—Nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are not provided under the plan or coverage.

''(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified external appeal entity' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

''(A) The entity meets the independence requirements of paragraph (3).

''(B) The entity conducts external appeal activities through at least three clinical peers who are practicing physicians.

''(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

''(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

''(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to a group health plan or health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements—

''(i) by the applicable State authority (or under a process recognized or approved by such authority); or

''(ii) if the State has not established a certification and recertification process for such entities, by the Secretary, under a process recognized or approved by the Secretary, or to the extent provided in subparagraph (C)(ii), by a qualified private standard-setting organization (certified under such subparagraph), if elected by the entity.

''(B) RECERTIFICATION PROCESS.—The Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a review of—

''(i) the number of cases reviewed;

''(ii) a summary of the disposition of those cases;

''(iii) the length of time in making determinations on those cases;

''(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

''(v) information necessary to assure that the entity meets the independence requirements (described in paragraph (3)) with respect to plans and issuers for which it conducts external review activities.

''(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of subparagraph (A)(ii), the Secretary may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external appeal entities. Such an organization shall only be certified if the organization does not certify an external appeal entity unless it meets standards as least as stringent as the standards required for certification of such an entity by the Secretary under subparagraph (A)(ii).

''(3) INDEPENDENCE REQUIREMENTS.—

''(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

''(i) the peer or entity is not affiliated with any related party;

''(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

''(iii) the plan and the issuer (if any) have no recourse against the peer or entity in connection with the external review; and

''(iv) the peer or entity does not otherwise have a conflict of interest with a related party.

''(B) RELATED PARTY.—For purposes of this paragraph, the term 'related party' means—

''(i) with respect to—

''(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

''(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

''(ii) the health care professional that provided the health care involved in the coverage decision;

''(iii) the institution at which the health care involved in the coverage decision is provided; or

''(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision.

''(C) AFFILIATED.—For purposes of this paragraph, the term 'affiliated' means, in connection with any peer or entity, having a familial, financial, or fiduciary relationship with such peer or entity.

''(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

''(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—

''(1) IN GENERAL.—The determination by an external appeal entity shall be binding on the plan (and issuer, if any) involved in the determination.

''(2) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as removing any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law, including the right to file judicial actions to enforce rights.

''(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL APPEAL ENTITY.—

''(1) MONETARY PENALTIES.—In any case in which the determination of an external appeal entity is not followed in a timely fashion by a group health plan, or by a health insurance issuer offering health insurance coverage, any named fiduciary who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external appeal entity until the date the refusal to provide the benefit is corrected.

''(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

''(A) to cease and desist from the alleged action or failure to act; and

''(B) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

''(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as removing or limiting any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law (including section 502 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

''SEC. 2804. ESTABLISHMENT OF A GRIEVANCE PROCESS.

''(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

''(2) GRIEVANCE DEFINED.—In this section, the term 'grievance' means any question, complaint, or concern brought by a participant, beneficiary, or enrollee that is not a claim for benefits.

''(b) GRIEVANCE SYSTEM.—Such system shall include the following components with respect to individuals who are participants, beneficiaries, or enrollees:

''(1) Written notification to all such individuals and providers of the telephone numbers and business addresses of the plan or issuer personnel responsible for resolution of grievances and appeals.

''(2) A system to record and document, over a period of at least 3 previous years beginning two months after the date of the enactment of this Act, all grievances and appeals made and their status.

''(3) A process providing processing and resolution of grievances within 60 days.

''(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

Grievances are not subject to appeal under the previous provisions of this subtitle.

''Subtitle B—Access to Care

''SEC. 2811. CONSUMER CHOICE OPTION.

''(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such nonnetwork coverage through another health insurance issuer.

''(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

''(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

''SEC. 2812. CHOICE OF HEALTH CARE PROFESSIONAL.

''(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

''(b) SPECIALISTS.—A group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

''SEC. 2813. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

''(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

''(i) by a nonparticipating health care provider with or without prior authorization, or

''(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

''(2) DEFINITIONS.—In this section:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act; and

''(ii) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(B) EMERGENCY SERVICES.—The term 'emergency services' means—

''(i) with respect to an emergency medical condition described in subparagraph (A)(i)—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

''(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment

as are required under section 1867 of such Act to stabilize the patient; or

''(ii) with respect to an emergency medical condition described in subparagraph (A)(ii), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(C) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—If benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, with respect to maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with such guidelines).

''(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2))) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

''(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''SEC. 2814. ACCESS TO SPECIALTY CARE.

''(a) SPECIALTY CARE FOR COVERED SERVICES.—

''(1) IN GENERAL.—If—

''(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

''(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist or the individual requires physician pathology services, and

''(C) benefits for such treatment or services are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible (consistent with standards developed under section 2818) to provide the treatment for such condition or disease or to provide such services.

''(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition or services, a health care practitioner, facility, or center or physician pathologist that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise and in the case of a pregnant woman, appropriate obstetrical expertise) to provide high quality care in treating the condition or to provide physician pathology services.

''(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) with respect to treatment be—

''(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

''(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have a specialist that is available and accessible to treat the individual's condition or provide physician pathology services and that is a participating provider with respect to such treatment or services.

''(5) REFERRALS TO NONPARTICIPATING PROVIDERS.—In a case in which a referral of an individual to a nonparticipating specialist is required under paragraph (1), the group health plan or health insurance issuer shall provide the individual the option of at least three nonparticipating specialists.

''(6) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

''(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

''(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

''(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

''(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term 'ongoing special condition' means a condition or disease that—

''(A) is life-threatening, degenerative, or disabling, and

''(B) requires specialized medical care over a prolonged period of time.

''(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition from having the individual's primary care physician assume the responsibilities for providing and coordinating care described in paragraph (1).

''(c) STANDING REFERRALS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

''(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''SEC. 2815. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

''(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

''(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for covered gynecological care (including preventive women's health examinations) or for covered pregnancy-related services provided by a participating physician (including a family practice physician) who specializes or is trained and experienced in gynecology or obstetrics, respectively, to the extent such care is otherwise covered; and

''(2) shall treat the ordering of other gynecological or obstetrical care by such a participating physician as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

''(1) waive any exclusions of coverage under the terms of the plan with respect to coverage of gynecological or obstetrical care;

''(2) preclude the group health plan or health insurance issuer involved from requiring that the gynecologist or obstetrician notify the primary care health care professional or the plan of treatment decisions; or

''(3) prevent a plan or issuer from offering, in addition to physicians described in subsection (a)(1), non-physician health care professionals who are trained and experienced in gynecology or obstetrics.

"SEC. 2816. ACCESS TO PEDIATRIC CARE.

''(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician (including a family practice physician) who specializes or is trained and experienced in pediatrics as the child's primary care provider.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

"SEC. 2817. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

''(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

''(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

''(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(3) DEFINITIONS.—For purposes of this section:

''(A) ONGOING SPECIAL CONDITION.—The term 'ongoing special condition' has the meaning given such term in section 2814(b)(3), and also includes pregnancy.

''(B) TERMINATION.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

''(3) PREGNANCY.—If—

''(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—If—

''(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

"SEC. 2818. NETWORK ADEQUACY.

''(a) REQUIREMENT.—A group health plan, and a health insurance issuer providing health insurance coverage, shall meet such standards for network adequacy as are established by law pursuant to this section.

''(b) DEVELOPMENT OF STANDARDS.—

''(1) ESTABLISHMENT OF PANEL.—There is established a panel to be known as the Health Care Panel to Establish Network Adequacy Standards (in this section referred to as the 'Panel').

''(2) DUTIES OF PANEL.—The Panel shall devise standards for group health plans and health insurance issuers that offer health insurance coverage to ensure that—

''(A) participants, beneficiaries, and enrollees have access to a sufficient number, mix, and distribution of health care professionals and providers; and

''(B) covered items and services are available and accessible to each participant, beneficiary, and enrollee—

''(i) in the service area of the plan or issuer;

''(ii) at a variety of sites of service;

''(iii) with reasonable promptness (including reasonable hours of operation and after hours services);

''(iv) with reasonable proximity to the residences or workplaces of enrollees; and

''(v) in a manner that takes into account the diverse needs of enrollees and reasonably assures continuity of care.

''(c) MEMBERSHIP.—

''(1) SIZE AND COMPOSITION.—The Panel shall be composed of 15 members. The Secretary of Health and Human Services, the Majority Leader of the Senate, and the Speaker of House of Representatives shall each appoint 1 member from representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, and State medical specialty societies.

''(2) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

''(3) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

''(d) PROCEDURES.—

''(1) MEETINGS.—The Panel shall meet at the call of a majority of its members.

''(2) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

''(3) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

''(4) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

''(e) ADMINISTRATION.—

''(1) COMPENSATION.—Except as provided in paragraph (1), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

''(2) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(3) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(4) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

''(f) REPORT AND ESTABLISHMENT OF STANDARDS.—Not later than 2 years after the first meeting, the Panel shall submit a report to Congress and the Secretary of Health and Human Services detailing the standards devised under subsection (b) and recommendations regarding the implementation of such standards. Such standards shall take effect to the extent provided by Federal law enacted after the date of the submission of such report.

''(g) TERMINATION.—The Panel shall terminate on the day after submitting its report to the Secretary of Health and Human Services under subsection (f).

"SEC. 2819. ACCESS TO EXPERIMENTAL OR INVESTIGATIONAL PRESCRIPTION DRUGS.

''No use of a prescription drug or medical device shall be considered experimental or investigational under a group health plan or under health insurance coverage provided by a health insurance issuer if such use is included in the labeling authorized by the U.S. Food and Drug Administration under section 505, 513 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under section 351 of the Public Health Service Act (42 U.S.C. 262), unless such use is demonstrated to be unsafe or ineffective.

"SEC. 2820. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage) provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan or an enrollee in health insurance coverage and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan (or health insurance issuer offering health insurance) shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) ROUTINE PATIENT CARE COSTS.—For purposes of this section—

''(A) IN GENERAL.—The term 'routine patient care costs' includes the costs associated with the provision of items and services that—

''(i) would otherwise be covered under the group health plan or health insurance coverage if such items and services were not provided in connection with an approved clinical trial program; and

''(ii) are furnished according to the protocol of an approved clinical trial program.

''(B) EXCLUSION.—Such term does include the costs associated with the provision of—

''(i) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(ii) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(3) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable items or services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of the Employee Retirement Income Security Act of 1974.

''(g) STUDY AND REPORT.—

''(1) STUDY.—The Secretary of Health and Human Services, in consultation with the Secretary and the Secretary of the Treasury, shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(A) the cost of patient care in trials versus standard care;

''(B) the cost effectiveness achieved in different sites of service;

''(C) research outcomes;

''(D) volume of research subjects available in different sites of service;

''(E) access to research sites and clinical trials by cancer patients;

''(F) patient cost sharing or copayment costs realized in different sites of service;

''(G) health outcomes experienced in different sites of service;

''(H) long term health care services and costs experienced in different sites of service;

''(I) morbidity and mortality experienced in different sites of service; and

''(J) patient satisfaction and preference of sites of service.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary of Health and Human Services shall submit a report to Congress that contains—

''(A) an assessment of any incremental cost to group health plans and health insurance issuers resulting from the provisions of this section;

''(B) a projection of expenditures to such plans and issuers resulting from this section;

''(C) an assessment of any impact on premiums resulting from this section; and

''(D) recommendations regarding action on other diseases.

"Subtitle C—Access to Information

"SEC. 2821. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—

''(1) GROUP HEALTH PLANS.—A group health plan shall—

''(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b);

''(B) provide to participants and beneficiaries, within a reasonable period (as specified by the Secretary) before or after the date of significant changes in the information described in subsection (b), information on such significant changes; and

''(C) upon request, make available to participants and beneficiaries, the Secretary, and prospective participants and beneficiaries, the information described in subsection (b) or (c).

The plan may charge a reasonable fee for provision in printed form of any of the information described in subsection (b) or (c) more than once during any plan year.

''(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

''(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b);

''(B) provide to enrollees, within a reasonable period (as specified by the Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

''(C) upon request, make available to the Secretary, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c).

''(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer shall be provided to a participant, beneficiary, or enrollee free of charge at least once a year and includes the following:

''(1) SERVICE AREA.—The service area of the plan or issuer.

''(2) BENEFITS.—Benefits offered under the plan or coverage, including—

''(A) those that are covered benefits ''(all of which shall be referred to by such relevant CPT and DRG codes as are available), limits and conditions on such benefits, and those benefits that are explicitly excluded from coverage (all of which shall be referred to by

such relevant CPT and DRG codes as are available);

''(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

''(C) the extent to which benefits may be obtained from nonparticipating providers;

''(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

''(E) process for determining experimental coverage; and

''(F) use of a prescription drug formulary.

''(3) ACCESS.—A description of the following:

''(A) The number, mix, and distribution of providers under the plan or coverage.

''(B) Out-of-network coverage (if any) provided by the plan or coverage.

''(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

''(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

''(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

''(F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

''(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 2812(b)(2).

''(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

''(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(B) the process and procedures of the plan or issuer for obtaining emergency services; and

''(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

''(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

''(8) ACCOUNTABILITY.—A description of the legal recourse options available for participants and beneficiaries under the plan including—

''(A) the preemption that applies under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) to certain actions arising out of the provision of health benefits; and

''(B) the extent to which coverage decisions made by the plan are subject to internal review or any external review and the proper time frames under

''(9) QUALITY ASSURANCE.—Any information made public by an accrediting organization in the process of accreditation of the plan or issuer or any additional quality indicators the plan or issuer makes available.

''(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

''(11) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

''(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

''(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 2801.

''(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

''(3) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

''(4) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

''Subtitle D—Protecting the Doctor-Patient Relationship

''SEC. 2831. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

''(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

''SEC. 2832. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

''(b) CONSTRUCTION.—Subsection (a) shall not be construed—

''(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

''(2) to override any State licensure or scope-of-practice law;

''(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer; or

''(4) as prohibiting a family practice physician with appropriate expertise from providing pediatric or obstetrical or gynecological care.

''SEC. 2833. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

''(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

''SEC. 2834. PAYMENT OF CLEAN CLAIMS.

''A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer,in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

''Subtitle E—Definitions

''SEC. 2841. DEFINITIONS.

''(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this title:

''(1) APPLICABLE AUTHORITY.—The term 'applicable authority' means—

''(A) in the case of a group health plan, the Secretary of Health and Human Services; and

''(B) in the case of a health insurance issuer with respect to a specific provision of this title, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

''(2) CLINICAL PEER.—The term 'clinical peer' means, with respect to a review or appeal, a practicing physician or other health care professional who holds a nonrestricted license and who is—

''(A) appropriately certified by a nationally recognized, peer reviewed accrediting body in the same or similar specialty as typically manages the medical condition,

procedure, or treatment under review or appeal, or

''(B) is trained and experienced in managing such condition, procedure, or treatment,

and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

''(3) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

''(4) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(5) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

''(6) NETWORK.—The term 'network' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

''(7) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(8) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(9) PHYSICIAN.—The term 'physician' means an allopathic or osteopathic physician.

''(10) PRACTICING PHYSICIAN.—The term 'practicing physician' means a physician who is licensed in the State in which the physician furnishes professional services and who provides professional services to individual patients on average at least two full days per week.

''(11) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

''SEC. 2842. RULE OF CONSTRUCTION.

''(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

''(1) IN GENERAL.—Subject to paragraph (2), this title 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 except to the extent that such standard or requirement prevents the application of a requirement of this title.

''(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974.

''(b) 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 District of Columbia, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

''SEC. 2843. EXCLUSIONS.

''(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to provide specific benefits under the terms of such plan or coverage, other than those provided under the terms of such plan or coverage.

''(b) EXCLUSION FOR FEE-FOR-SERVICE COVERAGE.—

''(1) IN GENERAL.—

''(A) GROUP HEALTH PLANS.—The provisions of sections 2811 through 2821 shall not apply to a group health plan if the only coverage offered under the plan is fee-for-service coverage (as defined in paragraph (2)).

''(B) HEALTH INSURANCE COVERAGE.—The provisions of sections 2801 through 2821 shall not apply to health insurance coverage if the only coverage offered under the coverage is fee-for-service coverage (as defined in paragraph (2)).

''(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term 'fee-for-service coverage' means coverage under a group health plan or health insurance coverage that—

''(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

''(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

''(C) allows access to any provider that is lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

''(D) for which the plan or issuer does not require prior authorization before providing for any health care services.

''SEC. 2844. COVERAGE OF LIMITED SCOPE PLANS.

''Only for purposes of applying the requirements of this title under sections 2707 and 2753, section 2791(c)(2)(A) shall be deemed not to apply.

''SEC. 2845. REGULATIONS.

''The Secretary of Health and Human Services shall issue such regulations as may be necessary or appropriate to carry out this title under sections 2707 and 2753. The Secretary may promulgate such regulations in the form of interim final rules as may be necessary to carry out this title in a timely manner.

''SEC. 2846. LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.

''The requirements of this title shall apply with respect to group health plans only—

''(1) in the case of a plan that is a non-Federal governmental plan (as defined in section 2791(d)(8)(C)), and

''(2) 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), except that subtitle A shall apply with respect to such coverage only to the extent it is offered in connection with a non-Federal governmental plan or a church plan.''.

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

SEC. 201. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. PATIENT PROTECTION STANDARDS.

''A group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of part 8 and such requirements shall be deemed to be incorporated into this section.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subpart A of part 8 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial. For purposes of applying the previous sentence, the exceptions provided under section 732 shall be deemed to apply.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

SEC. 202. IMPROVING MANAGED CARE.

(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 8—IMPROVING MANAGED CARE

''SUBPART A—GRIEVANCE AND APPEALS

''SEC. 801. UTILIZATION REVIEW ACTIVITIES.

''(a) COMPLIANCE WITH REQUIREMENTS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage in connection with such a plan, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

''(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

''(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms 'utilization review' and 'utilization review activities' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

''(b) WRITTEN POLICIES AND CRITERIA.—

''(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

''(2) USE OF WRITTEN CRITERIA.—

''(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate practicing physicians, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

''(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for a participant or beneficiary under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the individual during the same course of treatment.

''(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for periodic evaluation at reasonable intervals of the clinical appropriateness of a sample of denials of claims for benefits.

''(c) CONDUCT OF PROGRAM ACTIVITIES.—

''(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by appropriate physician specialists who shall be selected by the plan or issuer and who shall oversee review decisions.

''(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

''(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

''(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits. This subparagraph shall not preclude any capitation arrangements between plans and providers.

''(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

''(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

''(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

''(d) DEADLINE FOR DETERMINATIONS.—

''(1) PRIOR AUTHORIZATION SERVICES.—

''(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, no later than the deadline specified in subparagraph (B). The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided.

''(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a utilization review program—

''(I) receives a request for a prior authorization,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 2 business days after notification,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in section 802(c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of the request for prior authorization.

''(2) ONGOING CARE.—

''(A) CONCURRENT REVIEW.—

''(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed or electronic form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 802(c)(1)(A) to be completed before the termination or reduction takes effect.

''(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

''(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

''(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

''(4) FAILURE TO MEET DEADLINE.—In a case in which a group health plan or health insurance issuer fails to make a determination on a claim for benefit under paragraph (1), (2)(A), or (3) by the applicable deadline established under the respective paragraph, the failure shall be treated under this subpart as a denial of the claim as of the date of the deadline.

''(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, POST-STABILIZATION CARE, AND EMERGENCY AMBULANCE SERVICES.—For waiver of prior authorization requirements in certain cases involving emergency services, maintenance care and post-stabilization care, and emergency ambulance services, see subsections (a)(1), (b), and (c)(1) of section 813, respectively.

''(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

''(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed or electronic form and written in a manner calculated to be understood by the participant or beneficiary and shall include—

''(A) the reasons for the denial (including the clinical rationale);

''(B) instructions on how to initiate an appeal under section 802; and

''(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

''(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

''(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subpart:

''(1) CLAIM FOR BENEFITS.—The term 'claim for benefits' means any request for coverage (including authorization of coverage), or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage offered in connection with such a plan.

''(2) DENIAL OF CLAIM FOR BENEFITS.—The term 'denial' means, with respect to a claim for benefits, a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide or pay for benefits (including items and services) required to be provided or paid for under this part.

''SEC. 802. INTERNAL APPEALS PROCEDURES.

''(a) RIGHT OF REVIEW.—

''(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage in connection with such a plan—

''(A) shall provide adequate notice in written or electronic form to any participant or beneficiary under such plan whose claim for benefits under the plan or coverage has been denied (within the meaning of section 801(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in layman's terms to be understood by the participant or beneficiary; and

''(B) shall afford such a participant or beneficiary (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to

provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity of not less than 180 days to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to such coverage) of the decision denying the claim.

''(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in written or electronic form.

''(b) INTERNAL REVIEW PROCESS.—

''(1) CONDUCT OF REVIEW.—

''(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual (who shall be a physician in a case involving medical judgment) who has been selected by the plan or issuer and who did not make the initial denial in the internally appealable decision, except that in the case of limited scope coverage (as defined in subparagraph (B)) an appropriate specialist shall review the decision.

''(B) LIMITED SCOPE COVERAGE DEFINED.—For purposes of subparagraph (A), the term 'limited scope coverage' means a group health plan or health insurance coverage the only benefits under which are for benefits described in section 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)).

''(2) TIME LIMITS FOR INTERNAL REVIEWS.—

''(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed or electronic form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided. The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

''(I) receives a request for internal review,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 48 hours after notification,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of request for review.

''(c) EXPEDITED REVIEW PROCESS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

''(A) in which, as determined by the plan or issuer or as certified in writing by a treating physician, the application of the normal timeframe for making the determination could seriously jeopardize the life or health of the participant or beneficiary or such individual's ability to regain maximum function; or

''(B) described in section 801(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

''(2) PROCESS.—Under such procedures—

''(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

''(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

''(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

''(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 48 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

''(d) WAIVER OF PROCESS.—A plan or issuer may waive its rights for an internal review under subsection (b). In such case the participant or beneficiary involved (and any designee or provider involved) shall be relieved of any obligation to complete the review involved and may, at the option of such participant, beneficiary, designee, or provider, proceed directly to seek further appeal through any applicable external appeals process.

''SEC. 803. EXTERNAL APPEALS PROCEDURES.

''(a) RIGHT TO EXTERNAL APPEAL.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with such a plan, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made (within a reasonable period not to exceed 365 days) either by the plan or issuer or by the participant or beneficiary (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent).

''(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'externally appealable decision' means a denial of claim for benefits (as defined in section 801(f)(2)), if—

''(i) the item or service involved is covered under the plan or coverage,

''(ii) the amount involved exceeds $100, increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from such index for September 2000, and

''(iii) the requirements of subparagraph (B) are met with respect to such denial.

Such term also includes a failure to meet an applicable deadline for internal review under section 802 or such standards as are established pursuant to section 818.

''(B) REQUIREMENTS.—For purposes of subparagraph (A)(iii), the requirements of this subparagraph are met with respect to a denial of a claim for benefits if—

''(i) the denial is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or

''(ii) in such denial, the decision as to whether an item or service is covered involves a medical judgment.

''(C) EXCLUSIONS.—The term 'externally appealable decision' does not include—

''(i) specific exclusions or express limitations on the amount, duration, or scope of coverage; or

''(ii) a decision regarding eligibility for any benefits.

''(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 802(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 802, but only if the decision is made in a timely basis consistent with the deadlines provided under this subpart.

''(4) FILING FEE REQUIREMENT.—

''(A) IN GENERAL.—A plan or issuer may condition the use of an external appeal process upon payment in advance to the plan or issuer of a $25 filing fee.

''(B) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse the denial of a claim for benefits which is the subject of the appeal.

''(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

''(1) USE OF QUALIFIED EXTERNAL APPEAL ENTITY.—

''(A) IN GENERAL.—The external appeal process under this section of a plan or issuer shall be conducted between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)). Nothing in this subsection shall be construed as requiring that such procedures provide for the selection for any plan of more than one such entity.

''(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The Secretary shall implement procedures to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner.

''(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of this paragraph shall be consistent with the standards the Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. All costs of the process (except those incurred by the participant, beneficiary, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant or beneficiary. The previous sentence shall not be construed as applying to the imposition of a filing fee under subsection (a)(4).

''(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the Secretary that include at least the following:

''(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination described in subparagraph (B) based on evidence described in subparagraphs (C) and (D).

''(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's or issuer's decision is appropriate for the medical condition of the patient involved (as determined by the entity) taking into account as of the time of the entity's determination the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraphs (C) and (D). If the entity determines the decision is appropriate for such condition, the entity shall affirm the decision and to the extent that the entity determines the decision is not appropriate for such condition, the entity shall reverse the decision. Nothing in this subparagraph shall be construed as providing for coverage of items or services not provided or covered by the plan or issuer.

''(C) REQUIRED CONSIDERATION OF CERTAIN MATTERS.—In making such determination, the external appeal entity shall consider, but not be bound by—

''(i) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms;

''(ii) the decision made by the plan or issuer upon internal review under section 802 and any guidelines or standards used by the plan or issuer in reaching such decision; and

''(iii) the opinion of the individual's treating physician or health care professional.

The entity also shall consider any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed. The entity also shall consider the results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

''(D) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

''(i) The results of professional consensus conferences.

''(ii) Practice and treatment policies.

''(iii) Community standard of care.

''(iv) Generally accepted principles of professional medical practice consistent with the best practice of medicine.

''(v) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

''(vi) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

''(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—

''(i) IN GENERAL.—A qualified external appeal entity shall determine—

''(I) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

''(II) whether an externally appealable decision involves an expedited appeal;

''(III) for purposes of initiating an external review, whether the internal review process has been completed; and

''(IV) whether the item or services is covered under the plan or coverage.

''(ii) CONSTRUCTION.—Nothing in a determination by a qualified external appeal entity under this section shall be construed as authorizing, or providing for, coverage of items and services for which benefits are not provided under the plan or coverage.

''(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

''(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide to the external appeal entity timely access to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity. The provider involved shall provide to the external appeal entity timely access to information relevant to the matter of the externally appealable decision, as determined by the entity.

''(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

''(i) be made orally or in written or electronic form and, if it is made orally, shall be supplied to the parties in written or electronic form as soon as possible;

''(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 48 hours after the time) of requesting an external appeal of the decision;

''(iii) state, in layperson's language, the scientific rationale for such determination as well as the basis for such determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

''(iv) inform the participant or beneficiary of the individual's rights (including any limitation on such rights) to seek binding arbitration or further review by the courts (or other process) of the external appeal determination.

''(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity determines that a denial of a claim for benefits was not reasonable and reverses the denial, the plan or issuer—

''(i) shall (upon the receipt of the determination) authorize benefits in accordance with such determination;

''(ii) shall take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

''(iii) shall submit information to the entity documenting compliance with the entity's determination and this subparagraph.

''(J) CONSTRUCTION.—Nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are not provided under the plan or coverage.

''(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified external appeal entity' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

''(A) The entity meets the independence requirements of paragraph (3).

''(B) The entity conducts external appeal activities through at least three clinical peers who are practicing physicians.

''(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

''(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

''(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to a group health plan or a health insurance issuer in connection with a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified), under such standards as may be prescribed by the Secretary, as meeting the requirements of paragraph (1)—

''(i) by the Secretary;

''(ii) under a process recognized or approved by the Secretary; or

''(iii) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization (certified under such subparagraph), if elected by the entity.

''(B) RECERTIFICATION PROCESS.—The Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a review of—

''(i) the number of cases reviewed;

''(ii) a summary of the disposition of those cases;

''(iii) the length of time in making determinations on those cases;

''(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

''(v) information necessary to assure that the entity meets the independence requirements (described in paragraph (3)) with respect to plans and issuers for which it conducts external review activities.

''(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of subparagraph (A)(iii), the Secretary shall provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external appeal entities. Such an organization shall only be certified if the organization does not certify an external appeal entity unless it meets standards at least as stringent as the standards required for certification of such an entity by the Secretary under subparagraph (A)(i).

''(D) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting the Secretary to delegate certification or regulatory authority under clause (i) of such subparagraph to any person outside the Department of Labor.

''(3) INDEPENDENCE REQUIREMENTS.—

''(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

''(i) the peer or entity is not affiliated with any related party;

''(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

''(iii) the plan and the issuer (if any) have no recourse against the peer or entity in connection with the external review; and

''(iv) the peer or entity does not otherwise have a conflict of interest with a related party.

''(B) RELATED PARTY.—For purposes of this paragraph, the term 'related party' means—

''(i) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

''(ii) the health care professional that provided the health care involved in the coverage decision;

''(iii) the institution at which the health care involved in the coverage decision is provided; or

''(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision.

''(C) AFFILIATED.—For purposes of this paragraph, the term 'affiliated' means, in connection with any peer or entity, having a familial, financial, or fiduciary relationship with such peer or entity.

''(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty,

function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

''(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—

''(1) IN GENERAL.—The determination by an external appeal entity shall be binding on the plan (and issuer, if any) involved in the determination.

''(2) PROTECTION OF LEGAL RIGHTS.—Nothing in this subpart shall be construed as removing any legal rights of participants, beneficiaries, and others under State or Federal law, including the right to file judicial actions to enforce rights.

''(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL APPEAL ENTITY.—

''(1) MONETARY PENALTIES.—In any case in which the determination of an external appeal entity is not followed in a timely fashion by a group health plan, or by a health insurance issuer offering health insurance coverage in connection with such a plan, any named fiduciary who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant or beneficiary for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external appeal entity until the date the refusal to provide the benefit is corrected.

''(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant or beneficiary with respect to a group health plan, or a health insurance issuer offering health insurance coverage in connection with such a plan, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subpart, or has failed to take an action for which such person is responsible under the plan, coverage, or this part and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

''(A) to cease and desist from the alleged action or failure to act; and

''(B) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

''(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subpart shall be construed as removing or limiting any legal rights of participants, beneficiaries, and others under State or Federal law (including section 502), including the right to file judicial actions to enforce rights.

''SEC. 804. ESTABLISHMENT OF A GRIEVANCE PROCESS.

''(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants or beneficiaries or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

''(2) GRIEVANCE DEFINED.—In this section, the term 'grievance' means any question, complaint, or concern brought by a participant or beneficiary that is not a claim for benefits.

''(b) GRIEVANCE SYSTEM.—Such system shall include the following components with respect to individuals who are participants or beneficiaries:

''(1) Written notification to all such individuals and providers of the telephone numbers and business addresses of the plan or issuer personnel responsible for resolution of grievances and appeals.

''(2) A system to record and document, over a period of at least 3 previous years beginning two months after the date of the enactment of this Act, all grievances and appeals made and their status.

''(3) A process providing processing and resolution of grievances within 60 days.

''(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

Grievances are not subject to appeal under the previous provisions of this subpart.

''SUBPART B—ACCESS TO CARE

''SEC. 812. CHOICE OF HEALTH CARE PROFESSIONAL.

''(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage in connection with such a plan, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer shall permit each participant and beneficiary to designate any participating primary care provider who is available to accept such individual.

''(b) SPECIALISTS.—A group health plan and a health insurance issuer that offers health insurance coverage in connection with such a plan shall permit each participant or beneficiary to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

''SEC. 813. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer in connection with such a plan, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

''(C) in a manner so that, if such services are provided to a participant or beneficiary—

''(i) by a nonparticipating health care provider with or without prior authorization, or

''(ii) by a participating health care provider without prior authorization,

the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

''(2) DEFINITIONS.—In this section:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act; and

''(ii) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(B) EMERGENCY SERVICES.—The term 'emergency services' means—

''(i) with respect to an emergency medical condition described in subparagraph (A)(i)—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

''(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(ii) with respect to an emergency medical condition described in subparagraph (A)(ii), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(C) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—If benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer in connection with such a plan, with respect to maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant or beneficiary other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with such guidelines).

''(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer in connection with such a plan, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2))) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

''(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term 'emergency ambulance services' means ambulance services (as defined for purposes of section

1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

"SEC. 814. ACCESS TO SPECIALTY CARE.

''(a) SPECIALTY CARE FOR COVERED SERVICES.—

''(1) IN GENERAL.—If—

''(A) an individual is a participant or beneficiary under a group health plan or is covered under health insurance coverage offered by a health insurance issuer in connection with such a plan,

''(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist or the individual requires physician pathology services, and

''(C) benefits for such treatment or services are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible (consistent with standards developed under section 818) to provide the treatment for such condition or disease or to provide such services.

''(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition or services, a health care practitioner, facility, or center or physician pathologist that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise and in the case of a pregnant woman, appropriate obstetrical expertise) to provide high quality care in treating the condition or to provide physician pathology services.

''(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) with respect to treatment be—

''(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

''(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have a specialist that is available and accessible to treat the individual's condition or provide physician pathology services and that is a participating provider with respect to such treatment or services.

''(5) REFERRALS TO NONPARTICIPATING PROVIDERS.—In a case in which a referral of an individual to a nonparticipating specialist is required under paragraph (1), the group health plan or health insurance issuer shall provide the individual the option of at least three nonparticipating specialists.

''(6) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

''(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

''(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage in connection with such a plan, shall have a procedure by which an individual who is a participant or beneficiary and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

''(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

''(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term 'ongoing special condition' means a condition or disease that—

''(A) is life-threatening, degenerative, or disabling, and

''(B) requires specialized medical care over a prolonged period of time.

''(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an individual who is a participant or beneficiary and who has an ongoing special condition from having the individual's primary care physician assume the responsibilities for providing and coordinating care described in paragraph (1).

''(c) STANDING REFERRALS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, shall have a procedure by which an individual who is a participant or beneficiary and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

''(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

"SEC. 815. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

''(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, requires or provides for a participant or beneficiary to designate a participating primary care health care professional, the plan or issuer—

''(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for covered gynecological care (including preventive women's health examinations) or for covered pregnancy-related services provided by a participating physician (including a family practice physician) who specializes or is trained and experienced in gynecology or obstetrics, respectively, to the extent such care is otherwise covered; and

''(2) shall treat the ordering of other gynecological or obstetrical care by such a participating physician as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

''(1) waive any exclusions of coverage under the terms of the plan with respect to coverage of gynecological or obstetrical care;

''(2) preclude the group health plan or health insurance issuer involved from requiring that the gynecologist or obstetrician notify the primary care health care professional or the plan of treatment decisions; or

''(3) prevent a plan or issuer from offering, in addition to physicians described in subsection (a)(1), non-physician health care professionals who are trained and experienced in gynecology or obstetrics.

"SEC. 816. ACCESS TO PEDIATRIC CARE.

''(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, requires or provides for a participant or beneficiary to designate a participating primary care provider for a child of such individual, the plan or issuer shall permit the participant or beneficiary to designate a physician (including a family practice physician) who specializes or is trained and experienced in pediatrics as the child's primary care provider.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

"SEC. 817. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant or beneficiary in the plan or coverage is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

''(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

''(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

''(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan

and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(3) DEFINITIONS.—For purposes of this section:

''(A) ONGOING SPECIAL CONDITION.—The term 'ongoing special condition' has the meaning given such term in section 814(b)(3), and also includes pregnancy.

''(B) TERMINATION.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

''(3) PREGNANCY.—If—

''(A) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—If—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(B) the provider was treating the terminal illness before the date of termination, the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''SEC. 818. NETWORK ADEQUACY.

''(a) REQUIREMENT.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with such a plan, shall meet such standards for network adequacy as are established by law pursuant to this section.

''(b) DEVELOPMENT OF STANDARDS.—

''(1) ESTABLISHMENT OF PANEL.—There is established a panel to be known as the Health Care Panel to Establish Network Adequacy Standards (in this section referred to as the 'Panel').

''(2) DUTIES OF PANEL.—The Panel shall devise standards for group health plans and health insurance issuers that offer health insurance coverage in connection with such a plan to ensure that—

''(A) participants and beneficiaries have access to a sufficient number, mix, and distribution of health care professionals and providers; and

''(B) covered items and services are available and accessible to each participant and beneficiary—

''(i) in the service area of the plan or issuer;

''(ii) at a variety of sites of service;

''(iii) with reasonable promptness (including reasonable hours of operation and after hours services);

''(iv) with reasonable proximity to the residences or workplaces of participants and beneficiaries; and

''(v) in a manner that takes into account the diverse needs of such individuals and reasonably assures continuity of care.

''(c) MEMBERSHIP.—

''(1) SIZE AND COMPOSITION.—The Panel shall be composed of 15 members. The Secretary of Health and Human Services, the Majority Leader of the Senate, and the Speaker of House of Representatives shall each appoint 1 member from representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, and State medical specialty societies.

''(2) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

''(3) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

''(d) PROCEDURES.—

''(1) MEETINGS.—The Panel shall meet at the call of a majority of its members.

''(2) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

''(3) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

''(4) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

''(e) ADMINISTRATION.—

''(1) COMPENSATION.—Except as provided in paragraph (1), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

''(2) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(3) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(4) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

''(f) REPORT AND ESTABLISHMENT OF STANDARDS.—Not later than 2 years after the first meeting, the Panel shall submit a report to Congress and the Secretary of Health and Human Services detailing the standards devised under subsection (b) and recommendations regarding the implementation of such standards. Such standards shall take effect to the extent provided by Federal law enacted after the date of the submission of such report.

''(g) TERMINATION.—The Panel shall terminate on the day after submitting its report to the Secretary of Health and Human Services under subsection (f).

''SEC. 819. ACCESS TO EXPERIMENTAL OR INVESTIGATIONAL PRESCRIPTION DRUGS.

''No use of a prescription drug or medical device shall be considered experimental or investigational under a group health plan or under health insurance coverage provided by a health insurance issuer in connection with such a plan if such use is included in the labeling authorized by the U.S. Food and Drug Administration under section 505, 513 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under section 351 of the Public Health Service Act (42 U.S.C. 262), unless such use is demonstrated to be unsafe or ineffective.

''SEC. 820. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage in connection with such a plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan (or health insurance issuer offering health insurance) shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) ROUTINE PATIENT CARE COSTS.—For purposes of this section—

''(A) IN GENERAL.—The term 'routine patient care costs' includes the costs associated with the provision of items and services that—

''(i) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(ii) are furnished according to the protocol of an approved clinical trial program.

''(B) EXCLUSION.—Such term does include the costs associated with the provision of—

''(i) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(ii) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(3) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable items or services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''SUBPART C—ACCESS TO INFORMATION

''SEC. 821. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—

''(1) GROUP HEALTH PLANS.—A group health plan shall—

''(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b);

''(B) provide to participants and beneficiaries, within a reasonable period (as specified by the Secretary) before or after the date of significant changes in the information described in subsection (b), information on such significant changes; and

''(C) upon request, make available to participants and beneficiaries, the Secretary, and prospective participants and beneficiaries, the information described in subsection (b) or (c).

The plan may charge a reasonable fee for provision in printed form of any of the information described in subsection (b) or (c) more than once during any plan year.

''(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage in connection with a group health plan shall—

''(A) provide to participants and beneficiaries enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b);

''(B) provide to such participants and beneficiaries, within a reasonable period (as specified by the Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

''(C) upon request, make available to the Secretary, to individuals who are prospective participants and beneficiaries, and to the public the information described in subsection (b) or (c).

''(3) EMPLOYERS.—Effective 5 years after the date this part first becomes effective, each employer (other than an employer described in paragraph (1) of subsection (d)) shall provide to each employee at least annually information (consistent with such subsection) on the amount that the employer contributes on behalf of the employee (and any dependents of the employee) for health benefits coverage.

''(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer shall be provided to a participant or beneficiary free of charge at least once a year and includes the following:

''(1) SERVICE AREA.—The service area of the plan or issuer.

''(2) BENEFITS.—Benefits offered under the plan or coverage, including—

''(A) those that are covered benefits ''(all of which shall be referred to by such relevant CPT and DRG codes as are available), limits and conditions on such benefits, and those benefits that are explicitly excluded from coverage (all of which shall be referred to by such relevant CPT and DRG codes as are available);

''(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

''(C) the extent to which benefits may be obtained from nonparticipating providers;

''(D) the extent to which a participant or beneficiary may select from among participating providers and the types of providers participating in the plan or issuer network;

''(E) process for determining experimental coverage; and

''(F) use of a prescription drug formulary.

''(3) ACCESS.—A description of the following:

''(A) The number, mix, and distribution of providers under the plan or coverage.

''(B) Out-of-network coverage (if any) provided by the plan or coverage.

''(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

''(D) The procedures for participants and beneficiaries to select, access, and change participating primary and specialty providers.

''(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

''(F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

''(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 812(b)(2).

''(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

''(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(B) the process and procedures of the plan or issuer for obtaining emergency services; and

''(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

''(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

''(8) ACCOUNTABILITY.—A description of the legal recourse options available for participants and beneficiaries under the plan including—

''(A) the preemption that applies under section 514 to certain actions arising out of the provision of health benefits; and

''(B) the extent to which coverage decisions made by the plan are subject to internal review or any external review and the proper time frames under

''(9) QUALITY ASSURANCE.—Any information made public by an accrediting organization in the process of accreditation of the plan or issuer or any additional quality indicators the plan or issuer makes available.

''(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants and beneficiaries in seeking information or authorization for treatment.

''(11) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

''(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

''(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 801.

''(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

''(3) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

''(4) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

''(d) EMPLOYER INFORMATION.—

''(1) SMALL EMPLOYER EXEMPTION.—Subsection (a)(3) shall not apply to an employer that is a small employer (as defined in section 712(c)(1)(B)) or would be such an employer if '100' were substituted for '50' in such section.

''(2) COMPUTATION.—The amount described in subsection (a)(3) may be computed on an average, per employee basis, and may be based on rules similar to the rules applied in computing the applicable premium under section 604.

''(3) FORM OF DISCLOSURE.—The information under subsection (a)(3) may be provided in any reasonable form, including as part of the summary plan description, a letter, or information accompanying a W–2 form.

''(e) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

''SUBPART D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

''SEC. 831. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage offered in connection with such a plan (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

''(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

''SEC. 832. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with such a plan shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

''(b) CONSTRUCTION.—Subsection (a) shall not be construed—

''(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

''(2) to override any State licensure or scope-of-practice law;

''(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer; or

''(4) as prohibiting a family practice physician with appropriate expertise from providing pediatric or obstetrical or gynecological care.

''SEC. 833. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with such a plan may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

''(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant or beneficiary with the plan or organization, respectively.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

''SEC. 834. PAYMENT OF CLEAN CLAIMS.

''A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant or beneficiary with respect to benefits covered by the plan or issuer,in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant or beneficiary as well as claims referred to in such subparagraph.

''SUBPART E—DEFINITIONS

''SEC. 841. DEFINITIONS.

''(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 733 shall apply for purposes of this part in the same manner as they apply for purposes of part 7.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this part:

''(1) APPLICABLE AUTHORITY.—The term 'applicable authority' means—

''(A) in the case of a group health plan, the Secretary of Labor; and

''(B) in the case of a health insurance issuer with respect to a specific provision of this part, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

''(2) CLINICAL PEER.—The term 'clinical peer' means, with respect to a review or appeal, a practicing physician or other health care professional who holds a nonrestricted license and who is—

''(A) appropriately certified by a nationally recognized, peer reviewed accrediting body in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review or appeal, or

''(B) is trained and experienced in managing such condition, procedure, or treatment,

and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

''(3) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

''(5) NETWORK.—The term 'network' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants or beneficiaries.

''(6) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(7) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage offered by a health insurance issuer in connection with such a plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(8) PHYSICIAN.—The term 'physician' means an allopathic or osteopathic physician.

''(9) PRACTICING PHYSICIAN.—The term 'practicing physician' means a physician who is licensed in the State in which the physician furnishes professional services and who provides professional services to individual patients on average at least two full days per week.

''(10) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of

obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

"SEC. 842. RULE OF CONSTRUCTION.

''Nothing in this part or section 714 shall be construed to affect or modify the provisions of section 514.

"SEC. 843. EXCLUSIONS.

''(a) NO BENEFIT REQUIREMENTS.—Nothing in this part shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage in connection with such a plan to provide specific benefits under the terms of such plan or coverage, other than those provided under the terms of such plan or coverage.

''(b) EXCLUSION FOR FEE-FOR-SERVICE COVERAGE.—

''(1) IN GENERAL.—

''(A) GROUP HEALTH PLANS.—The provisions of sections 811 through 821 shall not apply to a group health plan if the only coverage offered under the plan is fee-for-service coverage (as defined in paragraph (2)).

''(B) HEALTH INSURANCE COVERAGE.—The provisions of sections 801 through 821 shall not apply to health insurance coverage if the only coverage offered under the coverage is fee-for-service coverage (as defined in paragraph (2)).

''(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term 'fee-for-service coverage' means coverage under a group health plan or health insurance coverage that—

''(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

''(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

''(C) allows access to any provider that is lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

''(D) for which the plan or issuer does not require prior authorization before providing for any health care services.

"SEC. 844. COVERAGE OF LIMITED SCOPE PLANS.

''Only for purposes of applying the requirements of this part under section 714, section 733(c)(2)(A) shall be deemed not to apply.

"SEC. 845. REGULATIONS.

''(a) REGULATIONS.—The Secretary of Labor shall issue such regulations as may be necessary or appropriate to carry out this part under section 714. The Secretary may promulgate such regulations in the form of interim final rules as may be necessary to carry out this part in a timely manner.''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—IMPROVING MANAGED CARE

''SUBPART A—GRIEVANCE AND APPEALS

''Sec. 801. Utilization review activities.
''Sec. 802. Internal appeals procedures.
''Sec. 803. External appeals procedures.
''Sec. 804. Establishment of a grievance process.

''SUBPART B—ACCESS TO CARE

''Sec. 812. Choice of health care professional.
''Sec. 813. Access to emergency care.
''Sec. 814. Access to specialty care.
''Sec. 815. Access to obstetrical and gynecological care.
''Sec. 816. Access to pediatric care.
''Sec. 817. Continuity of care.
''Sec. 818. Network adequacy.
''Sec. 819. Access to experimental or investigational prescription drugs.
''Sec. 820. Coverage for individuals participating in approved cancer clinical trials.

''SUBPART C—ACCESS TO INFORMATION

''Sec. 821. Patient access to information.

''SUBPART D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

''Sec. 831. Prohibition of interference with certain medical communications.
''Sec. 832. Prohibition of discrimination against providers based on licensure.
''Sec. 833. Prohibition against improper incentive arrangements.
''Sec. 834. Payment of clean claims.

''SUBPART E—DEFINITIONS

''Sec. 841. Definitions.
''Sec. 842. Preemption; State flexibility; construction.
''Sec. 843. Exclusions.
''Sec. 844. Coverage of limited scope plans.
''Sec. 845. Regulations.

SEC. 203. AVAILABILITY OF COURT REMEDIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

''(1) IN GENERAL.—In any case in which—

''(A) a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan or plan sponsor (not including a participating physician, other than a physician who participated in making the final decision under section 802 pursuant to section 802(b)(1)(A)) and who, under the plan, has authority to make final decisions under 802—

''(i) fails to exercise ordinary care in making an incorrect determination in the case of a participant or beneficiary that an item or service is excluded from coverage under the terms of the plan based on the fact that the item or service—

''(I) does not meet the requirements for medical appropriateness or necessity,

''(II) would constitute experimental treatment or technology (as defined under the plan), or

''(III) is not a covered benefit, or

''(ii) fails to exercise ordinary care to ensure that—

''(I) any denial of claim for benefits (within the meaning of section 801(f)), or

''(II) any decision by the plan on a request, made by a participant or beneficiary under section 802 or 803, for a reversal of an earlier decision of the plan,

is made and issued to the participant or beneficiary (in such form and manner as may be prescribed in regulations of the Secretary) before the end of the applicable period specified in section 801, 802, or 803, and

''(B) such failure is the proximate cause of substantial harm to, or wrongful death of, the participant or beneficiary,

such person shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (10)). For purposes of this subsection, the term 'final decision' means, with respect to a group health plan, the sole final decision of the plan under section 802.

''(2) ORDINARY CARE.—For purposes of this subsection, the term 'ordinary care' means the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent individual acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

''(3) SUBSTANTIAL HARM.—The term 'substantial harm' means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain.

''(4) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

''(i) any cause of action against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting within the scope of employment),

''(ii) a right of recovery or indemnity by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1), or

''(iii) any cause of action in connection with the provision of excepted benefits described in section 733(c), other than those described in section 733(c)(2).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) commenced against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment), but only if—

''(i) such action is based on the direct participation of the employer or other plan sponsor (or employee of the employer or plan sponsor) in the final decision of the plan with respect to a specific participant or beneficiary on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the decision on the claim resulted in substantial harm to, or the wrongful death of, such participant or beneficiary.

''(C) DIRECT PARTICIPATION.—For purposes of this subsection, the term 'direct participation' means, in connection with a final decision under section 802, the actual making of such final decision as a plan fiduciary or the actual exercise of final controlling authority in the approval of such final decision. In determining whether an employer or other plan sponsor (or employee of an employer or other plan sponsor) is engaged in direct participation in the final decision of the plan on a claim, the employer or plan sponsor (or employee) shall not be construed to be engaged in such direct participation (and to be liable for any damages whatsoever) because of any form of decisionmaking or other conduct, whether or not fiduciary in nature, that does not involve a final decision with respect to a specific claim for benefits by a specific participant or beneficiary, including (but not limited to)—

''(i) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

''(ii) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

''(iii) any participation by the employer or other plan sponsor (or employee) in the creation, continuation, modification, or termination of the plan or of any coverage, benefit, or item or service covered by the plan;

''(iv) any participation by the employer or other plan sponsor (or employee) in the design of any coverage, benefit, or item or service covered by the plan, including the amount of copayment and limits connected with such coverage, and the specification of any protocol, procedure, or policy for determining whether any such coverage, benefit,

or item or service is medically necessary and appropriate or is experimental or investigational;

''(v) any action by an agent of the employer or plan sponsor in making such a final decision on behalf of such employer or plan sponsor;

''(vi) any decision by an employer or plan sponsor (or employee) or agent acting on behalf of an employer or plan sponsor either to authorize coverage for, or to intercede or not to intercede as an advocate for or on behalf of, any specific participant or beneficiary (or group of participants or beneficiaries) under the plan;

''(vii) the approval of, or participation in the approval of, the plan provisions defining medical necessity or of policies or procedures that have a direct bearing on the outcome of the final decision; or

''(viii) any other form of decisionmaking or other conduct performed by the employer or other plan sponsor (or employee) in connection with the plan or coverage involved unless it involves the making of a final decision of the plan consisting of a failure described in clause (i) or (ii) of paragraph (1)(A) as to specific participants or beneficiaries who suffer substantial harm or wrongful death as a proximate cause of such decision.

''(5) REQUIRED DEMONSTRATION OF DIRECT PARTICIPATION.—An action against an employer or plan sponsor (or employee thereof) under this subsection shall be immediately dismissed—

''(A) in the absence of an allegation in the complaint of direct participation by the employer or plan sponsor in the final decision of the plan with respect to a specific participant or beneficiary who suffers substantial harm or wrongful death, or

''(B) upon a demonstration to the court that such employer or plan sponsor (or employee) did not directly participate in the final decision of the plan.

''(6) TREATMENT OF THIRD-PARTY PROVIDERS OF NONDISCRETIONARY ADMINISTRATIVE SERVICES.—Paragraph (1) does not authorize any action against any person providing nondiscretionary administrative services to employers or other plan sponsors.

''(7) REQUIREMENT OF EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(A) IN GENERAL.—Paragraph (1) applies in the case of any cause of action only if all remedies under section 503 (including remedies under sections 802 and 803, made applicable under section 714) with respect to such cause of action have been exhausted.

''(B) EXTERNAL REVIEW REQUIRED.—For purposes of subparagraph (A), administrative remedies under section 503 shall not be deemed exhausted until available remedies under section 803 have been elected and are exhausted by issuance of a final determination by an external appeal entity under such section.

''(C) CONSIDERATION OF ADMINISTRATIVE DETERMINATIONS.—Any determinations made under section 802 or 803 made while an action under this paragraph is pending shall be given due consideration by the court in such action.

''(8) USE OF EXTERNAL APPEAL ENTITY IN ESTABLISHING ABSENCE OF SUBSTANTIAL HARM OR CAUSATION IN LITIGATION.—

''(A) IN GENERAL.—In any action under this subsection by an individual in which damages are sought on the basis of substantial harm to the individual, the defendant may obtain (at its own expense), under procedures similar to procedures applicable under section 803, a determination by a qualified external appeal entity (as defined in section 803(c)(1)) that has not been involved in any stage of the grievance or appeals process which resulted in such action as to—

''(i) whether such substantial harm has been sustained, and

''(ii) whether the proximate cause of such injury was the result of the failure of the defendant to exercise ordinary care, as described in paragraph (1)(A).

''(B) EFFECT OF FINDING IN FAVOR OF DEFENDANT.—If the external appeal entity determines that such an injury has not been sustained or was not proximately caused by such a failure, such a finding shall be an affirmative defense, and the action shall be dismissed forthwith unless such finding is overcome upon a showing of clear and convincing evidence to the contrary. Notwithstanding subsection (g), in any case in which the plaintiff fails in any attempt to make such a showing to the contrary, the court shall award to the defendant reasonable attorney's fees and the costs of the action incurred in connection with such failed showing.

''(9) REBUTTABLE PRESUMPTION.—In the case of any action commenced pursuant to paragraph (1), there shall be a rebuttable presumption in favor of the decision of the external appeal entity rendered upon completion of any review elected under section 803 and such presumption may be overcome only upon a showing of clear and convincing evidence to the contrary.

''(10) MAXIMUM NONECONOMIC DAMAGES.—Total liability for noneconomic loss under this subsection in connection with any failure with respect to any participant or beneficiary may not exceed the lesser of—

''(A) $500,000, or

''(B) 2 times the amount of economic loss. The dollar amount under subparagraph (A), shall be increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from such index for September 2000

''(11) PROHIBITION OF AWARD OF PUNITIVE DAMAGES.—

''(A) GENERAL RULE.—Except as provided in this paragraph, nothing in this subsection shall be construed as authorizing a cause of action for punitive, exemplary, or similar damages.

''(B) EXCEPTION.—Punitive damages are authorized in any case described in paragraph (1)(A)(ii)(II) in which the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with a conscious, flagrant indifference to the rights or safety of others was the proximate cause of the harm that is the subject of the action and that such conduct was contrary to the recommendations of an external appeal entity issued in the determination in such case rendered pursuant to section 803.

''(C) LIMITATION ON AMOUNT.—

''(i) IN GENERAL.—The amount of punitive damages that may be awarded in an action described in subparagraph (B) may not exceed the greater of—

''(I) 2 times the sum of the amount awarded to the claimant for economic loss; or

''(II) $250,000.

''(ii) SPECIAL RULE.—Notwithstanding clause (i), in any action described in subparagraph (B) against an individual whose net worth does not exceed $500,000 or against an owner of an unincorporated business, or any partnership, corporation, association, unit of local government, or organization which has fewer that 25 employees, the punitive damages shall not exceed the lesser of—

''(I) 2 times the amount awarded to the claimant for economic loss; or

''(II) $250,000.

''(iii) CONTROLLED GROUPS.—

''(I) IN GENERAL.—For the purpose of determining the applicability of clause (ii) to any employer, in determining the number of employees of an employer who is a member of a controlled group, the employees of any person in such group shall be deemed to be employees of the employer.

''(II) CONTROLLED GROUP.—For purposes of subclause (I), the term 'controlled group' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

''(D) EXCEPTION FOR INSUFFICIENT AWARD IN CASES OF EGREGIOUS CONDUCT.—

''(i) DETERMINATION BY COURT.—If the court makes a determination, based on clear and convincing evidence and after considering each of the factors in subparagraph (E), that the application of subparagraph (C) would result in an award of punitive damages that is insufficient to punish the egregious conduct of the defendant against whom the punitive damages are to be awarded or to deter such conduct in the future, the court shall determine the additional amount of punitive damages (referred to in this subparagraph as the 'additional amount') in excess of the amount determined in accordance with subparagraph (C) to be awarded against the defendant in a separate proceeding in accordance with this subparagraph.

''(ii) ABSOLUTE LIMIT ON PUNITIVES.—Nothing in this subtitle shall be construed to authorize the court to award an additional amount greater than an amount equal to the maximum amount applicable under subparagraph (C).

''(iii) REQUIREMENTS FOR AWARDING ADDITIONAL AMOUNT.—If the court awards an additional amount pursuant to this subparagraph, the court shall state its reasons for setting the amount of the additional amount in findings of fact and conclusions of law.

''(E) FACTORS FOR CONSIDERATION IN CASES OF EGREGIOUS CONDUCT.—In any proceeding under subparagraph (D), the matters to be considered by the court shall include (but are not limited to)—

''(i) the extent to which the defendant acted with actual malice;

''(ii) the likelihood that serious harm would arise from the conduct of the defendant;

''(iii) the degree of the awareness of the defendant of that likelihood;

''(iv) the profitability of the misconduct to the defendant;

''(v) the duration of the misconduct and any concurrent or subsequent concealment of the conduct by the defendant;

''(vi) the attitude and conduct of the defendant upon the discovery of the misconduct and whether the misconduct has terminated;

''(vii) the financial condition of the defendant; and

''(viii) the cumulative deterrent effect of other losses, damages, and punishment suffered by the defendant as a result of the misconduct, reducing the amount of punitive damages on the basis of the economic impact and severity of all measures to which the defendant has been or may be subjected, including—

''(I) compensatory and punitive damage awards to similarly situated claimants;

''(II) the adverse economic effect of stigma or loss of reputation;

''(III) civil fines and criminal and administrative penalties; and

''(IV) stop sale, cease and desist, and other remedial or enforcement orders.

''(F) APPLICATION BY COURT.—This paragraph shall be applied by the court and, in the case of a trial by jury, application of this paragraph shall not be disclosed to the jury.

''(G) LIMITATION ON PUNITIVE DAMAGES.—No person shall be liable for punitive, exemplary, or similar damages in an action under this subsection based on any failure described in paragraph (1) if such failure was in compliance with the recommendations of an external appeal entity issued in a determination under section 803.

''(H) BIFURCATION AT REQUEST OF ANY PARTY.—

''(i) IN GENERAL.—At the request of any party the trier of fact in any action that is subject to this paragraph shall consider in a separate proceeding, held subsequent to the determination of the amount of compensatory damages, whether punitive damages are to be awarded for the harm that is the subject of the action and the amount of the award.

''(ii) INADMISSIBILITY OF EVIDENCE RELATIVE ONLY TO A CLAIM OF PUNITIVE DAMAGES IN A PROCEEDING CONCERNING COMPENSATORY DAMAGES.—If any party requests a separate proceeding under clause (i), in a proceeding to determine whether the claimant may be awarded compensatory damages, any evidence, argument, or contention that is relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible.

''(12) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after the later of—

''(A) 1 year after (i) the date of the last action which constituted a part of the failure, or (ii) in the case of an omission, the latest date on which the fiduciary could have cured the failure, or

''(B) 1 year after the earliest date on which the plaintiff first knew, or reasonably should have known, of the substantial harm resulting from the failure.

''(13) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by a fiduciary which consists of full compliance with the reversal under section 803 of a denial of claim for benefits (within the meaning of section 801(f)).

''(14) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action for the failure to provide an item or service which is not covered under the group health plan involved.

''(15) PROTECTION OF MEDICAL MALPRACTICE AND SIMILAR ACTIONS UNDER STATE LAW.—This subsection shall not be construed to preclude any action under State law (as defined in section 514(c)(1)) not otherwise preempted under this title with respect to the duty (if any) under such State law imposed on any person to exercise a specified standard of care when making a health care treatment decision in any case in which medical services are provided by such person or in any case in which such decision affects the quality of care or treatment provided or received.

''(16) COEXISTING ACTIONS IN FEDERAL AND STATE COURTS DISALLOWED.—

''(A) PRECEDENCE OF FEDERAL ACTION.—An action may be commenced under this subsection only if no action for damages has been commenced by the plaintiff under State law (as defined in section 514(c)(1)) based on the same substantial harm.

''(B) ACTIONS UNDER STATE LAW SUPERSEDED.—Upon the commencement of any action under this subsection, this subsection supersedes any action authorized under State law (as so defined) against any person based on the same substantial harm during the pendency of the action commenced under this subsection.

''(C) DOUBLE RECOVERY OF DAMAGES PRECLUDED.—This subsection supersedes any action under State law (as so defined) for damages based on any substantial harm to the extent that damages for such substantial harm have been recovered in an action under this subsection.

''(17) LIMITATION ON RELIEF WHERE DEFENDANT'S POSITION PREVIOUSLY SUPPORTED UPON EXTERNAL REVIEW.—In any case in which the court finds the defendant to be liable in an action under this subsection, to the extent that such liability is based on a finding by the court of a particular failure described in paragraph (1) and such finding is contrary to a determination by an external review entity in a decision previously rendered under section 803 with respect to such defendant, no relief shall be available under this subsection in addition to the relief otherwise available under subsection (a)(1)(B).''.

(b) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of such Act (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or (n)'' after ''subsection (c)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the date of the enactment of this Act.

SEC. 204. AVAILABILITY OF BINDING ARBITRATION.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this Act) is amended further—

(1) in subsection (a), by inserting ''IN GENERAL.—'' after ''(a)'';

(2) in subsection (b), by striking ''(b) In the case'' and inserting the following:

''(b) GROUP HEALTH PLANS.—

''(1) IN GENERAL.—In the case''; and

(3) by adding at the end of subsection (b) the following:

''(2) BINDING ARBITRATION PERMITTED AS ALTERNATIVE MEANS OF DISPUTE RESOLUTION.—

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements of the preceding provisions of this section relating to review of any adverse coverage decision rendered by or under the plan, if—

''(i) in lieu of the procedures otherwise provided under the plan in accordance with such provisions and in lieu of any subsequent review of the matter by a court under section 502—

''(I) the aggrieved participant or beneficiary elects in the request for the review a procedure by which the dispute is resolved by binding arbitration which is available under the plan with respect to similarly situated participants and beneficiaries and which meets the requirements of subparagraph (B); or

''(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of binding arbitration which meets the requirements of subparagraph (B); and

''(ii) the additional requirements of subparagraph (B) are met.

''(B) ADDITIONAL REQUIREMENTS.—The Secretary shall prescribe by regulation requirements for arbitration procedures under this paragraph, including at least the following requirements:

''(i) ARBITRATION PANEL.—The arbitration shall be conducted by an arbitration panel meeting the requirements of subparagraph (C).

''(ii) FAIR PROCESS; DE NOVO DETERMINATION.—The procedure shall provide for a fair, de novo determination.

''(iii) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to the arbitration procedure—

''(I) may submit and review evidence related to the issues in dispute;

''(II) may use the assistance or representation of one or more individuals (any of whom may be an attorney); and

''(III) may make an oral presentation.

''(iv) PROVISION OF INFORMATION.—The plan shall provide timely access to all its records relating to the matters under arbitration and to all provisions of the plan relating to such matters.

''(v) TIMELY DECISIONS.—A determination by the arbitration panel on the decision shall—

''(I) be made in writing;

''(II) be binding on the parties; and

''(III) be made in accordance with the medical exigencies of the case involved.

''(vi) EXHAUSTION OF EXTERNAL REVIEW REQUIRED.—The arbitration procedures under this paragraph shall not be available to party unless the party has exhausted external review procedures under section 804.

''(vii) VOLUNTARY ELECTION.—A group health plan may not require, through the plan document, a contract, or otherwise, that a participant or beneficiary make the election described in subparagraph (A)(i)(I).

''(C) ARBITRATION PANEL.—

''(i) IN GENERAL.—Arbitrations commenced pursuant to this paragraph shall be conducted by a panel of arbitrators selected by the parties made up of 3 individuals, including at least one practicing physician and one practicing attorney.

''(ii) QUALIFICATIONS.—Any individual who is a member of an arbitration panel shall meet the following requirements:

''(I) There is no real or apparent conflict of interest that would impede the individual conducting arbitration independent of the plan and meets the independence requirements of clause (iii).

''(II) The individual has sufficient medical or legal expertise to conduct the arbitration for the plan on a timely basis.

''(III) The individual has appropriate credentials and has attained recognized expertise in the applicable medical or legal field.

''(IV) The individual was not involved in the initial adverse coverage decision or any other review thereof.

''(iii) INDEPENDENCE REQUIREMENTS.—An individual described in clause (ii) meets the independence requirements of this clause if—

''(I) the individual is not affiliated with any related party,

''(II) any compensation received by such individual in connection with the binding arbitration procedure is reasonable and not contingent on any decision rendered by the individual,

''(III) under the terms of the plan, the plan has no recourse against the individual or entity in connection with the binding arbitration procedure, and

''(IV) the individual does not otherwise have a conflict of interest with a related party as determined under such regulations as the Secretary may prescribe.

''(iv) RELATED PARTY.—For purposes of clause (iii), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(III) the institution at which the medical care involved in the coverage decision is provided,

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

''(V) any other party determined under such regulations as the Secretary may prescribe to have a substantial interest in the coverage decision .

''(iv) AFFILIATED.—For purposes of clause (iii), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(D) DECISIONS.—

''(i) IN GENERAL.—Decisions rendered by the arbitration panel shall be binding on all parties to the arbitration and shall be enforcible under section 502 as if the terms of the decision were the terms of the plan, except that the court may vacate any award made pursuant to the arbitration for any cause described in paragraph (1), (2), (3), (4), or (5) of section 10(a) of title 9, United States Code.

''(ii) ALLOWABLE REMEDIES.—The remedies which may be implemented by the arbitration panel shall consist of those remedies which would be available in an action timely commenced by a participant or beneficiary under section 502 after exhaustion of administrative remedies, except that a money award may be made in the arbitration proceedings in any amount not to exceed 3 times the maximum amount of damages that would be allowable in such case in an action described in section 502(n).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to adverse coverage decisions initially rendered by group health plans on or after the date of the enactment of this Act.

TITLE III— AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

SEC. 301. APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to chapter 101.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO CHAPTER 101.

''A group health plan shall comply with the requirements of chapter 101 and such requirements shall be deemed to be incorporated into this section.''.

SEC. 302. IMPROVING MANAGED CARE.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

''CHAPTER 101—IMPROVING MANAGED CARE

''Subchapter A. Access to care.

''Subchapter B. Access to information.

''Subchapter C. Protecting the doctor-patient relationship.

''Subchapter D. Definitions.

''Subchapter A—Access to Care

''Sec. 9901. Choice of health care professional.

''Sec. 9902. Access to emergency care.

''Sec. 9903. Access to specialty care.

''Sec. 9904. Access to obstetrical and gynecological care.

''Sec. 9905. Access to pediatric care.

''Sec. 9906. Continuity of care.

''Sec. 9907. Network adequacy.

''Sec. 9908. Access to experimental or investigational prescription drugs.

''Sec. 9909. Coverage for individuals participating in approved cancer clinical trials.

''SEC. 9901. CHOICE OF HEALTH CARE PROFESSIONAL.

''(a) PRIMARY CARE.—If a group health plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan shall permit each participant and beneficiary to designate any participating primary care provider who is available to accept such individual.

''(b) SPECIALISTS.—A group health plan shall permit each participant or beneficiary to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

''SEC. 9902. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital, the plan shall cover emergency services (as defined in paragraph (2)(B))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

''(C) in a manner so that, if such services are provided to a participant or beneficiary—

''(i) by a nonparticipating health care provider with or without prior authorization, or

''(ii) by a participating health care provider without prior authorization,

the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

''(2) DEFINITIONS.—In this section:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act; and

''(ii) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(B) EMERGENCY SERVICES.—The term 'emergency services' means—

''(i) with respect to an emergency medical condition described in subparagraph (A)(i)—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

''(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(ii) with respect to an emergency medical condition described in subparagraph (A)(ii), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(C) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—If benefits are available under a group health plan with respect to maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act, the plan shall provide for reimbursement with respect to such services provided to a participant or beneficiary other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with such guidelines).

''(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

''(1) IN GENERAL.—If a group health plan provides any benefits with respect to ambulance services and emergency services, the plan shall cover emergency ambulance services (as defined in paragraph (2))) furnished under the plan under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

''(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''SEC. 9903. ACCESS TO SPECIALTY CARE.

''(a) SPECIALTY CARE FOR COVERED SERVICES.—

''(1) IN GENERAL.—If—

''(A) an individual is a participant or beneficiary under a group health plan,

''(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist or the individual requires physician pathology services, and

''(C) benefits for such treatment or services are provided under the plan,

the plan shall make or provide for a referral to a specialist who is available and accessible (consistent with standards developed under section 9907) to provide the treatment for such condition or disease or to provide such services.

''(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition or services, a health care practitioner, facility, or center or physician pathologist that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise and in the case of a pregnant woman, appropriate obstetrical expertise) to provide high quality

care in treating the condition or to provide physician pathology services.

''(3) CARE UNDER REFERRAL.—A group health plan may require that the care provided to an individual pursuant to such referral under paragraph (1) with respect to treatment be—

''(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

''(B) in accordance with applicable quality assurance and utilization review standards of the plan.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan does not have a specialist that is available and accessible to treat the individual's condition or provide physician pathology services and that is a participating provider with respect to such treatment or services.

''(5) REFERRALS TO NONPARTICIPATING PROVIDERS.—In a case in which a referral of an individual to a nonparticipating specialist is required under paragraph (1), the group health plan shall provide the individual the option of at least three nonparticipating specialists.

''(6) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

''(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

''(1) IN GENERAL.—A group health plan shall have a procedure by which an individual who is a participant or beneficiary and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan shall refer the individual to such specialist.

''(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

''(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term 'ongoing special condition' means a condition or disease that—

''(A) is life-threatening, degenerative, or disabling, and

''(B) requires specialized medical care over a prolonged period of time.

''(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an individual who is a participant or beneficiary and who has an ongoing special condition from having the individual's primary care physician assume the responsibilities for providing and coordinating care described in paragraph (1).

''(c) STANDING REFERRALS.—

''(1) IN GENERAL.—A group health plan shall have a procedure by which an individual who is a participant or beneficiary and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan, or if the primary care provider in consultation with the medical director of the plan and the specialist (if any), determines that such a standing referral is appropriate, the plan shall make such a referral to such a specialist if the individual so desires.

''(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''SEC. 9904. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

''(a) IN GENERAL.—If a group health plan requires or provides for a participant or beneficiary to designate a participating primary care health care professional, the plan—

''(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for covered gynecological care (including preventive women's health examinations) or for covered pregnancy-related services provided by a participating physician (including a family practice physician) who specializes or is trained and experienced in gynecology or obstetrics, respectively, to the extent such care is otherwise covered; and

''(2) shall treat the ordering of other gynecological or obstetrical care by such a participating physician as the authorization of the primary care health care professional with respect to such care under the plan.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

''(1) waive any exclusions of coverage under the terms of the plan with respect to coverage of gynecological or obstetrical care;

''(2) preclude the group health plan involved from requiring that the gynecologist or obstetrician notify the primary care health care professional or the plan of treatment decisions; or

''(3) prevent a plan from offering, in addition to physicians described in subsection (a)(1), non-physician health care professionals who are trained and experienced in gynecology or obstetrics.

''SEC. 9905. ACCESS TO PEDIATRIC CARE.

''(a) PEDIATRIC CARE.—If a group health plan requires or provides for a participant or beneficiary to designate a participating primary care provider for a child of such individual, the plan shall permit the individual to designate a physician (including a family practice physician) who specializes or is trained and experienced in pediatrics as the child's primary care provider.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

''SEC. 9906. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant or beneficiary in the plan is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

''(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

''(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(3) DEFINITIONS.—For purposes of this section:

''(A) ONGOING SPECIAL CONDITION.—The term 'ongoing special condition' has the meaning given such term in section 9903(b)(3), and also includes pregnancy.

''(B) TERMINATION.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

''(3) PREGNANCY.—If—

''(A) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—If—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(B) the provider was treating the terminal illness before the date of termination, the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''SEC. 9907. NETWORK ADEQUACY.

''(a) REQUIREMENT.—A group health plan shall meet such standards for network adequacy as are established by law pursuant to this section.

''(b) DEVELOPMENT OF STANDARDS.—

''(1) ESTABLISHMENT OF PANEL.—There is established a panel to be known as the Health Care Panel to Establish Network Adequacy Standards (in this section referred to as the 'Panel').

''(2) DUTIES OF PANEL.—The Panel shall devise standards for group health plans and to ensure that—

''(A) participants and beneficiaries have access to a sufficient number, mix, and distribution of health care professionals and providers; and

''(B) covered items and services are available and accessible to each participant and beneficiary—

''(i) in the service area of the plan;

''(ii) at a variety of sites of service;

''(iii) with reasonable promptness (including reasonable hours of operation and after hours services);

''(iv) with reasonable proximity to the residences or workplaces of participants and beneficiaries; and

''(v) in a manner that takes into account the diverse needs of such individuals and reasonably assures continuity of care.

''(c) MEMBERSHIP.—

''(1) SIZE AND COMPOSITION.—The Panel shall be composed of 15 members. The Secretary of Health and Human Services, the Majority Leader of the Senate, and the Speaker of House of Representatives shall each appoint 1 member from representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, and State medical specialty societies.

''(2) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

''(3) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

''(d) PROCEDURES.—

''(1) MEETINGS.—The Panel shall meet at the call of a majority of its members.

''(2) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

''(3) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

''(4) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

''(e) ADMINISTRATION.—

''(1) COMPENSATION.—Except as provided in paragraph (1), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

''(2) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(3) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(4) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

''(f) REPORT AND ESTABLISHMENT OF STANDARDS.—Not later than 2 years after the first meeting, the Panel shall submit a report to Congress and the Secretary of Health and Human Services detailing the standards devised under subsection (b) and recommendations regarding the implementation of such standards. Such standards shall take effect to the extent provided by Federal law enacted after the date of the submission of such report.

''(g) TERMINATION.—The Panel shall terminate on the day after submitting its report to the Secretary of Health and Human Services under subsection (f).

''SEC. 9908. ACCESS TO EXPERIMENTAL OR INVESTIGATIONAL PRESCRIPTION DRUGS.

''No use of a prescription drug or medical device shall be considered experimental or investigational under a group health plan if such use is included in the labeling authorized by the U.S. Food and Drug Administration under section 505, 513 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under section 351 of the Public Health Service Act (42 U.S.C. 262), unless such use is demonstrated to be unsafe or ineffective.

''SEC. 9909. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan provides coverage to a qualified individual (as defined in subsection (b)), the plan—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) ROUTINE PATIENT CARE COSTS.—For purposes of this section—

''(A) IN GENERAL.—The term 'routine patient care costs' includes the costs associated with the provision of items and services that—

''(i) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(ii) are furnished according to the protocol of an approved clinical trial program.

''(B) EXCLUSION.—Such term does include the costs associated with the provision of—

''(i) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(ii) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(3) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of the Employee Retirement Income Security Act of 1974.

''Subchapter B—Access to Information

''Sec. 9911. Patient access to information.

''SEC. 9911. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—A group health plan shall—

''(1) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b);

''(2) provide to participants and beneficiaries, within a reasonable period (as specified by the Secretary) before or after the date of significant changes in the information described in subsection (b), information on such significant changes; and

''(3) upon request, make available to participants and beneficiaries, the Secretary, and prospective participants and beneficiaries, the information described in subsection (b) or (c).

The plan may charge a reasonable fee for provision in printed form of any of the information described in subsection (b) or (c) more than once during any plan year.

''(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan shall be provided to a participant or beneficiary free of charge at least once a year and includes the following:

''(1) SERVICE AREA.—The service area of the plan.

''(2) BENEFITS.—Benefits offered under the plan, including—

''(A) those that are covered benefits ''(all of which shall be referred to by such relevant CPT and DRG codes as are available), limits and conditions on such benefits, and those benefits that are explicitly excluded from coverage (all of which shall be referred to by such relevant CPT and DRG codes as are available);

''(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

''(C) the extent to which benefits may be obtained from nonparticipating providers;

''(D) the extent to which a participant or beneficiary may select from among participating providers and the types of providers participating in the plan network;

''(E) process for determining experimental coverage; and

''(F) use of a prescription drug formulary.

''(3) ACCESS.—A description of the following:

''(A) The number, mix, and distribution of providers under the plan.

''(B) Out-of-network coverage (if any) provided by the plan.

''(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

''(D) The procedures for participants and beneficiaries to select, access, and change participating primary and specialty providers.

''(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

''(F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

''(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 9901(b)(2).

''(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(B) the process and procedures of the plan for obtaining emergency services; and

''(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

''(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals.

''(8) ACCOUNTABILITY.—A description of the legal recourse options available for participants and beneficiaries under the plan including—

''(A) the preemption that applies under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) to certain actions arising out of the provision of health benefits; and

''(B) the extent to which coverage decisions made by the plan are subject to internal review or any external review and the proper time frames under

''(9) QUALITY ASSURANCE.—Any information made public by an accrediting organization in the process of accreditation of the plan or any additional quality indicators the plan makes available.

''(10) INFORMATION ON TREATMENT AUTHORIZATION.—Notice of appropriate mailing addresses and telephone numbers to be used by participants and beneficiaries in seeking information or authorization for treatment.

''(11) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

''(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

''(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program maintained by the plan.

''(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

''(3) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

''(4) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

''Subchapter C—Protecting the Doctor-Patient Relationship

''Sec. 9921. Prohibition of interference with certain medical communications.

''Sec. 9922. Prohibition of discrimination against providers based on licensure.

''Sec. 9923. Prohibition against improper incentive arrangements.

''Sec. 9924. Payment of clean claims.

''SEC. 9921. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

''(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

''SEC. 9922. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

''(a) IN GENERAL.—A group health plan shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

''(b) CONSTRUCTION.—Subsection (a) shall not be construed—

''(1) as requiring the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan;

''(2) to override any State licensure or scope-of-practice law;

''(3) as requiring a plan that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan; or

''(4) as prohibiting a family practice physician with appropriate expertise from providing pediatric or obstetrical or gynecological care.

"SEC. 9923. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

''(a) IN GENERAL.—A group health plan may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

''(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the Secretary of the Treasury, a group health plan, and a participant or beneficiary with the plan, respectively.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

"SEC. 9924. PAYMENT OF CLEAN CLAIMS.

''A group health plan shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant or beneficiary with respect to benefits covered by the plan, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant or beneficiary as well as claims referred to in such subparagraph.

"Subchapter D—Definitions

''Sec. 9931. Definitions.
''Sec. 9933. Exclusions.
''Sec. 9933. Coverage of limited scope plans.
''Sec. 9934. Regulations; coordination; application under different laws.

"SEC. 9931. DEFINITIONS.

For purposes of this chapter—

''(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 9831 shall apply for purposes of this chapter in the same manner as they apply for purposes of chapter 100.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this chapter:

''(1) CLINICAL PEER.—The term 'clinical peer' means, with respect to a review or appeal, a practicing physician or other health care professional who holds a nonrestricted license and who is—

''(A) appropriately certified by a nationally recognized, peer reviewed accrediting body in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review or appeal, or

''(B) is trained and experienced in managing such condition, procedure, or treatment,

and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

''(4) NETWORK.—The term 'network' means, with respect to a group health plan, the participating health care professionals and providers through whom the plan provides health care items and services to participants or beneficiaries.

''(5) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that is not a participating health care provider with respect to such items and services.

''(6) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan.

''(7) PHYSICIAN.—The term 'physician' means an allopathic or osteopathic physician.

''(8) PRACTICING PHYSICIAN.—The term 'practicing physician' means a physician who is licensed in the State in which the physician furnishes professional services and who provides professional services to individual patients on average at least two full days per week.

''(9) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of obtaining prior approval from a group health plan for the provision or coverage of medical services.

"SEC. 9932. EXCLUSIONS.

''(a) NO BENEFIT REQUIREMENTS.—Nothing in this chapter shall be construed to require a group health plan to provide specific benefits under the terms of such plan, other than those provided under the terms of such plan.

''(b) EXCLUSION FOR FEE-FOR-SERVICE COVERAGE.—

''(1) GROUP HEALTH PLANS.—The provisions of sections 9901 through 9911 shall not apply to a group health plan if the only coverage offered under the plan is fee-for-service coverage (as defined in paragraph (2)).

''(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term 'fee-for-service coverage' means coverage under a group health plan that—

''(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

''(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

''(C) allows access to any provider that is lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan; and

''(D) for which the plan does not require prior authorization before providing for any health care services.

"SEC. 9933. COVERAGE OF LIMITED SCOPE PLANS.

''Only for purposes of applying the requirements of this chapter under section 9813, section 9832(c)(2)(A) shall be deemed not to apply.

"SEC. 9934. REGULATIONS.

''The Secretary of the Treasury shall issue such regulations as may be necessary or appropriate to carry out this chapter under section 9813. The Secretary may promulgate such regulations in the form of interim final rules as may be necessary to carry out this chapter in a timely manner.''.

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle K of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''CHAPTER 101. Improving managed care.''

TITLE IV—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 401. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by title I (other than section 102), sections 201 and 202, and title III shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2000 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by title I (other than section 102), sections 201 and 202, and title III shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

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 Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 102 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage, to include as providers religious nonmedical providers;

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider; or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

SEC. 402. COORDINATION IN IMPLEMENTATION.

The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury 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 both Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) 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.

TITLE V—OTHER PROVISIONS

Subtitle A—Protection of Information

SEC. 501. PROTECTION FOR CERTAIN INFORMATION.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discover, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

(c) DEFINITIONS.—For purposes of this section:

(1) ACCREDITING BODY.—The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) HEALTH CARE RESPONSE INFORMATION.—The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for the purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(4) STATE.—The term ''State'' includes a State, the District of Columbia, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(d) EFFECTIVE DATE.—The provisions of this section are effective on the date of the enactment of this Act.

Subtitle B—Other Matters

SEC. 511. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services, in consultation with the Majority Leader of the Senate and the Speaker of the House of Representatives, shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(C) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting its the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection (a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

The CHAIRMAN. Pursuant to House Resolution 323, the gentleman from Florida (Mr. GOSS) and the gentleman from Michigan (Mr. DINGELL) will each control 30 minutes.

The Chair recognizes the gentleman from Florida (Mr. GOSS).

Mr. GOSS. Mr. Chairman, I yield myself 1½ minutes.

Mr. Chairman, I am honored to offer this substitute along with the gentleman from Arizona (Mr. SHADEGG), the gentleman from Oklahoma (Mr. COBURN), the gentleman from California (Mr. THOMAS), the gentleman from Pennsylvania (Mr. GREENWOOD), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Kentucky (Mr. FLETCHER), and a host of other Members.

A few months ago the Speaker asked me to bring all of the voices and viewpoints on this issue together and craft a consensus bill that was sound public policy and not just another sound bite. It is clear that the Norwood-Dingell approach, while crafted with good intention, falls far short of sound public policy because it invites an avalanche of lawsuits and unlimited, uncontrollable damages. This is unacceptably costly, disruptive, and hardly good medicine for anyone, except maybe the trial bar.

Where Norwood is excessive, our substitute firmly stands on responsible middle ground. We hold all health plans accountable. I repeat, we hold all health plans accountable. Patients who have been harmed can sue and recover damages. Instead of guaranteeing lawsuits at the front end, we encourage patients to get the health care they need first.

Some have commented about special interest endorsements in this process, about the various proposals before us today. I am told that over 100 patient and provider groups have endorsed our substitute amendment, but no, repeat,

no trial lawyer groups or insurance associations have. I therefore suggest we have struck the right balance, and urge Members' support accordingly.

Mr. DINGELL. Mr. Chairman, I yield myself 1½ minutes.

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

Mr. DINGELL. Mr. Chairman, the advocates of the substitute here, for whom I have enormous respect and affection, are going to talk about only one thing this morning, trial lawyers. Let us talk about the other things that are important, because other issues are being ignored by them.

Our bill, the Norwood-Dingell-Ganske bill, guarantees that your health plan will give you the prescription medicines you need. Theirs does not.

Our bill guarantees that you will be able to get into an approved clinical trial if you are threatened with serious diseases such as multiple sclerosis, Alzheimer's or Parkinson's. Theirs does not.

Our bill guarantees that the doctor can be an advocate for a patient, through internal and external appeal of a plan's decision, without any fear of being terminated by the HMO. Their doctor has no such assurance.

Their bill allows the HMO to punish your doctor. Our bill guarantees that you will be told when your insurance company offers rewards to health care providers for not providing you with a specialist or giving you cheaper but less effective treatment.

Their bill allows HMOs to keep you in the dark. Our bill allows none of these things.

These are not the only real differences between the substitutes. Others will be addressed in further detail by different participants in the debate.

In the end, the bill offered by my good friends, the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG), for whom again I repeat I have great respect and affection, is no substitute whatsoever for real managed care reform.

Give managed care reform that protects the patient, that protects the doctor, that sees to it that medical necessity is dealt with by the doctor, and that the rights of the patient are assured.

Mr. GOSS. Mr. Chairman, I am pleased to yield 5 minutes to the distinguished gentleman from Arizona (Mr. SHADEGG), a principal author of this substitute.

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

Mr. SHADEGG. Mr. Chairman, I am passionate about this issue. For the last 2 years, I have done almost nothing else. I believe this is a momentous debate. But I am greatly offended by what is going on on the floor. The truth is that there are two extreme positions here, and there is a lot of misrepresentation going on.

Some of the most serious misrepresentation that is going on is the allegation that Republicans do not care about patients and that the Coburn-Shadegg bill will not protect them. I am enraged by that comment.

There is not a Member of this House, not one, Republican or Democrat, man or woman, not the gentleman from Georgia (Mr. NORWOOD), not the gentleman from Iowa (Mr. GANSKE), not the gentleman from Michigan (Mr. DINGELL), who is more passionate that HMOs must be held liable when they kill or maim someone. No one. No one beats me on that issue.

I have written a series of ''dear colleagues,'' which you all should have read, and given them to the press, and it says, point blank, ERISA abuses people. Courts cry out for reform. It is quote after quote after quote from Federal judges describing that absolute immunity is wrong. And from my conservative friends I have been beaten up because I am not sufficiently pro-business.

But let me say that the gentleman from Georgia (Mr. NORWOOD), whom I love and respect, is wrong, because the gentleman from Georgia (Mr. NORWOOD) said the only bill that can become law is a bipartisan bill, and he would be right if yours were a bipartisan bill. But it is not a bipartisan bill, because just as immunity is extreme and wrong and bad public policy, so is outright, absolute, total liability.

The sad truth is that in the gentleman's to change the law, and in his decision to throw in with the other side, including the President, this issue became political, and not about patients. It needs to be about patients.

The reality is no bill we pass here on the floor can, in fact, become law if it is so extreme that it results in employers being sued; and the gentleman's provision to protect employers fails.

Now, I know that the gentleman from Georgia intended to write it to protect employers, but it does not do that. If they use simple discretionary authority, they can be sued.

I also know that the gentleman did not want and may not have intended to throw the door open to wide open liability so that one can sue anyone, anywhere, any time, for everything. But that is the way the bill is written. The gentleman's bill will result in handing the entire process over to the trial lawyers. That will never become law.

What we need is a middle ground which holds plans accountable, says you can no longer kill and maim people the way United Health Care did in United Health Care versus Corcoran, killing Mrs. Corcoran's baby. But we also need a law that says we are not going to turn the entire system over to the tort lawyers and let the tort lawyers get rich and buy Cadillacs and Lexuses and other cars out of the winnings of this system, driving people away from health care.

If American businesses walk away from insuring America's workers, we have not helped the system. We need a reasonable middle ground. We do not need one extreme immunity or another extreme turning the system over to the trial lawyers.

Now, I know you are well intended, but the sad truth, contrary to the description of the gentleman from Michigan (Mr. DINGELL), is that your bill goes too far. It can never be law.

I want a law that protects American people, that gives them health care. Employees working for American businesses need health care, and giving the system to the trial lawyers will not do that, any more than giving the system to the greed of the trial lawyers. Greed by insurance company fails. Greed by trial lawyers fails.

We need a middle ground system. We need desperately to pass a bill that strikes a fair balance, that says no, you do not get immunity, you cannot injure and kill people and, no, we are not going to give the whole system over to the trial lawyers. We are going to require people to take reasonable steps, and we are not going to let the trial lawyers ring the bell and get multimillion dollar judgments and have that come out of all of our pockets and have it drive Americans away from health care. Tick through your liability provision; tick through your employer protections. You may have intended them to work, but they do not.

In this debate it has been said that the truth has been lost. It is alleged that we have preempted State law. There is no one in this Congress that is more States rights than JOHN SHADEGG. We have not preempted State law. We have specifically said that Texas, Georgia, Louisiana, and any other State which passes a law to protect its patients may do so, and that law remains in effect.

I implore you to pass the Coburn-Shadegg substitute.

Mr. DINGELL. Mr. Chairman, I am happy to yield 4 minutes to the gentleman from Georgia (Mr. NORWOOD), my friend that I have come to respect and admire greatly.

Mr. NORWOOD. Mr. Chairman, I thank the gentleman for yielding me time.

Mr. Chairman, let me start by saying I agree with the gentleman from Arizona (Mr. SHADEGG), my good friend, that he really does, I believe, sincerely want to try to protect patients; and he really does think that he is in the middle.

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We dealt earlier with one bill that absolutely does not at all, and we are dealing with their bill that does not, in some respects either, and my view is that we are in the middle.

I have listened to all of my colleagues make the argument that they protect businesses and that we do not. I have listened to my colleagues take on the use of the term discretionary authority and how by using direct participation, my colleague's bill protects employers so much better. But when

we look at the terms very closely, we see, really, that there are not really any differences.

We protect an employer from liability for their choice of plan and any benefits they put in their plan. They protect an employer from liability for their choice of plan and any benefits they put in their plan. Notice, the same thing. We protect an employer who provides an extra contractual benefit that is not in a plan. My colleagues protect an employer who provides an extra contractual benefit that is not in the plan. Notice we are saying the same things. We protect an employer who does not intervene in a review. My colleagues protect an employer who does not intervene in a review. Notice, I am repeating myself. But my colleagues want to go further. My colleagues want to protect an employer who advocates for a patient.

Now, I would not disagree, and I would argue that our bill does not make an employer liable who advocates for a patient, unless by advocating my colleagues mean an employer can get in and settle a dispute by making a medical decision about what coverage is appropriate, what coverage is medically needed. If that is what my colleagues mean by advocate, then I am not going to support that. But the bottom line is our efforts to protect employers really say the same thing.

Our bill does not authorize any cause of action against an employer, plan sponsor, or employee. That will be the new Federal law that goes into ERISA. In our bill, there is no right of recovery by a person against an employer, plan sponsor, or employee for damages.

Now, we go on further to say, there is one exception. In our bill we simply say, one can be liable for a cause of action against an employer, plan sponsor or employee if, if, any of the above exercise their discretionary authority to make a decision on a claim that is a benefit in the plan covered by the plan, and that decision results in personal injury or wrongful death.

I do not know how to say that any clearer. Discretionary authority simply means that the employer has the power to make a decision. One can make a decision in our bill to give an employee a benefit that maybe is not in the plan. The new Federal law will say, one is not liable if one wishes to do that. It is clear as a bell. Look on page 99.

We further protect employers by allowing the employer to put in what they want in the plan and what they do not want in the plan. If they want to exclude hospitalization, that is not my business. They can exclude hospitalization in the plan that they buy. The new Federal law will make certain that they are not liable because they did that.

One is not liable in our bill for not being involved in external review. My word, it is so very narrow. It simply says if the CEO, and it is much like the Thomas bill in the protections that it gives. We simply say, if the CEO really wants to get in there and make a medical necessity decision that takes away a benefit that is a benefit in the claim and the patient dies, one needs to be liable.

Mr. GOSS. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from the Commonwealth of Pennsylvania (Mr. GREENWOOD), a principal author also.

Mr. GREENWOOD. Mr. Chairman, I thank the gentleman for yielding me this time.

Last weekend I went to the Doylestown Township Octoberfest, and I was talking to some of my constituents, and a gentleman came up to me and he said, tell me that it is not true that you guys in Washington are getting ready to pass a bill that would allow me to get sued because I provide insurance coverage to my employees; and I said well, we are going to have that debate, and I am going to go down there and try to protect you from that consequence.

I am not a lawyer, and I have listened to the debate go back and forth between the lawyers and nonlawyers and doctors and so forth. But here is what common sense tells me. Common sense tells me that under the Norwood-Dingell bill, employers will get dragged into court. Now, not in all cases will they be found liable, but they will get dragged into court, because someone will make an allegation that they were harmed; someone will make an allegation that the employer exercised discretionary authority, and there is the employer, the small employer, sitting in a courtroom. And the first time we drag an employer into a courtroom is the last time that employer is going to provide health care coverage for his employees, because it is not worth it. He does not want to get dragged into a courtroom for trying to provide a benefit for his employees.

This is obviously a balancing act. It has been said over and over again, but this is a balancing act between too little liability and too much liability. The Goss-Coburn-Shadegg-Greenwood-Thomas, et cetera, coalition product is the middle ground. It is the exact right, in my opinion, balance between these two extremes.

I bet my colleagues, if the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) were sitting here at the dawn of the creation of malpractice liability, they would be about where we are, at best. They would be in the middle. They would be trying to design a system that leaves doctors accountable for this negligence, but not exposed to the maelstrom of liability cases that they are exposed to today.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Texas (Mr. GREEN).

(Mr. GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GREEN of Texas. Mr. Chairman, I thank my colleague, the ranking member of the Committee on Commerce, for yielding me this time.

I am glad to follow my colleague from Pennsylvania, because I do not know if I would call their amendment anywhere near middle ground. It may be middle ground from that side of the aisle, but it is not middle ground between the two aisles, and that is what the Norwood-Dingell-Ganske amendment does. The middle ground is really the amendment that is the base of this bill.

The Coburn-Shadegg proposal falls short of meeting the needs of the American people in the most critical issue: accountability. Unlike the Norwood-Dingell-Ganske, the amendment we are considering now will force patients harmed by their HMOs to seek remedies in Federal court. The practical effect of the Federal court provision would be devastating for patients.

First, the Federal court system is more difficult to access than our State courts. People have to travel longer distances, particularly in large States or rural areas. Worse yet, in Federal courts, Federal courts give priority to criminal cases. I know in Texas we have civil courts, we have State civil courts, we have county civil courts; but the Federal courts have to give preference to criminal cases. So these cases will sit behind them.

The Norwood-Dingell-Ganske builds on the success of our State's efforts, the State of Texas, both rural, urban, rich and poor and great diversity, and we need to learn by example.

One of the concerns I have about the amendment, Coburn-Shadegg-Greenwood, et al., is that it would actually overturn current laws that we have. Not only in my home State of Texas, but Missouri, Georgia, and California already have laws in effect to protect their citizens against negligent HMOs. In plain English, no State law can protect its citizens when HMO's medical decisions causes harm or death, and that is what Coburn-Shadegg says, and it is the section of the bill. They are preempting State law that our States have used. The State of Texas has had it for 2 years now, and it has stood the test of time. We have only had three court cases filed, but what we found out because of the effectiveness of the appeals process and, ultimately, judicial accountability, that is why we only have three cases filed, the appeals panel is working. They are finding for the patients over half the time, and that is why we need to make sure that we will not be faked out or pass a false amendment. The Coburn-Shadegg amendment is not a compromise; it may be a compromise on one side of the aisle.

Mr. GOSS. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Louisiana (Mr. COOKSEY) who has assisted me mightily from his medical professional point of view.

Mr. COOKSEY. Mr. Chairman, I want to address the American people and the patients.

Since I have been in Washington, I find that there are a lot of groups out there that are looking out for themselves. There is big insurance, and they have overstepped the bounds. HMOs have ridden behind ERISA and overstepped their bounds, and they are guilty as charged. The trial lawyers are here and have been here at least for the last 7 years getting their message out, and they all spread a lot of money. And yes, the physicians are represented with their organizations, and I am a member of that profession and a member of those organizations.

But too often I get the feeling that there is no one here really representing the patients, the public; and that is what we really need to do today. We need to address the excesses of the HMOs. But at the same time, we do not need to open this up to unlimited litigation, because litigation is not going to improve the quality of health care, and that is what the issue is about. It is access to health care and quality of health care. That is the reason I am supporting this bill.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Chairman, I rise in strong opposition to this amendment. This amendment provides the illusion of accountability, but there is a serious flaw blocking the right of people to get to the courts, and that flaw has to do with apparently the unilateral right of managed care industries to refer findings of fact and conclusions of law on whether there was substantial harm and whether that substantial harm was proximately caused by the decisions of the managed care plans to a private, corporate, nonjudicial body, which can act in an ex parte way; which can act in a way without regard to the Rules of Procedure or evidence.

Mr. Chairman, I include a letter from Dean Rand Rosenblatt of Rutgers Law School and Professor Rosenbaum of George Washington University which outlines these concerns.

THE GEORGE WASHINGTON UNIVERSITY,
Washington, DC, October 6, 1999.

Re: Analysis of the amendment in the nature of a substitute, to be offered by Mr. Coburn to H.R. 2723, The Health Care Quality and Choice Act of 1999.

Hon. JOHN DINGELL,
Ranking Member, Committee on Commerce, U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVE DINGELL: This letter responds to your request for a legal analysis of the amendment that Mr. Coburn will offer to H.R. 2723 (hereinafter referred to as the Coburn amendment).

The Coburn amendment purports to add a federal remedy to the current range of judicial remedies under both ERISA and state law in cases involving patient injury. In fact, however, the amendment appears to be a legislative attempt to preempt all available medical malpractice remedies under state law as applied to managed care companies. In other words, the amendment appears to give companies a complete shield against any further medical malpractice cases under state law in which they would be a named defendant. As such, this amendment, which to the best of my knowledge has received no careful analysis and has not been subject to any prior debate, appears to reverse the leading case in the field, Dukes versus U.S. Healthcare Inc.

this federal legislative attempt to sweep away two centuries of state malpractice law in favor of a new and untested federal remedy appears to fly directly in the face of recent Supreme Court decisions regarding the limitations of Congressional authority to displace state law in areas historically committed to the powers of the states. The creation of remedies for personal injuries is the epitome of historic state powers to protect the health and welfare of their citizens.

Finally, close scrutiny of the ''remedy'' created in the Coburn amendment so tips the scales in favor of managed care companies that the amendment, even if not an unconstitutional exercise of Congressional powers in an area of law reserved to the states, may violate basic principles of constitutional due process.

Our analysis follows.

The amendment appears to preempt all state law remedies for medical malpractice cases involving managed care companies.

Section 502(n)(15) as added by the Coburn amendment purports to ''save'' malpractice remedies available under state law. However, the amendment is very carefully worded to limit the types of actions that would in fact be ''saved:''

Protection of medical malpractice and similar actions under state law—This subsection shall not be construed to preclude any action under State law * * * not otherwise preempted under this title with respect to the duty (if any) under state law imposed on any person to exercise a specified standard of care when making a health care treatment decision in any case in which medical services are provided by such person, or in any case in which such decision affects the quality of care or treatment provided or received.

At first blush, the amendment appears to save both actions aimed at persons who provide medical care as well as persons who make decisions that affect the quality of the care. But a closer look reveals that these actions are saved only to the extent that they are ''not otherwise preempted under this title.'' In fact, the new federal remedy is squarely aimed at persons whose decisions affect the quality of care. Specifically, the remedy would allow a right of action against substandard decision making by health benefit plan fiduciaries. It is their failure to ''exercise ordinary care in making an incorrect determination'' regarding the medical necessity or availability of a treatment that would be the subject of the new federal remedy. As a result, this new remedy would appear to preempt existing remedies grounded in state malpractice theory, that are aimed at the companies themselves.

This attempt to preempt the application of medical malpractice principles to managed care companies should come as no surprise. This is a critical juncture in the development of judicial theory regarding the conduct of managed care companies. In recent years, a growing number of courts have specifically have held that under various theories of direct and vicarious liability, managed care companies themselves—not just the doctors who work for them—can be liable for injuries caused by substandard decisions that affect the quality of care. These courts have distinguished for ERISA preemption purposes between state law-governed actions for damages as a result of injuries arising out of negligent coverage decisions (which are preempted) and state law actions alleging injuries as a result of the poor quality of medical care (which are not).

By appearing to ''save'' malpractice actions while at the same time creating a new federal right of action for injuries caused by substandard treatment decisions made by fiduciaries, the amendment thus appears to reverse these recent decisions and shields companies from the effects of state law.

The amendment appears to violate recent Supreme Court decisions regarding the limits of Congressional authority to legislate in areas historically left to the powers of the states.

The process envisioned in the new federal remedy appears to run headlong into the Constitution. There are so many deficiencies in the procedures set forth in the amendment that it is impossible to enumerate all of them. Most fundamentally in our view, the amendment appears to give defendants (e.g., health plans and health insurance issuers) the right to seek an ex parte determination from any qualified external appeal entity regarding whether the plaintiff actually sustained a personal injury, and/or whether the defendant's conduct was the proximate cause of the injury. Giving a private corporation the power to halt a federal judicial action through the use of non-judicial procedures, and with no statutory requirement of notice to the plaintiff or other due process rights, is unprecedented in American civil law.

The provisions of the amendment are simply extraordinary. The bill provides that even after an individual has exhausted the internal and external review process and filed an action in federal court, a managed care company is empowered to nullify the jurisdiction of that court by unilaterally deciding that the action will be heard before a private entity with no clearly relevant legal expertise and with no provision for a right to counsel, a jury trial or any other due process protections for the plaintiff.

Private companies would have the power to obtain a definitive ruling against patients without patients ever having the opportunity to be heard before the entity making the certification decision. And a federal court with Constitutional authority to hear a case would be stripped of its Constitutional authority and directed to dismiss the case with prejudice based on a ruling by a non-judicial entity.

Nothing in the bill would prohibit a defendant from consulting entity after entity until it finds one that will decide in its favor. Fundamental questions of fact and law would be definitively determined by employees of an external review entity who could theoretically consist entirely of physicians with no judicial training. The measure grants neither discovery nor cross examination rights as part of the certification procedure.

Moreover, unlike a jury, employees of the external review entity would make critical findings of fact, not pursuant to a set of instructions from a legally trained and constitutionally impartial judge, but based on their own legally unguided impressions.

Finally, these findings of fact would not be subject to challenge or appeal by a judicial body, but rather would become legally binding in all judicial venues. Under the amendment, it appears that even the United States Supreme Court could not overturn the certification of an external review entity that the cause of the plaintiff's injury was not the negligence of the defendant.

Between the apparent ex parte nature of the certification process and the granting of

sweeping judicial powers to private medical review bodies, the bill violates all notions of Constitutional due process.

Apart from its basic Constitutional problems, the right of action created by the bill contains additional serious shortcomings. The measure permits actions only against persons who have the authority to make the final determination of coverage. Such a provision could shield from liability a utilization review company under subcontract to the managed care organization, thereby undercutting any incentive to ensure better utilization review procedures.

Furthermore, the bill would condition the new right of action on exhaustion of the internal and external review process even when the injury already has occurred and exhaustion is futile. This rigid requirement is contrary to current law, which permits individuals to proceed directly to court under ERISA §502 in situations in which exhaustion would serve no purpose.

Furthermore, in cases in which a plaintiff has commenced both an action for damages under state law, as well as an action under this new federal remedy, the commencement of the federal action would immediately supercede ''any action authorized under state law'' against any person based on the same substantial harm.'' Section 502(n)(16)(B), as added. In other words, even if the amendment does not completely preempt actions against managed care companies that are grounded in state malpractice theory, it would effectively halt malpractice actions once an action under this new federal remedy is filed.

Not only does the filing of a federal action stop a state malpractice action, but the resolution of the federal case would fundamentally determine the course of the state case, as well. Under normal principles of collateral estoppel, when faced with a successful affirmative defense to the new federal right of action, a court with a malpractice action before it that turns on the same facts would inevitably dismiss the malpractice action.

Rather than allowing state law regarding malpractice liability in managed care to evolve, the bill would impose a radical, unnecessary, and untested remedy on state governments in an area traditionally committed to state discretion.

The question of when and under what circumstances insurers' liability for damages arising from negligent coverage decisions should be recognized under the law is a complex matter.

State courts began to address this issue in the early 1970s and the theory of insurer liability has slowly evolved. The application of ERIS to liability claims against insurers that sold products to employee benefit plans seriously affected the application of such laws to injured employees. In recent years, as ERISA preemption law has been refined and narrowed by the courts, states once again have begun to carefully approach this issue in the context of employee benefits.

In our view, this is not the time to create a new federal remedy, especially one as controversial as this. In light of the evolutionary nature of American health law, and the limits on Constitutional authority to displace state law, we believe that it is far more advisable to permit states to move the matter forward through legislation that best meets the needs of the residents of their states, particularly since the evidence to date indicates that the growth of such state laws has not resulted in either major cost increases in health insurance or a withdrawal of insurers from the market.

Sincerely,

SARA ROSENBAUM,
Harold and Jane Hirsh Professor of Health Law and Policy, The George Washington University Medical Center, School of Public Health and Health Services.
RAND ROSENBLATT,
Associate Dean for Academic Affairs and Professor of Law, Rutgers University Law School—Camden.

Mr. ANDREWS. Mr. Chairman, I believe that these are more than technical flaws. I believe they are substantive blockages which preclude the right of people to pursue remedies in the Federal courts. For these reasons, I strongly oppose the amendment.

Mr. GOSS. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Louisiana (Mr. VITTER), who I believe is not only one of the freshest new Members, but is the freshest new Member from Louisiana on the Republican side.

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

Mr. VITTER. Mr. Chairman, I rise today as an original cosponsor of a strong bill to provide patient protection, and I rise in support of this version in particular, because many of its provisions are the strongest available on the very patient protection issues we care about.

This version goes further than any other proposal in granting access to hospital emergency rooms and ambulance services, and in ensuring that women have hassle-free access to OB/GYNs. It goes further by providing a quicker independent review process and fully protecting employers from lawsuits while allowing patients the right to sue their HMO.

So this very version, in my opinion, goes further on so many important fronts on the patient protection issue, even leaving the liability debate to the side.

Mr. Chairman, many would rather create partisan issues or enrich the coffers of trial lawyers than provide meaningful protections, the strongest available, to patients. Let us stop the political gamesmanship and pass strong patient protection.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Missouri (Ms. MCCARTHY).

(Ms. MCCARTHY of Missouri asked and was given permission to revise and extend her remarks.)

Ms. MCCARTHY of Missouri. Mr. Chairman, I thank the gentleman from Michigan and rise in opposition to the amendment and in strong support of the bipartisan Norwood-Dingell managed care act.

We have all heard horror stories from our constituents, family members and friends. It is time for real reform. A constituent of mine in a head-on car wreck with massive trauma on his head, a collapsed lung, three broken ribs, and a shattered hip went through numerous surgeries in a struggle to regain the life he had before the accident. He contacted me because he had been denied productive physical therapy from his HMO despite his doctor and orthopedic specialist prescribing the physical therapy.

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Passing the Norwood-Dingell bill will improve patient care at the most fundamental level, and return medical decisions to patients and health care professionals.

This approach is working well at the State level. The current amendment we are considering will wipe out these State laws. I urge my colleagues to oppose the Coburn-Goss-Shadegg amendment and support the Norwood-Dingell bill.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to my good friend, the gentleman from Washington (Mr. BAIRD).

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

Mr. BAIRD. Mr. Chairman, I would like to just raise two simple points. We have heard briefly a minute ago, who is here to represent patients? Well, I am here to represent patients. Prior to coming to serve in the Congress, I worked for 23 years in the mental health field as a licensed clinical psychologist.

Every major health care organization supports the Dingell-Norwood bill, every single one, bar none. If you are going to see a health care provider, be they a doctor, nurse, a clinical psychologist, a social worker, a physical therapist, occupational therapist, you name it, their professional occupation supports Dingell-Norwood. Those same professionals to whom we trust our health care would oppose this poison pill amendment.

As a psychologist, I am particularly concerned about one provision of this bill, the exemption for liability claims when mental health is damaged. I personally had the experience of working with a patient who was suicidal. Twenty-three years of clinical experience said if this patient did not get additional care, they very likely might go out and kill themselves. This bill would exempt insurance companies from liability for mental health damage. That is wrong. We need to support Norwood-Dingell.

Mr. GOSS. Mr. Chairman, I am happy to yield 2¼ minutes to the gentleman from Kentucky (Mr. FLETCHER), who was instrumental in guiding us on some of the provisions of this substitute amendment.

Mr. FLETCHER. Mr. Chairman, I thank the gentleman for yielding time to me. I appreciate the opportunity to address this bill.

I want to give my thanks to the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) for the extensive work they have done on this, coming from a great deal of concern about patients and a great deal of clinical experience in providing care.

Certainly I appreciate my colleagues, the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD), for all the work they have done to bring this debate here to the floor this day.

I am here to support the coalition bill, the Coburn-Shadegg bill, because it is the best bill to provide the patients that I have taken care of real protection. It is real patient protection. It is not real trial lawyer protection, I will grant that. No ambulance chasers are going to be smiling today when we pass this bill.

But patients will, because they will be assured that, first, physicians are making medical decisions, not insurance bureaucrats. Secondly, they will make sure that the cost does not go up so much that they end up with no insurance. Causing patients to lose their health insurance is not patient protection. If anyone has seen what the plight of patients are when they do not have health care, how they deliberate at home as to whether they are going to go to the physician, whether they are going to go to the emergency room, because they know it may result in bankruptcy, you know what it means to a family and patient not to have health insurance.

Yet, I believe this bill, the Norwood-Dingell bill, will drive up health care costs and drive up the number of uninsured. It is very important that we pass this coalition bill.

It is kind of interesting to me. As a physician, my primary concern is patients. It is not the special interest groups, whatever they are. I will say that this bill probably does not please a lot of the special interest groups. I think when we reach a bill that probably is balanced and fair, it really protects patients, primarily.

It is interesting to me that, as a physician, we have cried out for help with tort reform for years. We have said, give us some relief and we can reduce the cost. I talked to an OB–GYN physician just this last week who said, my malpractice insurance has gone up to $40,000 a year. This bill will increase the cost of malpractice. It will increase the cost of health care. That money will go into the pockets of trial lawyers.

That is not what we want to do for the patients. That is not real patient protection. Vote for the Coburn-Shadegg coalition bill, for our patients' sake.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I appreciate the concerns of my fellow physician, the gentleman from Kentucky, particularly on the issue of cost. This is an important issue. We think that the cost to the bipartisan managed care bill will be very small, and that that is part of the reason why Members should support it.

Why is that? The critics of our bill have said that it is going to result in a lot of lawsuits, but if we look at a study that was recently done by Coopers & Lybrand for the Kaiser Family Foundation, where they compared group health plans that do not have a liability shield to those that do, the incidence of lawsuits was in the range of from .3 to 1.4 cases per 100,000 enrollees, and they showed that the legal costs for those group health plans that are not shielded was from 3 to 13 cents per month per employee.

That is a small price to pay for somebody who is spending thousands of dollars for their HMO coverage to be sure that that health plan then will not cut the corners too tight in the pursuit of profits that could result in harm or injury, when under current ERISA law they are shielded from that liability.

Under the plain meaning limits of our bill, the provisions, as looked at by a leading ERISA law firm in the country, have shown that we do exempt employers. It is the plain meaning of our bill. That is part of the reason why the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) put in about 5 or 6 extra pages that are very circular that in the end, basically, in my opinion, and we will go into that in more detail, shield the employer, or rather, shield the health plans, just like the problem we are trying to correct.

Mr. Chairman, we have a chance today to fix a problem that Congress created 25 years ago. The substitute we are debating now just does not do it.

Mr. GOSS. Mr. Chairman, I am pleased to yield 1 minute to the distinguished gentleman from Wisconsin (Mr. GREEN), to demonstrate the broadness of the consensus group that we have.

Mr. GREEN of Wisconsin. Mr. Chairman, I thank the gentleman for yielding time to me.

I would like to draw attention back to one very simple thing. For better or worse, we have an employer-based health care system in this Nation. That is a fact. Some of us would like to change that, but today, as we are standing here, we have an employer-based system. As long as we do, we must reject plans that would lead employers to drop coverage.

The debate over liability, and we are hearing it on both sides as to what that means, the debate over liability shows at the very least that it creates uncertainty for employers. Where they have uncertainty, we know in order to avoid risks they are going to drop coverage.

In Wisconsin, we have the lowest level of uninsureds in the Nation. We understand that we cannot protect patients unless they have health insurance. Unfortunately, unless we pass this amendment, all we are going to do is drive up costs, drive up uninsured levels. We will not have access to care and we will not have patient protection. Please support this amendment.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Tennessee (Mr. FORD).

Mr. FORD. Mr. Chairman, if we listen to the debate, one could become easily confused that it is trial lawyers who are telling patients no, it is trial lawyers who are denying care.

I understand there may be some aversion, there may be some opposition on the other side to the role that trial lawyers play in helping to even the playing field here in America, but they are not the cause or root of this problem.

As a matter of fact, things have gotten so bad that some of my friends on the other side, and I indeed say friends because many of them are, that their own front-runner presidential nominee has suggested that they soften their image, that perhaps they have gone overboard and exceeded the boundaries of fairness and perhaps even compassion, here in this body and in this Nation.

I applaud the leadership that the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) and the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Louisiana (Mr. COOKSEY) and others in this body have demonstrated on this issue. But I do think it is important that we put this issue in its proper context. This is just about accountability.

I think there are issues that can be resolved between Coburn-Shadegg and Norwood-Dingell. There are legal issues which some of the lawyers in the Chamber perhaps understand and others do not. But around here, this is just about accountability. HMOs and foreign diplomats are the only people who are above the law. That should end, and we could do it with the Norwood-Dingell bill.

Mr. GOSS. Mr. Chairman, I am happy to yield 1 minute to the distinguished gentleman from the Commonwealth of Pennsylvania (Mr. ENGLISH), who has contributed, as well, to our effort.

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

Mr. ENGLISH. Mr. Chairman, I rise in strong support of the Goss-Coburn-Shadegg substitute. This amendment arguably provides better health care quality standards than the Dingell-Norwood plan and better protection for working families by, among other things, including emergency ambulance services in the prudent lay persons standard for emergency care coverage, to ensure that patients are not worried about calling their insurance company before calling an ambulance; by reducing the time limits in expedited cases from 72 hours to 48 hours; by providing broader access to all cancer clinical trials; by providing for a voluntary alternative dispute resolution system, binding arbitration for those who do not want to go to court; by guaranteeing pathology and laboratory services; by creating a panel to establish network adequacy standards, to

ensure that each plan has enough doctors in specialties for plan participants; by prohibiting plans from considering FDA-approved drugs or medical devices, experimental or investigational; and by protecting employers from indiscriminately being held liable in lawsuits.

Health care access will suffer if employers or even trade unions are exposed to legal liability for providing health care coverage for workers. Goss-Coburn has a commonsense liability provision that holds HMOs responsible, but also caps damages and puts time limits on lawsuits.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Chairman, I rise in opposition to this amendment, which falls short, far short, on important patient protections.

If a patient has been denied a screen test or a treatment which results in a serious health care problem, the HMO must be held accountable. This amendment contains a $100 threshold for patients to be eligible even for external review. Mammograms cost $95. A routine EKG is $50. A PSA for prostate cancer is $25.

As a nurse, I am very concerned that a person who is denied a simple, inexpensive, lifesaving test would never be eligible for that review. The Coburn-Shadegg substitute will diminish fundamental constitutional rights of patients to seek redress in the courts when they have suffered serious physical harm or even been killed. This provision will save HMOs a few dollars and cents, but it defies common sense.

Mr. Chairman, patients must no longer take a back seat to profits. I urge my colleagues to oppose this amendment and to support the Norwood-Dingell bill.

Mr. GOSS. Mr. Chairman, I am pleased to yield 1 minute to a close colleague and friend, the gentleman from Florida (Mr. WELDON), who obviously has been of much assistance in putting on this measure.

Mr. WELDON of Florida. I thank the gentleman for yielding time to me, Mr. Chairman, and I rise in support of the Goss-Coburn-Shadegg substitute.

Mr. Chairman, I came to Washington from my medical practice in 1995, feeling at that time that the managed care industry had placed the bottom line ahead of quality of care, that insurance company and HMO bureaucrats were practicing medicine, and that they needed to be held accountable, as accountable as I was when I practiced medicine.

□ 1330

However, I also felt that our society had become too litigious, that we had too many lawsuits. I believe that this substitute before the body now strikes the right balance between these two conflicting needs. It allows for the maintenance of quality through strong internal and independent external appeals processes, but it still reserves the right of individuals to seek redress in court for their injuries. I feel that it is the piece of legislation that we should be enacting.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from New York (Mrs. MCCARTHY).

(Mrs. MCCARTHY of New York asked and was given permission to revise and extend her remarks.)

Mrs. MCCARTHY of New York. Mr. Chairman, I rise in support of the Bipartisan Consensus Managed Care Improvement Act. I rise today to speak as a Congresswoman from Long Island, a mother, and a nurse.

I spent close to over 30 years as a nurse, and I speak from experience when I remind my colleagues health care is about people. Real health care means direct access to specialists, especially in OB/GYN for women. Real health care means access to emergency room care. Real health care protects health care workers from retaliation from their employers when they blow the whistle on wrongdoing. Real health care saves lives by making clinical trials available to patients, not just cancer patients, but to patients that are suffering from many diseases. Real health care is a clean Norwood-Dingell bill.

The reason is, the first lesson I learned in nursing school was the patient always comes first. I hope we remember that when we vote today.

One other thing that I would just like to bring up very rapidly, 5 years ago, when I was an average citizen and had my health care insurance, I could not sue my HMO. Today, because I work for Congress, I am allowed to sue.

Mr. GOSS. Mr. Chairman, I am privileged to yield 1 minute to the gentlewoman from New York (Mrs. KELLY), a distinguished medical professional and activist.

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

Mrs. KELLY. Mr. Chairman, it is as a professional health care advocate that I rise in support of the Goss-Coburn-Shadegg-Greenwood-Thomas substitute amendment.

This amendment provides patients with vital protections that the Norwood-Dingell bill does not, such as shorter external appeal times, network adequacy standards, access to ambulance services, guaranteed pathology services, and a prohibition on plans labeling FDA approved drugs and devices as ''experimental.''

This amendment ensures patients get the care they need when they need it. It leaves medical decisions up to doctors, not insurers, and not lawyers. It allows doctors to treat their patients and prevents insurers from making medical necessity decisions. Insurers will be held accountable for wrongful actions; and patients, if injured, can go to court to sue for damages.

This substitute amendment also broadens the appeals process a patient may use by allowing binding arbitration as an alternative option to court. Arbitration will provide those patients who choose to select it the opportunity to appeal medical coverage decisions and to hold health insurers financially accountable for wrongful decisions in a nonthreatening forum with the same protections as court, but without the cost and time consumption.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Chairman, the Norwood-Dingell bill protects States' rights to regulate medical malpractice, a right that has existed for over 200 years.

In Texas, we passed patient protection legislation. It is working. There is no reason to conclude that we will run to the courthouse or that there has been a rush of litigation.

This House rejected the Boehner substitute because it allows insurance companies to avoid accountability. But equally damaging is to allow insurance companies to avoid medical malpractice laws of our 50 States by creating an exclusive preemptive Federal cause of action that is nothing more than the insurance company protection act of 1999.

The Coburn substitute blatantly tips the scales of justice in favor of the insurance companies. It privatizes justice by giving a private panel the authority to make judicial findings that are binding on the Federal court. Giving private entities the power to make findings that bind the Federal court is unprecedented in American law, and this provision should be rejected.

This substitute gives legal protection from liability to insurance companies enjoyed by no other group except foreign diplomats. We must protect patients. We must preserve accountability. We must preserve States' rights and reject the Coburn substitute.

Mr. DINGELL. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from Georgia (Mr. NORWOOD), which is going to be a benefit to both the gentleman from Florida (Mr. GOSS) and to myself.

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from Michigan for yielding me this time.

Let me make this very clear. Let me also just thank the gentleman from Oklahoma (Mr. COBURN). I think that his bill has tremendous things in it in terms of patient protections. They have tried very hard. He and I have worked together for months and months and months.

But the problem is, and I will try to get through some of them at this point, the problem is that, when they get into their liability section, it takes us for the first time to Federal court. There are so many concoctions in there that it is going to be basically very impossible for a patient who has been wronged to have that wrong made right.

Now, there is really a reason why the California Medical Association and the Texas Medical Association and the Medical Association of Georgia have all sent letters to their Members of Congress saying that the Coburn bill would preempt State law. They are right.

My colleagues tried. I congratulate them for trying. But they failed. Let us take a look at what the bill says. Nothing shall be construed to preclude any action under State law not otherwise preempted under this title. The title they are amending is ERISA, section 502.

The courts have consistently ruled from the Pilot Life case on that any remedy that exists under ERISA, section 502, will preempt State law. By allowing a patient to sue in Federal court, their bill creates a new Federal remedy under ERISA, section 502. The courts have consistently ruled a Federal remedy preempts State law. Any cause of action under State law like California or Georgia or Texas that would conflict with a new Federal cause of action they have created is necessarily preempted. Their own language says so. There is no way the Texas, Georgia, and California laws would not be preempted.

Now my colleagues tried. I do not blame them for trying. I would not want to tell the Members from California or Texas or Georgia that my colleagues are preempting their State laws. Then, again, I do not have to do that.

In addition to what we are putting in ERISA, Federal law is supreme and has been so since 1819 and the Barron v. Baltimore case that the Supreme Court ruled on.

Now, that is one of my hiccups being from Georgia, and I think a lot of people might have that, that we are taking away State law.

Let us point out another little problem, because they are in there. Lord knows I am not against the gentleman from Oklahoma (Mr. COBURN). I love his bill except for these little issues, and that is why we have to defeat it.

Under the Norwood-Dingell bill, a person is held accountable for the consequences of the decision based on the medical merits of that decision. If a doctor makes a decision, he is judged on whether or not that decision was good. Good medicine. We want an insurer who overrules a doctor judged by the same standard. We want an insurer who overrules a doctor judged by the same standard. Now, under the Coburn-Shadegg substitute, an insurer will be judged by whether they practice good accounting.

Mr. GOSS. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Tennessee (Mr. BRYANT).

Mr. BRYANT. Mr. Chairman, as we have heard from a number of our doctors today on both sides of this issue, I want to give my colleagues the perspective of an attorney who practiced law representing health care providers in malpractice cases.

I am somewhat confused because I have seen firsthand how unrestricted litigation against doctors and hospitals have caused the cost of medical care to rise dramatically. It caused doctors to practice defensive medicine. It caused premiums to go up and to see the cost of this service, the tests, and all of that to go up to where it is almost unaffordable.

Yet, here, we are today talking about trying to do the same thing to health care organizations. Why do we want to do that?

I have studied these bills, and I have come to a conclusion that there is a need for accountability for managed care. We have to hold them accountable, but we can do so in a fashion that does not chase people out of the health care industry, does not raise the expenses, does not cause more people to become uninsured. That is done in the Shadegg-Coburn bill.

It is a balanced, reasoned, measured approach which holds our HMOs accountable for good care and, on the other hand, does not run people out, does not make it too expensive that we have got more uninsureds on the rolls.

Mr. DINGELL. Mr. Chairman, I yield 1½ minutes to the distinguished gentleman from Texas (Mr. SANDLIN).

Mr. SANDLIN. Mr. Chairman, do we need a new Federal tort in this country? Do we want the Federal courts preempting State law in this country? Do we want the Federal courts taking over the traditional role of regulating insurance that is assumed by the States in this country?

I submit to my colleagues that the answer to those questions is no, but that is exactly what Coburn-Shadegg will do, allow Federal courts to preempt State law and create a brand-new Federal tort. Let us create health care in this country for American citizens. Let us do not create new torts.

What happened to local control? What happened to that argument? Do we not trust our own State courts in this country? Do we not respect local government? Do we turn everything over in this country to the Federal courts? Is that what we are about? That is just what this bill does.

I am here to tell my colleagues that, under Coburn-Shadegg, our State courts are gagged just like the doctors are gagged. On the other hand, Norwood-Dingell will not override protections already provided by State laws, States such as Texas, New York, Michigan, Iowa all across this great country. Norwood-Dingell is a common-sense local approach to these problems. If an insurer makes a decision, the insurer is responsible for that decision.

A final matter, the employer is not responsible for the decisions made by others. The employer is not responsible for the decisions made by others. The employer is not responsible for the decision made by others, period. That is what the States say.

Let us create medical care. Let us do not create a new tort.

Mr. GOSS. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from Louisiana (Mr. MCCRERY).

Mr. SHADEGG. Mr. Chairman, will the gentleman yield briefly?

Mr. MCCRERY. I yield to the gentleman from Arizona.

Mr. SHADEGG. Mr. Chairman, I simply want to set the record straight on this issue. Apparently the question of whether or not State law is preempted under Coburn-Shadegg has become important, and I tried to ask the gentleman from Georgia (Mr. NORWOOD) about that issue.

I want to point out that, in his argument, he said that it is preempted because ERISA preempts all State law. That was his premise, because ERISA preempts all State law, and our bill said not otherwise preempted. He said that is the flaw in our logic.

The problem is he is wrong about that. ERISA does preempt all benefits claims, but it does not preempt quality of care claims. That is precisely what the Texas Legislature took advantage of. They wrote a law that says quality of care is not preempted. Georgia, Louisiana, and other States have followed, so his premise is simply wrong.

Mr. MCCRERY. Mr. Chairman, I thank the gentleman from Arizona for his comments.

To the gentleman from Texas (Mr. SANDLIN) who spoke so fervently about employers not being liable, I would simply say that, as a lawyer, he knows, and I am a lawyer, and I know that lawyers are not prevented from suing anybody no matter what the wording of any statute is.

I can guarantee him that some lawyers are going to sue employers because they sue everybody, everybody in sight that they think might be brought into court and have a settlement at hand. Those employers are going to have to fight that. Even though they may ultimately win under the wording of the statute, they are going to have to spend a lot of money fighting that lawsuit, and that is part of the problem.

Let us talk about liability for just a minute.

□ 1345

And I understand the American Medical Association is supporting Norwood-Dingell and not supporting Coburn-Shadegg, which is just beyond belief to me. The American Medical Association, as well as some of my colleagues who are supporting Norwood-Dingell, have been fighting for years for medical malpractice reform, saying that the liability system is out of control. And yet, by passing Norwood-Dingell, they would impose on health care plans the same out-of-control liability system they have been complaining about for years on doctors. I just do not get it.

Mr. Chairman, besides the liability issue, though, which I think is clear, Norwood-Dingell does impose on health plans, the same out-of-control liability

system that we have everywhere else, Coburn-Shadegg, on the other hand, puts some reasonable restraints on that liability system. But let us put that aside. Let us talk about the rest of the bill. I think my colleagues, especially on the free market side of the aisle, should be very concerned about the regulatory aspects of Norwood-Dingell. Their bill includes language stating that external appeals panels, for example, can consider as evidence government-issued practice and treatment policies and guidelines.

This gives bureaucrats the potential to outline practice in this country; bureaucrats writing down how health care will be administered, not doctors. Unlike the Coburn-Shadegg substitute, Norwood-Dingell gives unfettered discretion to Federal bureaucrats to determine if health care workers suffered from inappropriate retaliation from their employer.

This bill, the Norwood-Dingell bill, is too heavily regulatory. Vote against it and support the Coburn-Shadegg substitute.

Mr. DINGELL. Mr. Chairman, I yield 30 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I would just point out that in our bill we have limited punitive damages. That is a step forward. We go to the State courts because we know that there is a great deal of tort reform around the States, 30 States or so have limited punitives or none, caps on noneconomics.

So I would say that is another good reason not to set up a new Federal tort where we just simply do not have any type of tort reform. And we cannot depend on the States to do the right thing in an area that they have typically and historically controlled for the last 200 years.

Mr. DINGELL. Mr. Chairman, I yield 1½ minutes to the gentleman from Massachusetts (Mr. FRANK).

Mr. FRANK of Massachusetts. Mr. Chairman, for those who have contested the theory of evolution, we have the Republican Party's position on this issue. It has been evolving very rapidly.

We started out with many saying, no, there should not be any basis for lawsuits. They have moved. And I give credit to those who have helped them move, but they have been held back by some who still do not like the notion at all. We now have, apparently, agreement that there should be a right to sue HMOs. That is a considerable evolution. How wholeheartedly some believe in what they agree to, I am not sure. But we do have some agreement.

The question is what kind of lawsuits. And, in fact, what we have are people who have been grudgingly brought to the notion that there should be lawsuits but, because it was grudging, have designed flawed lawsuits. They have designed, surprisingly to me, a Federal supremacy situation which is premised on the notion that we cannot trust the States. Indeed, what we have from some on the other side is a distrust of two entities with whom they have previously professed a lot of solidarity: States and doctors. They have to say that we cannot allow the States the freedom to deal with the lawsuits, and they also show a distrust of doctors.

I also want to talk about the kind of lawsuits. Members on the other side have said, well, how has the AMA switched their position. These are very different kinds of malpractice lawsuits. Whatever we think of the other kinds of malpractice lawsuits, they are cases where the doctor who treated the patient is being sued and other people who did not treat that patient are coming in.

Here the lawsuits authorized are a very specific kind. They will require the cooperation of the doctor who treated that patient. Here the malpractice claim is that the doctor who actually treated the patient was overruled and interfered with. So the doctor who treated the patient stands as a gatekeeper to prevent illegitimate lawsuits.

Mr. GOSS. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from California (Mr. THOMAS).

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

Mr. THOMAS. Mr. Chairman, while we are talking about evolution, let us talk about the fact that there are a number of unions that support the Norwood-Dingell bill. And why in the world would the American Medical Association align itself with unions? Perhaps my colleagues were asleep when the American Medical Association decided to adopt collective bargaining.

The arguments that we have heard, no matter how strongly or forcefully presented about the fact that the coalition bill tramples State law, are simply wrong. Let us not try to rely on each other. Let us go to the independent, professional attorneys that we have relied on since Congress created itself, the Congressional Research Service. Those lawyers, totally objective, analyzing the coalition bill said this: ''This provision would not interfere with, but would support, a recent holding in a Federal district court decision upholding the ordinary care provision of the Texas law.''

Now, my friend is a lot of things, but the gentleman from Georgia (Mr. NORWOOD) is not an attorney. The Congressional Research Service says the coalition bill supports State law.

Now, if we want to meet a trial lawyer, follow an ambulance. If we want to know who is supporting this measure, take a look at their list of supporters. On the coalition bill we will find that virtually medical association for medical association they match. But we cannot stay with them when the unions endorse their provision and the trial lawyers support their provision.

Why? Because people whose lives are on the line, in terms of their economic survival, say this: ''The Chamber of Commerce strongly opposes any proposal which permits jury trial lawsuits for unlimited punitive and compensatory damages.''

Do we believe the trial lawyers? No. Who will butter their bread? Take a look at the list of supporters of the coalition. We do not have the trial lawyers. Take a look at Norwood-Dingell. The trial lawyers and the doctors are together. Now, talk about evolution. Not only are they going to be following an ambulance, but they are going to be in the ambulance.

This is exactly the wrong approach to take when employers still have the ability to say, yes, I will provide health insurance; or, no, I am not going to run the risk of unlimited punitive and compensatory damages. That is the risk that will be run if Norwood-Dingell becomes law. And I can assure my colleagues that employers will say, at some point, it is not worth the risk. Do not feed trial lawyers.

Mr. DINGELL. Mr. Chairman, I yield 15 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I just want to point out to the gentleman from California (Mr. THOMAS) that we all try to use independent, well-experienced lawyers. The lawyer from CRS who says that we do not preempt State law is out of law school for 3 years and has never practiced ERISA law. We tried to find some experienced people to do our ruling.

Mr. DINGELL. Mr. Chairman, I yield 2½ minutes to the gentleman from Missouri (Mr. GEPHARDT), the minority leader.

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

Mr. GEPHARDT. Mr. Chairman, I rise in opposition to the Coburn-Shadegg amendment and to speak for the Norwood-Dingell bill. And I want to commend the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) and all of the Republicans and Democrats who have worked so hard on this bill and especially the gentleman from Michigan (Mr. DINGELL) for all that he has done to make this happen.

The Coburn-Shadegg amendment, in my view, does not do what it claims to do. It fails to hold health care providers accountable. It lets them off the hook. It will not go far enough to guarantee that American families get the health care they need. In my view, only the Norwood-Dingell bill will return control of medical care back to where it belongs, to doctors and patients. It will deliver much-needed patient protections at a small cost to consumers and to business. I believe the cost is a modest price to pay to restore the much-needed balance in our health care system.

The health insurance lobby and their allies are spreading a false message that the Norwood-Dingell will and managed care reform will force employers to drop plans and will cause a

loss of jobs and blunt economic growth. This is not reality. All we have to do is look at the experience in Texas, which has had a bill much like the Norwood-Dingell bill. Information filed with the Texas State Department of Insurance shows that there has been no unusual increases in costs in HMOs. In fact, national HMOs that operate in Texas and other States have higher cost increases outside Texas.

A recent study by the Kaiser Family Foundation found that the premium increases likely to result from a bill like Norwood-Dingell would be very modest. In fact, their study showed that it would result in a premium increase of less than 1 percent to a typical HMO policyholder.

Now, let me say to the Members that if somebody is sick in my own family and is not getting the care that the doctor believes they should get, I can assure my colleagues that paying less than 1 percent more for a policy that would give me enforceable rights would be something that I would leap at, and I think all my colleagues would leap at, if someone in their family was direly sick.

I have said many times that back in the early 1970s my son was diagnosed with terminal cancer, given no hope. The pediatrician said, he is going to be dead in 6 weeks. Then another doctor came in the room and said, we got on the computer last night and we think we found something that might work. This was back in 1972. I had good insurance, thank God. He got the therapy. If that doctor had come in the room and said, we typed in the computer and we found a triple drug therapy but the HMO has refused it, boy, I would have wanted to pay that extra 1 percent or half a percent to get the right to have that happen.

And let me say, with all respect to my friends who have brought these other alternatives, the reason that we want enforceability and accountability and a right to get to court after a review by physicians is we want pressure on these HMOs and health insurance companies to make the decisions in accordance with what doctors and patients need.

This is an important moment. This is the right bill. I urge Members to turn down these alternatives. I have great respect for the people who have written them and their motive and intent; but with all my heart I say to the Members of the House of Representatives today, this Norwood-Dingell bill is the right bill for the people of this country. If somebody is sick in your family, you are going to need this bill. Turn down these alternatives and vote for this very, very positive piece of legislation.

□ 1400

Mr. GOSS. Mr. Chairman, I yield 5 minutes to the distinguished gentleman from Oklahoma (Mr. COBURN) who is the principal author of the patient protection act of this substitute.

Mr. COBURN. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, this is an issue that is very important to many of us. I have spent 21 years of my life in the medical field. Myself and one other doctor in this body goes home and practices every weekend. We all agree that there needs to be certain basic things changed. Everybody that voted on the last bill all know that all those basic things need to be changed.

Why? Because there were four Members in this body that really wrote them: The gentleman from Iowa (Mr. GANSKE), the gentleman from Oklahoma (Mr. COBURN), the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Arizona (Mr. SHADEGG). They constitute the entire base bill of all the bills that are written. We all agree on that. What we do not agree on, however, is what the risks are of going too far.

I believe that all in this debate are well-intended. And other than the statements made by our friend from Massachusetts, I believe all the motives are good. He said our motives are not good, we have been pulled. We have not been pulled. We care about patients immensely. The question is do we care just in the short-run? Are we only going to solve the problem now and then have to come back and fix a bigger problem?

I am known for my independence in this body. I have taken the AMA foursquare for their position, which puts people's future health care benefit at risk. And why are they doing it? They have a persecution complex. They have been sued out the kazoo. And if it is good enough for them, it is good enough for everybody else.

I am a pro-business conservative. I have had the ''little you know what'' beat out of me from the people who are my friends. Why would I position myself in the middle of those two? Because I want to fix health care. Not just now. I want to fix it down the road. And I do not want what we are about to do to end up being the reason why the Government is going to have to run health care.

Mr. Chairman, I want to tell my colleagues, if they do not believe that is true, listen to this: The closest the Health Care Financing Administration has ever come on any estimate of any cost with Medicare/Medicaid, they missed it by 800 percent. So just take .3 or 1 percent, multiply it by 800 percent, and that is what we are going to see.

There are motivations other than caring for the patients in this debate, and they are big business not wanting to pay the cost of full care. There are HMOs who oftentimes, too often, the bottom line is the most important thing. And there is the trial bar who will extort, we cannot deny it, they will extort businesses. And they will raise costs. And under the claim of a good purpose but all too often as a lawsuit that is intended to only do one thing, extort money because it costs more to defend than it does to settle.

I do not deny that there are serious problems in our health care delivery system. I have worked hard with my friend, the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Iowa (Mr. GANSKE) to try to solve those. But I beg this body to consider what we do. If we go too far and if we do not go far enough, we have failed. And if we fail, everyone in this country loses.

Government-run health care will kill the quality and leading nature of this country's health care. That is really what we are talking about. We are not really talking about lawsuits. We really are not talking about employer-based helped care. What we are talking about is getting over the brink to where what is going to happen is we are going to fulfill our obligation with a Government-run program.

And then talk about costs, talk about the ability to control care, talk about meeting our obligations to Social Security. We cannot even meet our obligations in Medicare now. How are we ever going to do that?

So as my colleagues consider this vote, think about why I would place myself against both sides of my friends, both sides. Because it is right and because it is correct. It does not do everything that the Norwood-Dingell bill does. We know that. But let us go here first. Let us hold plans accountable. There is no denying that we hold them accountable. The gentleman from Georgia (Mr. NORWOOD) knows that. It is how we hold them accountable and what are the costs associated with that.

I would beg my colleagues to look and walk before we leap. Our patients are worth that much.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to my good friend the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, this is the painful part. It is not any fun going against our friends. And the gentleman from Oklahoma (Mr. COBURN) is my friend. Of course, I wish he would not go against our bill which he worked so hard on and so long to help us write.

My colleagues, what this really is all about is about two very strong American principles. It is about the right to choose in this country and choose our own doctor, and it is about the right to ask people to be responsible for their actions. We do that all the time, and it is time that we ask the insurance industry to be responsible for its actions.

I am going to vote against the Coburn amendment because all the good things he has in his bill that he knows I agree with, he is right, I did help him write them, but I am going to vote against him because they really have gone too far with their liability part. And yes, they do and will make insurance companies liable in Federal court. There is no question that they will. But the problem is the poor patient has to jump through so many hurdles before they can get there.

It is correct for us to not endorse frivolous lawsuits and extortion that

happens out there in the legal profession today. We know that. That is why we have tried to do our best to protect the employers.

But I cannot support his bill because I have to worry about and I am worried about and I have been for 5 years, tomorrow, today, it is about that mother today who took her child to the pediatrician and the doctor says her child needs to be hospitalized and the insurance industry 2,000 miles away says, no, we cannot do that.

It is about a friend of mine, Bob Schumacher, who, like me, is a small businessman and lives in Macon, Georgia. Bob used to be a member in NFIBE. He used to be a member in the Chamber of Commerce. But his wife is dying and the plan that he bought as the employer will not pay the benefits, and he basically has no recourse today. I want him to get recourse and get it fast, and we think in our bill that is the best way to do that.

Mr. GOSS. Mr. Chairman, I yield the balance of my time to the distinguished gentleman from Illinois (Mr. HASTERT), the Speaker of the House.

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

Mr. HASTERT. Mr. Chairman, I rise today in strong support of the coalition substitute.

As many of my colleagues know, I have been involved in this whole idea of health care and health care reform for a long time, probably longer than I want to remember.

One of the things we have strived for is to be able to get people into health care, into the situation where they need to get treatment, try to get people into hospitals' rooms and doctors' offices and not necessarily going into lawyers' offices and courtrooms before they can get that treatment.

I have always believed that we have three goals in health care. It must be affordable. It must be available. And it must be accountable. If it is not affordable, it is not available. Trying to change a system and keep a balance so that we do not change that system too much that we completely upset it so patients cannot get the care that they need is the task before this House, to try to find balance to try to do those things that are the right things.

As we debate these bills and these options before us today, there are a lot of similarities. People getting the access, people being able to get into emergency care, getting to their caregiver, their pediatrician, or their Ob-Gyn so that they can take care of them. They are all the same. I have written that legislation for years. The gentleman from Georgia (Mr. NORWOOD) helped me to do it. And this is all the same.

The difference in these bills is to some a fine line, but the difference in these bills is how far we go, how far that we give license to the trial lawyers, how far that we take the incentive away from corporate and employers to provide health care for their employees.

I am pleased that the House passed an access bill yesterday in a bipartisan fashion that will help address the problem of the 44 million uninsured today. It would be shameful to take up the important issue of patient protections without doing something to protect the uninsured.

As my good friend the gentleman from Florida (Mr. GOSS) put together a package that does both, he wrestled with many issues, how to make sure that managed care plans come through on their promises to their patients, how can we be certain that patients get the care they need when they need it.

Mr. Chairman, the coalition substitute developed by the gentleman from Florida (Mr. GOSS), the gentleman from Oklahoma (Mr. COBURN), the gentleman from Arizona (Mr. SHADEGG), the gentleman from Pennsylvania (Mr. GREENWOOD), and the gentleman from California (Mr. THOMAS) is an excellent product. It took us a while to reach this point. Consensus takes time. But we have got a solid, balanced approach that I urge my colleagues to support.

This is what the coalition bill does: It provides access to binding, independent decisions by doctors. For patients, we enforce their rights in court. And if they are harmed, they have access and rights to go back to court and get their damages. We protect employers who offer health care as a voluntary benefit. And we do not end fee-for-service medicine. We protect States like California and Texas that have already passed the right to sue legislation.

Sound reasonable? I think so. What could possibly be the reason for division on such a common-sense approach? It is very simple. We do not protect the trial lawyers. We do not force people to sue their way to get better health care. We do not provide windfalls for the trial lawyers. We want to show them something. We want to show them a common-sense way.

I want to also show my colleagues something else. This is a class list from the University of Texas Law School. It is a class list of all kinds of courses on how to sue an HMO. Probably that is relevant in Texas. Folks in Texas argue that the right to sue has not increased costs and they have not exploded. And they may be right so far.

But under the Norwood-Dingell legislation, trial lawyers will be given unprecedented new rights to sue any time for any reason in any venue. The truth is no one has any idea what the cost implications can be when they go too far. The coalition bill, instead, gives patients the care they need when they need it.

My colleagues, we have come to an important point in this Congress in this debate. If we want to protect patients, vote for Goss. I urge support for the coalition substitute. And when it passes, I want to urge my colleagues to vote yes on final passage to move this legislation forward.

□ 1415

Mr. DINGELL. Mr. Chairman, I yield the balance of my time to the distinguished gentleman from Arkansas (Mr. BERRY).

The CHAIRMAN. The gentleman from Arkansas is recognized for 2¼ minutes.

Mr. BERRY. Mr. Chairman, I rise in opposition to this amendment and in support of the bipartisan Norwood-Dingell bill. Let me tell my colleagues one of the reasons why.

Under the Coburn-Shadegg amendment non-economic damages are limited to the lesser of two times economic damages or $500,000. As was already mentioned, the Cocoran case that the gentleman from Arizona (Mr. SHADEGG) talked about, since the victim was a baby with no earnings, economic damages are minor, possibly only the cost of a funeral. Do my colleagues want to tell the Cocorans that the life of their baby is only worth a couple of thousand dollars? Under the Coburn-Shadegg amendment that is all that they would receive. That is one of the reasons I am opposed to this amendment.

Unlike this substitute which creates a new Federal bureaucratic process, the Norwood-Dingell legislation would allow States to determine whether such liability should be expanded to self-insured plans.

Let me say this again. The Norwood-Dingell bill allows States to determine whether HMOs should be held liable, and it allows States to determine which limits to set on damages.

The gentleman from Oklahoma (Mr. COBURN) says that letting the States decide goes too far. I disagree. The State of Texas, which the Speaker just referred to, has only had three lawsuits in its experience with a very similar bill as we are about to pass. Only in States that allow such suits and only in cases where a person has gone through a competitive internal and external review process could a lawsuit be filed, and if a health insurer or HMO abided by the review process, it could not be sued for punitive damages.

Most important, the Norwood-Dingell bill specifically prohibits lawsuits against employers, unless an employer makes a medical decision to deny a covered benefit and a patient is seriously harmed as a result. Norwood-Dingell specifically prohibits the suit to an employer.

These safeguards virtually ensure costly trials. Unreasonable verdicts will not result. At the same time it will ensure insurance companies and HMOs provide the benefits that employers and employees have paid for.

Mr. HUTCHINSON. Mr. Chairman, presently, this Nation is awash with a sea of discontent—a belief, in our Nation, that managed care has eroded the traditional reliance of patients on the decisions and recommendations of the physicians.

Because of the growing discontent of patients who are subject to managed care agreements, Congress is prepared to step in with

additional patient protections and rights and to make sure those rights are enforceable. As we consider changes to our managed care system we need to keep in mind our guiding principles:

First, patients should be able to choose their own doctor—the most basic decision on health care. This means that a managed care agreement must allow a point of service option allowing patients to pay for procedures and physicians not covered by their plans; patients must also be guaranteed access to customary specialities such as OB/GYNs and pediatricians.

Second, physicians should be free to discuss all medical options with their patients—this means a prohibition of gag rules which restrict physicians from recommending all medical options with the patient;

Third, members of managed care plans should have immediate access to an emergency room based on a prudent lay person's standard and not be second guessed by an office clerk reviewing an emergency room bill thirty days after an emergency.

Finally, the protections and rights for patients are useless without the means for accountability and liability if those rights are ignored.

When organizations like insurance companies determine issues of medical necessity, they need to stand behind those decisions. However, while I believe there must be accountability, there also must be safeguards for employers who provide healthcare as a benefit and do not make medical decisions. Healthcare insurance is an employer sponsored system, and we must be careful that we maintain that system and encourage it to grow. Already, we have too many people who are without insurance, and we do not want to see those numbers rise because Congress irresponsibly passed legislation that drove up the cost of healthcare in a dramatic fashion.

Mr. Chairman, the bill before us that protects the patient and follows these guiding principles is the Goss, Shadegg, Coburn, Greenwood and Thomas Substitute. This requires group health plans to have a grievance system as well as an internal and external appeals process.

This would also allow a patient recourse when there is a denial of coverage if the benefits would exceed a hundred dollars. The legislation requires decisions within 14 days or 48 hours in expedited cases. In addition, for the first time a patient would be able to take the responsible party into court to protect their rights. The purpose of the court access is to protect rights, recoup damages and not to punish the healthcare plan if the plan is following the recommendation of the appeals review.

Just as important, employers who provide a self-funded health insurance plan will not be held liable unless they directly participate in the medical decisions of the plan. This provides adequate balance between patient protection and avoids astronomical price increases on health insurance premiums.

Mr. Chairman, I ask my colleagues to support the balanced approach of the patient protection provisions in Dr. COBURN's substitute amendment.

Mr. HILL of Montana, Mr. Chairman, Americans enjoy the best quality health care in the world. However, our system for delivering care can still be frustrating for patients, providers and employers. True comprehensive health care reform in my opinion must include the three A's—Accessibility, Affordability and Accountability. Yesterday, the House passed H.R. 2990 which will improve the accessibility and affordability in health care that we need today.

Today, we need to complete the Trifecta and address the most difficult of the three A's—Accountability. During the debate today we will have an opportunity to vote on four different ways to address the accountability issue. The main issue that we are debating when discussing patient protection legislation is how do we bring about accountability for insurance companies without creating a whirlwind of frivolous litigation.

Americans want and deserve patient protections, they do not want more lawsuits. And they don't want to fight with their employer, their doctor, or their insurance provider.

That is why I support the Coburn-Shadegg substitute to H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act.

There are a number of reasons that I feel this solution is the best for both patients and providers. I believe this substitute ensures responsibility by holding insurance companies accountable to patients by allowing physicians to make medical decisions. First, Coburn/Shadegg allows employers to provide health insurance to their employees without exposing them to increased litigation. Under this substitute, employers can not be held liable for providing health care coverage, selecting a plan, selecting a third-party to administer, determining coverage or increasing or reducing coverage, or intervening on behalf of an employee. Under H.R. 2723, the employer will be subject to lawsuits which in turn, I fear, will cause employers to drop their health plans for their employees.

Second, Coburn/Shadegg instills reasonable accountability. The substitute requires an exhaustion of administrative remedies required. Patients are allowed to go through an internal and external appeals process before going to court. This gives patients an expedited forum to air grievances. Most importantly, the appeals are decided by an independent panel of doctors, not by bureaucrats or insurance claims adjusters, not by lawyers or judges.

Under this substitute there is no liability for consequential damages if the plan's doctor's decision is upheld by the independent external appeals entity. The goal is to encourage care and the good decision making at the earliest point in time. We need to avoid a process such as that created in the Norwood/Dingell bill that would produce an avalanche of frivolous lawsuits. We can address the very real concern of patients in managed care plans by empowering patients, not trial lawyers, and do so by passing Coburn/Shadegg.

I want patients to get the care they are entitled to when they need it, not allow their heirs to sue for some large settlement after they die. In the end, excessive lawsuits will only take money away from care and put it into the pockets of attorneys. That is an unacceptable result.

By adopting the Coburn-Shadegg substitute, we will be completing the three A's—Accessibility, Affordability and Accountability. Only when we have the three A's, is when we have a common-sense approach to comprehensive health care reform that will make health insurance companies more accountable and give patients more choices.

Mrs. FOWLER. Mr. Chairman, today I rise in support of the Goss-Coburn-Shadegg substitute. I, too, have heard of the excesses of some managed care plans from constituents and doctors in my district. I agree that these excesses must be curtailed and that the health care plans should be held accountable when they practice bad medicine.

However, I do not believe that the only way to hold them accountable is to open them up to lawsuits without limits.

The Norwood-Dingell bill does not distinguish between managed care insurance and traditional fee-for-service insurance. Fee-for-service plans merely reimburse for care; they do not engage in the type of medical decision-making that we seek to address through this debate. This substitute, on the other hand, makes the distinction and protects fee-for-service plans from expanded liability.

This substitute, like the Norwood-Dingell bill, establishes internal and external review processes through which doctors make determinations about what care is appropriate for their patients. But, unlike the Norwood-Dingell bill, this substitute allows those processes a chance to work before sending patients to court.

Mr. Chairman, the ultimate goal we all share is to ensure that patients get the care that they need when they need it. An expedited review process like that set up in this substitute will get patients that care much more quickly than a lengthy lawsuit.

But should the insurance company defy the determinations of those independent doctors, and as a result a patient is injured or dies, court may be the only option. This substitute allows for full recovery of economic damages, but caps the non-economic and punitive damages that can be won so that they are fair.

Furthermore, Mr. Chairman, this substitute strikes the appropriate balance between the rights to patients to seek redress of their grievances and the legitimate concerns of employers of being subjected to unlimited lawsuits. Unlike the Norwood-Dingell bill, Mr. Chairman, this substitute, through very specific language, will protect employers who do the right thing and provide health insurance coverage to their employees.

Without this employer protection, more employers will be forced to drop their insurance coverage for their employees. Without these limits on liability, premiums will rise and more people will be unable to afford insurance coverage. If these things happen, Mr. Chairman, then all we've done here today and yesterday will have been for naught.

Mr. CLAY. Mr. Chairman. I rise in opposition to the Coburn substitute. This substitute is nothing more than a fig leaf to permit Members to say they voted for something on liability without giving the American people any real rights. Under this substitute it is so difficult to get to court that almost no one will be able to be redressed in court.

First, under Coburn, individuals may only go to court after they have exhausted all internal and external plan appeals. No exception. Even if injury has already occurred. Or if appealing would be futile. This is tougher than current ERISA law which permits individuals to go to court if the court finds the internal process futile.

Second, individuals may only bring suit in federal court. The backlog is far greater in federal court than in state court. Individuals who

do not live in big cities will have to travel long distances if they have been harmed.

Third, Coburn only permits individuals to sue the ''final decision maker''. This alone can be an impossible standard for an individual. Most individuals do not know who denied their claim and they certainly don't know who the final person was.

Furthermore, Coburn includes an unprecedented and likely unconstitutional limitation on the court's power to hear the case. Under Coburn, health plans can contract with private entities and permit them to determine if an individual was harmed and whether it was due to the plan's failure. If the private contractor finds for the health plan, then the court must dismiss the lawsuit unless there is clear and convincing evidence to the contrary. This is an unprecedented intrusion on the power of the courts. A private entity cannot determine whether there is a case or not. That is for the courts and the courts alone.

Even worse, Coburn mandates that the court award losing attorneys' fees and court costs if an individual's case is dismissed. Few working people can afford to go to court if they may be forced to pay the health plan's attorneys' fees if they lose.

Coburn is not a serious liability amendment. It makes it so difficult for an individual to bring a suit that almost no one will be able to go to court. Don't be fooled by this Trojan Horse. The American people want real rights and real reform. Support the Norwood-Dingell compromise.

Mr. KOLBE. Mr. Chairman, for the last 10 months, I've researched, analyzed, listened, and questioned, searching for the right answer to this policy conundrum. I believe there are four guiding principles that should govern any response:

(1) Legislation should permit an individual to sue an HMO as long as the amount of damages are reasonably related to the economic loss.

(2) Legislation should permit the right to sue over covered benefits only.

(3) Legislation should emphasize mediation over litigation.

(4) Legislation must provide sufficient protections for the employer—not the HMO—from lawsuits, unless the employer is actively engaged in making the health care decisions of the HMO.

In my view, Norwood-Dingell runs counter to these principles. Specifically, the bill would:

Allow lawsuits by anyone. No actual injury is required to recover damages under H.R. 2723.

Allow lawsuits at any time. H.R. 2723 does not require patients to seek administrative remedies—including internal and external appeals—before proceeding to litigation.

Allow lawsuits over anything. Plaintiffs may challenge any coverage decision or action by an HMO they disagree with, even if the procedure or service is not a covered benefit.

Allows lawsuits even when the HMO does everything right. Under H.R. 2723, an HMO may be sued even when it made the right decision according to an external medical review conducted by independent physicians.

Allows lawsuits without limits. This bill would let a patient sue for unlimited damages, driving up health care costs.

The Coburn-Shadegg substitute, however, meets these criteria. The bill:

Provides reasonable, but limited, liability for HMOs.

Protects employers from harassing litigation unless they choose to directly participate in any final decision to deny care.

Requires plaintiffs to complete an internal and external review process before proceeding to court.

Restricts lawsuits to covered benefits only, eliminating judicially mandated benefits.

To my colleagues here today, I say this: the Coburn-Shadegg substitute borrows the best of the Norwood-Dingell bill, rejects its worst, and improves upon the rest. It is a final example of pragmatic policy and deserves your support. It is essential that common sense and the common good prevail over rhetoric and political gamesmanship. I urge my colleagues to support the Coburn-Shadegg substitute. Americans are in need of a solution to this problem, not an issue for next year's elections.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from Florida (Mr. GOSS).

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. GOSS. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 193, noes 238, not voting 3, as follows:

[Roll No. 488]

AYES—193

Aderholt
Archer
Armey
Baker
Ballenger
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Biggert
Bilirakis
Bliley
Blunt
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth-Hage
Coble
Coburn
Collins
Combest
Cooksey
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Fossella
Fowler
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
LaTourette
Lazio
Lewis (CA)
Lewis (KY)
Linder
Lucas (KY)
Lucas (OK)
Manzullo
McCrery
McHugh
McInnis
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Myrick
Nethercutt
Ney
Northup
Nussle
Ose
Oxley
Packard
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Salmon
Schaffer
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NOES—238

Abercrombie
Ackerman
Allen
Andrews
Bachus
Baird
Baldacci
Baldwin
Barcia
Barr
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bilbray
Bishop
Blagojevich
Blumenauer
Boehlert
Boehner
Bonilla
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Campbell
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Cook
Costello
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Foley
Forbes
Ford
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Ganske
Gejdenson
Gephardt
Gilman
Gonzalez
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Horn
Hostettler
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Leach
Lee
Levin
Lewis (GA)
Lipinski
LoBiondo
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntosh
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (VA)
Morella
Murtha
Nadler
Napolitano
Neal
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Quinn
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roukema
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Saxton
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Terry
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NOT VOTING—3

Cox
Kaptur
Scarborough

□ 1439

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

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

AMENDMENT NO. 3 IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. HOUGHTON

Mr. HOUGHTON. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment No. 3 in the nature of a substitute offered by Mr. HOUGHTON:

Strike out all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Consensus Managed Care Improvement Act of 1999''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
TITLE I—IMPROVING MANAGED CARE
Subtitle A—Grievances and Appeals
Sec. 101. Utilization review activities.
Sec. 102. Internal appeals procedures.
Sec. 103. External appeals procedures.
Sec. 104. Establishment of a grievance process.
Subtitle B—Access to Care
Sec. 111. Consumer choice option.
Sec. 112. Choice of health care professional.
Sec. 113. Access to emergency care.
Sec. 114. Access to specialty care.
Sec. 115. Access to obstetrical and gynecological care.
Sec. 116. Access to pediatric care.
Sec. 117. Continuity of care.
Sec. 118. Access to needed prescription drugs.
Sec. 119. Coverage for individuals participating in approved clinical trials.
Subtitle C—Access to Information
Sec. 121. Patient access to information.
Subtitle D—Protecting the Doctor-Patient Relationship
Sec. 131. Prohibition of interference with certain medical communications.
Sec. 132. Prohibition of discrimination against providers based on licensure.
Sec. 133. Prohibition against improper incentive arrangements.
Sec. 134. Payment of claims.
Sec. 135. Protection for patient advocacy.
Subtitle E—Definitions
Sec. 151. Definitions.
Sec. 152. Preemption; State flexibility; construction.
Sec. 153. Exclusions.
Sec. 154. Coverage of limited scope plans.
Sec. 155. Regulations.
TITLE II—APPLICATION OF QUALITY STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT
Sec. 201. Application to group health plans and group health insurance coverage.
Sec. 202. Application to individual health insurance coverage.
TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 302. Additional judicial remedies.
Sec. 303. Availability of binding arbitration.
TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986
Sec. 401. Amendments to the Internal Revenue Code of 1986.
TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION
Sec. 501. Effective dates.
Sec. 502. Coordination in implementation.
TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION
Sec. 601. Health care paperwork simplification.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievance and Appeals

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for an evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—

(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the case, and in no event later than the deadline specified in subparagraph (B).

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of receipt of the request for prior authorization.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a utilization review program—

(I) receives a request for a prior authorization,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in

no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for prior authorization.

(2) ONGOING CARE.—

(A) CONCURRENT REVIEW.—

(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

(4) FAILURE TO MEET DEADLINE.—In a case in which a group health plan or health insurance issuer fails to make a determination on a claim for benefit under paragraph (1), (2)(A), or (3) by the applicable deadline established under the respective paragraph, the failure shall be treated under this subtitle as a denial of the claim as of the date of the deadline.

(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 113, respectively.

(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the reasons for the denial (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 102; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

(1) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(2) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, means a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

SEC. 102. INTERNAL APPEALS PROCEDURES.

(a) RIGHT OF REVIEW.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

(A) shall provide adequate notice in writing to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied (within the meaning of section 101(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in a manner calculated to be understood by the participant, beneficiary, or enrollee; and

(B) shall afford such a participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity (of not less than 180 days) to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to such coverage) of the decision denying the claim.

(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in writing.

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual who—

(i) in a case involving medical judgment, shall be a physician or, in the case of limited scope coverage (as defined in subparagraph (B), shall be an appropriate specialist;

(ii) has been selected by the plan or issuer; and

(iii) did not make the initial denial in the internally appealable decision.

(B) LIMITED SCOPE COVERAGE DEFINED.—For purposes of subparagraph (A), the term ''limited scope coverage'' means a group health plan or health insurance coverage the only benefits under which are for benefits described in section 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)).

(2) TIME LIMITS FOR INTERNAL REVIEWS.—

(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of receipt of the request for internal review.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

(I) receives a request for internal review,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for review.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

(A) in which, as determined by the plan or issuer or as certified in writing by a treating health care professional, the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function; or

(B) described in section 101(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

(2) PROCESS.—Under such procedures—

(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 72 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

(d) WAIVER OF PROCESS.—A plan or issuer may waive its rights for an internal review under subsection (b). In such case the participant, beneficiary, or enrollee involved (and any designee or provider involved) shall be relieved of any obligation to complete the review involved and may, at the option of such participant, beneficiary, enrollee, designee, or provider, proceed directly to seek

further appeal through any applicable external appeals process.

SEC. 103. EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which an appeal is made, within 180 days after completion of the plan's internal appeals process under section 102, either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent). The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term ''externally appealable decision'' means a denial of claim for benefits (as defined in section 101(f)(2))—

(i) that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental; or

(ii) in which the decision as to whether a benefit is covered involves a medical judgment.

(B) INCLUSION.—Such term also includes a failure to meet an applicable deadline for internal review under section 102.

(C) EXCLUSIONS.—Such term does not include—

(i) specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment; or

(ii) a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 102(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 102, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(4) FILING FEE REQUIREMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan or issuer may condition the use of an external appeal process upon payment to the plan or issuer of a filing fee that does not exceed $25.

(B) EXCEPTION FOR INDIGENCY.—The plan or issuer may not require payment of the filing fee in the case of an individual participant, beneficiary, or enrollee who certifies (in a form and manner specified in guidelines established by the Secretary of Health and Human Services) that the individual is indigent (as defined in such guidelines).

(C) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse or modify the denial of a claim for benefits which is the subject of the appeal.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Except as provided in subparagraph (D), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The applicable authority shall implement procedures—

(i) to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner, and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that all costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be construed as applying to the imposition of a filing fee under subsection (a)(4).

(D) STATE AUTHORITY WITH RESPECT QUALIFIED EXTERNAL APPEAL ENTITY FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in a manner determined by the State to assure an unbiased determination.

(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination. However, nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are specifically excluded under the plan or coverage.

(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's or issuer's decision is in accordance with the medical needs of the patient involved (as determined by the entity) taking into account, as of the time of the entity's determination, the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraph (D). If the entity determines the decision is in accordance with such needs, the entity shall affirm the decision and to the extent that the entity determines the decision is not in accordance with such needs, the entity shall reverse or modify the decision.

(C) CONSIDERATION OF PLAN OR COVERAGE DEFINITIONS.—In making such determination, the external appeal entity shall consider (but not be bound by) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms.

(D) EVIDENCE.—

(i) IN GENERAL.—An external appeal entity shall include, among the evidence taken into consideration—

(I) the decision made by the plan or issuer upon internal review under section 102 and any guidelines or standards used by the plan or issuer in reaching such decision;

(II) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed; and

(III) the opinion of the individual's treating physician or health care professional.

(ii) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

(I) The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

(II) The results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies.

(III) Practice and treatment guidelines prepared or financed in whole or in part by government agencies.

(IV) Government-issued coverage and treatment policies.

(V) Community standard of care and generally accepted principles of professional medical practice.

(VI) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

(VII) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine—

(i) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

(ii) whether an externally appealable decision involves an expedited appeal; and

(iii) for purposes of initiating an external review, whether the internal review process has been completed.

(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to the external appeal entity to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity.

(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

(i) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 72 hours after the time) of requesting an external appeal of the decision;

(iii) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek further review by the courts (or other process) of the external appeal determination.

(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity reverses or modifies the denial of a claim for benefits, the plan or issuer shall—

(i) upon the receipt of the determination, authorize benefits in accordance with such determination;

(ii) take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

(iii) submit information to the entity documenting compliance with the entity's determination and this subparagraph.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term ''qualified external appeal entity'' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

(A) The entity meets the independence requirements of paragraph (3).

(B) The entity conducts external appeal activities through a panel of not fewer than 3 clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

(D) The entity meets such other requirements as the appropriate Secretary may impose.

(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1)—

(I) by the Secretary of Labor;

(II) under a process recognized or approved by the Secretary of Labor; or

(III) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization (certified under such subparagraph); or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements—

(I) by the applicable State authority (or under a process recognized or approved by such authority); or

(II) if the State has not established a certification and recertification process for such entities, by the Secretary of Health and Human Services, under a process recognized or approved by such Secretary, or to the extent provided in subparagraph (C)(ii), by a qualified private standard-setting organization (certified under such subparagraph).

(B) RECERTIFICATION PROCESS.—The appropriate Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a review of—

(i) the number of cases reviewed;

(ii) a summary of the disposition of those cases;

(iii) the length of time in making determinations on those cases;

(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

(v) such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted.

(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—

(i) FOR EXTERNAL REVIEWS UNDER GROUP HEALTH PLANS.—For purposes of subparagraph (A)(i)(III), the Secretary of Labor may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(i)(I).

(ii) FOR EXTERNAL REVIEWS OF HEALTH INSURANCE ISSUERS.—For purposes of subparagraph (A)(ii)(II), the Secretary of Health and Human Services may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(ii)(II).

(3) INDEPENDENCE REQUIREMENTS.—

(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

(i) the peer or entity does not have a familial, financial, or professional relationship with any related party;

(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

(iii) except as provided in paragraph (4), the plan and the issuer have no recourse against the peer or entity in connection with the external review; and

(iv) the peer or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

(B) RELATED PARTY.—For purposes of this paragraph, the term ''related party'' means—

(i) with respect to—

(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

(ii) the health care professional that provided the health care involved in the coverage decision;

(iii) the institution at which the health care involved in the coverage decision is provided;

(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision; or

(v) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—The determination by an external appeal entity under this section is binding on the plan and issuer involved in the determination.

(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(1) MONETARY PENALTIES.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(A) to cease and desist from the alleged action or failure to act; and

(B) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(3) ADDITIONAL CIVIL PENALTIES.—

(A) IN GENERAL.—In addition to any penalty imposed under paragraph (1) or (2), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(i) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity in violation of the terms of such a plan, coverage, or this title; or

(ii) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or plans or coverage.

(B) STANDARD OF PROOF AND AMOUNT OF PENALTY.—Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice and shall be in an amount not to exceed the lesser of—

(i) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice, or

(ii) $500,000.

(4) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in paragraph (3)(A) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce actions.

SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

(2) GRIEVANCE DEFINED.—In this section, the term ''grievance'' means any question, complaint, or concern brought by a participant, beneficiary or enrollee that is not a claim for benefits (as defined in section 101(f)(1)).

(b) GRIEVANCE SYSTEM.—Such system shall include the following components with respect to individuals who are participants, beneficiaries, or enrollees:

(1) Written notification to all such individuals and providers of the telephone numbers and business addresses of the plan or issuer personnel responsible for resolution of grievances and appeals.

(2) A system to record and document, over a period of at least 3 previous years, all grievances and appeals made and their status.

(3) A process providing for timely processing and resolution of grievances.

(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

Grievances are not subject to appeal under the previous provisions of this subtitle.

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such nonnetwork coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)), and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—If benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, with respect to maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with such guidelines).

SEC. 114. ACCESS TO SPECIALTY CARE.

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(C) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling, and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

SEC. 115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for coverage of gynecological care (including preventive women's health examinations) and pregnancy-related services provided by a participating health care professional, including a physician, who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(2) shall treat the ordering of other obstetrical or gynecological care by such a participating professional as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of pediatric care.

SEC. 117. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) DEFINITIONS.—For purposes of this section:

(A) ONGOING SPECIAL CONDITION.—The term ''ongoing special condition'' has the meaning given such term in section 114(b)(3), and also includes pregnancy.

(B) TERMINATION.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation, and

(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—If—

(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

If a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

(1) ensure participation of participating physicians and pharmacists in the development of the formulary;

(2) disclose to providers and, disclose upon request under section 121(c)(5) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(3) consistent with the standards for a utilization review program under section 101, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

(1) IN GENERAL.—Under this section a group health plan or health insurance issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

(2) PAYMENT RATE.—In the case of covered items and services provided by—

(A) a participating provider, the payment rate shall be at the agreed upon rate, or

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

(B) A cooperative group or center of the National Institutes of Health.

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) or (c) in printed form.

(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to enrollees, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c) in printed form.

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

(1) SERVICE AREA.—The service area of the plan or issuer.

(2) BENEFITS.—Benefits offered under the plan or coverage, including—

(A) covered benefits, including benefit limits and coverage exclusions;

(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

(C) the extent to which benefits may be obtained from nonparticipating providers;

(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

(3) ACCESS.—A description of the following:

(A) The number, mix, and distribution of providers under the plan or coverage.

(B) Out-of-network coverage (if any) provided by the plan or coverage.

(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

(F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 112(b)(2).

(H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals.

(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan or issuer for obtaining emergency services; and

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(8) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

(9) QUALITY ASSURANCE.—Any information made public by an accrediting organization in the process of accreditation of the plan or issuer or any additional quality indicators the plan or issuer makes available.

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) NOTICE OF REQUIREMENTS.—Notice of the requirements of this title.

(12) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 101, including under any drug formulary program under section 118.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) METHOD OF PHYSICIAN COMPENSATION.—A general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which a specified prospective or treating health care professional is (or would be) compensated in connection with the provision of health care under the plan or coverage.

(4) SPECIFIC INFORMATION ON CREDENTIALS OF PARTICIPATING PROVIDERS.—In the case of each participating provider, a description of the credentials of the provider.

(5) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

(6) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(b) CONSTRUCTION.—Subsection (a) shall not be construed—

(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

(2) to override any State licensure or scope-of-practice law; or

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

(B) the professional reasonably believes the information to be true;

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ''protected health care professional'' means an individual who is a licensed or certified health care professional and who—

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) ACTIVELY PRACTICING.—The term ''actively practicing'' means, with respect to a physician or other health care professional, such a physician or professional who provides professional services to individual patients on average at least two full days per week.

(2) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this title, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(3) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, an actively practicing physician (allopathic or osteopathic) or other actively practicing health care professional who holds a nonrestricted license, and who is appropriately credentialed in the same or similar specialty or subspecialty (as appropriate) as typically handles the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician (allopathic or osteopathic) may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

(4) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(5) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974 and in section 2791(a)(1) of the Public Health Service Act.

(6) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(8) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(9) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(10) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(11) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this title 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 or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title 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) 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 District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to include specific items and services (including abortions) under the terms of such plan or coverage, other than those provided under the terms of such plan or coverage.

(b) EXCLUSION FROM ACCESS TO CARE MANAGED CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

(1) IN GENERAL.—The provisions of sections 111 through 117 shall not apply to a group health plan or health insurance coverage if the only coverage offered under the plan or coverage is fee-for-service coverage (as defined in paragraph (2)).

(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term ''fee-for-service coverage'' means coverage under a group health plan or health insurance coverage that—

(A) reimburses hospitals, health professionals, and other providers on the basis of a rate determined by the plan or issuer on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing coverage for any services.

SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2707. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

"SEC. 2753. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

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

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

"SEC. 714. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 112 (relating to choice of providers).

''(B) Section 113 (relating to access to emergency care).

''(C) Section 114 (relating to access to specialty care).

''(D) Section 115 (relating to access to obstetrical and gynecological care).

''(E) Section 116 (relating to access to pediatric care).

''(F) Section 117(a)(1) (relating to continuity in case of termination of provider contract) and section 117(a)(2) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(G) Section 118 (relating to access to needed prescription drugs).

''(H) Section 119 (relating to coverage for individuals participating in approved clinical trials.)

''(I) Section 134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the internal appeals process and the grievance system required to be established under sections 102 and 104, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 103, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 131 (relating to prohibition of interference with certain medical communications).

''(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 133 (relating to prohibition against improper incentive arrangements).

''(D) Section 135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

SEC. 302. ADDITIONAL JUDICIAL REMEDIES.

(a) CAUSE OF ACTION RELATING TO DENIAL OF HEALTH BENEFITS.—Section 502(a) of the

Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)) is amended—

(1) by striking ''or'' at the end of paragraph (8);

(2) by striking ''amounts.'' at the end of paragraph (9) and inserting ''amounts; or''; and

(3) by adding at the end the following new paragraph:

''(10) by a participant or beneficiary of a group health plan (or the estate of such a participant or beneficiary), for relief described in subsection (n), against a person who—

''(A) is a fiduciary of such plan, a health insurance issuer offering health insurance coverage in connection with such plan, or an agent of such plan or the plan sponsor,

''(B) under such plan, has authority to make the sole final decision described in subsection (n)(2) regarding claims for benefits, and

''(C) has exercised such authority in making such final decision denying such a claim by such participant or beneficiary in violation of the terms of the plan or this title and, in making such final decision, failed to exercise ordinary care in making an incorrect determination in the case of such participant or beneficiary that an item or service is excluded from coverage under the terms of the plan,

if the denial is the proximate cause of personal injury to, or the wrongful death of, such participant or beneficiary.''.

(b) JUDICIAL REMEDIES FOR DENIAL OF HEALTH BENEFITS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsections:

''(n) ADDITIONAL REMEDIES FOR DENIAL OF HEALTH BENEFITS.—

''(1) IN GENERAL.—In an action commenced under paragraph (10) of subsection (a) by a participant or beneficiary of a group health plan (or by the estate of such a participant or beneficiary) against a person described in subparagraphs (A), (B), and (C) of such paragraph, the court may award, in addition to other appropriate equitable relief under this section, monetary compensatory relief which may include both economic and noneconomic damages (but which shall exclude punitive damages). The amount of any such noneconomic damages awarded as monetary compensatory relief—

''(A) in a case in which 2 times the amount of the economic damages awarded as monetary compensatory relief is less than or equal to $250,000, may not exceed the greater of—

''(i) 2 times the amount of such economic damages so awarded, or

''(ii) $250,000; and

''(B) in a case in which 2 times the amount of the economic damages awarded as monetary compensatory relief is greater than $250,000, may not exceed $500,000.

''(2) APPLICATION TO DECISIONS INVOLVING MEDICAL NECESSITY AND MEDICAL JUDGMENT.—This subsection and subsection (a)(10) apply only with respect to final decisions described in section 103(a)(2) of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(3) DEFINITIONS.—For purposes of this subsection and subsection (a)(10)—

''(A) GROUP HEALTH PLAN; HEALTH INSURANCE ISSUER; HEALTH INSURANCE COVERAGE.—The terms 'group health plan', 'health insurance issuer', and 'health insurance coverage' shall have the meanings provided such terms under section 733, respectively.

''(B) FINAL DECISION.—The term 'final decision' means, with respect to a group health plan, the final decision of the plan under section 102 of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(C) PERSONAL INJURY.—The term 'personal injury' means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain, and includes a physical injury arising out of a failure to treat a mental illness or disease.

''(D) CLAIM FOR BENEFITS.—The term 'claim for benefits' has the meaning provided in section 101(f)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(E) FAILURE TO EXERCISE ORDINARY CARE.—The term 'failure to exercise ordinary care' means a negligent failure to provide—

''(i) the consideration of appropriate medical evidence, or

''(ii) the regard for the health and safety of the participant or beneficiary,

that a prudent individual acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with same or similar circumstances.

''(4) EXCEPTION FOR DENIALS IN ACCORDANCE WITH RECOMMENDATION OF EXTERNAL APPEAL ENTITY.—No person shall be liable under subsection (a)(10) for additional monetary compensatory relief described in paragraph (1) in any case in which the denial referred to in subsection (a)(10) is upheld by the recommendation of an external appeal entity issued with respect to such denial under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(5) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), subsection (a)(10) does not authorize—

''(i) any cause of action against an employer or other plan sponsor maintaining a group health plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

''(ii) a right of recovery or indemnity by a person against such an employer or sponsor (or such an employee) for relief assessed against the person pursuant to a cause of action under subsection (a)(10).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action under subsection (a)(10) commenced against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment), if—

''(i) such action is based on the direct participation of the employer or sponsor (or employee) in the sole final decision of the plan referred to in paragraph (2) with respect to a specific participant or beneficiary on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the decision on the claim resulted in personal injury to, or the wrongful death of, such participant or beneficiary.

''(C) DIRECT PARTICIPATION.—For purposes of this subsection, in determining whether an employer or other plan sponsor (or employee of an employer or other plan sponsor) is engaged in direct participation in the sole final decision of the plan on a claim under section 102 of the Bipartisan Consensus Managed Care Improvement Act of 1999, the employer or plan sponsor (or employee) shall not be construed to be engaged in such direct participation solely because of any form of decisionmaking or conduct, whether or not fiduciary in nature, that does not involve the final decision with respect to a specific claim for benefits by a specific participant or beneficiary, including (but not limited to) any participation in a decision relating to:

''(i) the selection or retention of the group health plan or health insurance coverage involved or the third party administrator or other agent, including any related cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

''(ii) the creation, continuation, modification, or termination of the plan or of any coverage, benefit, or item or service covered by the plan affecting a cross-section of the plan participants and beneficiaries;

''(iii) the design of any coverage, benefit, or item or service covered by the plan, including the amount of copayments and limits connected with such coverage, and the specification of protocols, procedures, or policies for determining whether any such coverage, benefit, or item or service is medically necessary and appropriate or is experimental or investigational;

''(iv) any action by an agent of the employer or plan sponsor (other than an employee of the employer or plan sponsor) in making such a final decision on behalf of such employer or plan sponsor;

''(v) any decision by an employer or plan sponsor (or employee) or agent acting on behalf of an employer or plan sponsor either to authorize coverage for, or to intercede or not to intercede as an advocate for or on behalf of, any specific participant or beneficiary (or group of participants or beneficiaries) under the plan; or

''(vi) any other form of decisionmaking or other conduct performed by the employer or plan sponsor (or employee) in connection with the plan or coverage involved, unless the employer makes the sole final decision of the plan consisting of a failure described in paragraph (1)(A) as to specific participants or beneficiaries who suffer personal injury or wrongful death as a proximate cause of such decision.

''(6) REQUIRED DEMONSTRATION OF DIRECT PARTICIPATION.—An action under subsection (a)(10) against an employer or plan sponsor (or employee thereof) for remedies described in paragraph (1) shall be immediately dismissed—

''(A) in the absence of an evidentiary demonstration in the complaint of direct participation by the employer or plan sponsor (or employee) in the sole final decision of the plan with respect to a specific participant or beneficiary who suffers personal injury or wrongful death,

''(B) upon a demonstration to the court that such employer or plan sponsor (or employee) did not directly participate in the final decision of the plan, or

''(C) in the absence of an evidentiary demonstration that a personal injury to, or wrongful death of, the participant or beneficiary resulted.

''(7) TREATMENT OF THIRD-PARTY PROVIDERS OF NONDISCRETIONARY ADMINISTRATIVE SERVICES.—Subsection (a)(10) does not authorize any action against any person providing nondiscretionary administrative services to employers or other plan sponsors.

''(8) REQUIREMENT OF EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(A) IN GENERAL.—Subsection (a)(10) applies in the case of any cause of action only if all remedies under section 503 (including remedies under sections 102 and 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 made applicable under section 714) with respect to such cause of action have been exhausted.

''(B) EXTERNAL REVIEW REQUIRED.—For purposes of subparagraph (A), administrative remedies under section 503 shall not be deemed exhausted until available remedies under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 have been elected and are exhausted.

''(C) CONSIDERATION OF ADMINISTRATIVE DETERMINATIONS.—Any determinations under section 102 or 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 made while an action under subsection (a)(10) is pending shall be given due consideration by the court in such action.

''(9) SUBSTANTIAL WEIGHT GIVEN TO EXTERNAL REVIEW DECISIONS.—In the case of any action under subsection (a)(10) for remedies described in paragraph (1), the external review decision under section 103 shall be given substantial weight when considered along with other available evidence.

''(10) LIMITATION OF ACTION.—Subsection (a)(10) shall not apply in connection with any action commenced after the later of—

''(A) 1 year after (i) the date of the last action which constituted a part of the failure, or (ii) in the case of an omission, the latest date on which the fiduciary could have cured the failure, or

''(B) 1 year after the earliest date on which the plaintiff first knew, or reasonably should have known, of the personal injury or wrongful death resulting from the failure.

''(11) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by the fiduciary which consists of full compliance with the reversal under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 of a denial of a claim for benefits.

''(12) CONSTRUCTION.—Nothing in this subsection or subsection (a)(10) shall be construed as authorizing an action—

''(A) for the failure to provide an item or service which is not covered under the group health plan involved, or

''(B) for any action taken by a fiduciary which consists of compliance with the reversal or modification under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 of a final decision under section 102 of such Act.

''(13) PROTECTION OF MEDICAL MALPRACTICE UNDER STATE LAW.—This subsection and subsection (a)(10) shall not be construed to preclude any action under State law not otherwise preempted under this section or section 503 or 514 with respect to the exercise of a specified professional standard of care in the provision of medical services.

''(14) REFERENCES TO THE BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999.—Any reference in this subsection to any provision of the Bipartisan Consensus Managed Care Improvement Act of 1999 shall be deemed a reference to such provision as in effect on the date of the enactment of such Act.

''(o) EXPEDITED COURT REVIEW.—In any case in which exhaustion of administrative remedies in accordance with section 102 or 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 otherwise necessary for an action for injunctive relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by clear and convincing evidence that such exhaustion is not reasonably attainable under the facts and circumstances without any further undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain such relief. Any determinations which already have been made under section 102 or 103 in such case, or which are made in such case while an action under this paragraph is pending, shall be given due consideration by the court in any action under this subsection in such case.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the date of the enactment of this Act.

SEC. 304. AVAILABILITY OF BINDING ARBITRATION.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this Act) is amended further by adding at the end the following new subsection:

''(p) BINDING ARBITRATION PERMITTED AS ALTERNATIVE MEANS OF DISPUTE RESOLUTION.—

''(1) IN GENERAL.—This subsection shall apply with respect to any adverse coverage decision rendered under a group health plan under section 102 or 103, if—

''(A) all administrative remedies under section 503 required for an action in court under this section have been exhausted,

''(B) under the terms of the plan, the aggrieved participant or beneficiary may elect to resolve the dispute by means of a procedure of binding arbitration which is available with respect to all similarly situated participants and beneficiaries (or which is available under the plan pursuant to a bona fide collective bargaining agreement pursuant to which the plan is established and maintained), and which meets the requirements of paragraph (3), and

''(C) the participant or beneficiary has elected such procedure in accordance with the terms of the plan.

''(2) EFFECT OF ELECTION.—In the case of an election by a participant or beneficiary pursuant to paragraph (1)—

''(A) decisions rendered under the procedure of binding arbitration shall be binding on all parties to the procedure and shall be enforceable under the preceding subsections of this section as if the terms of the decision were the terms of the plan, except that the court in an action brought under this section may vacate any award made pursuant to the arbitration for any cause described in paragraph (1), (2), (3), (4), or (5) of section 10(a) of title 9, United States Code, and

''(B) subject to subparagraph (A), such participant or beneficiary shall be treated as having effectively waived any right to further review of the decision by a court under the preceding subsections of this section.

''(3) ADDITIONAL REQUIREMENTS.—The requirements of this paragraph consist of the following:

''(A) ARBITRATION PANEL.—The arbitration shall be conducted by an arbitration panel meeting the requirements of paragraph (4).

''(B) FAIR PROCESS; DE NOVO DETERMINATION.—The procedure shall provide for a fair, de novo determination.

''(C) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to the arbitration procedure—

''(i) may submit and review evidence related to the issues in dispute;

''(ii) may use the assistance or representation of one or more individuals (any of whom may be an attorney); and

''(iii) may make an oral presentation.

''(D) PROVISION OF INFORMATION.—The plan shall provide timely access to all its records relating to the matters under arbitration and to all provisions of the plan relating to such matters.

''(E) TIMELY DECISIONS.—A determination by the arbitration panel on the decision shall—

''(i) be made in writing;

''(ii) be binding on the parties; and

''(iii) be made in accordance with the medical exigencies of the case involved.

''(4) ARBITRATION PANEL.—

''(A) IN GENERAL.—Arbitrations commenced pursuant to this subsection shall be conducted by a panel of arbitrators selected by the parties made up of 3 individuals, including at least one physician and one attorney.

''(B) QUALIFICATIONS.—Any individual who is a member of an arbitration panel shall meet the following requirements:

''(i) There is no real or apparent conflict of interest that would impede the individual conducting arbitration independent of the plan and meets the independence requirements of subparagraph (C).

''(ii) The individual has sufficient medical or legal expertise to conduct the arbitration for the plan on a timely basis.

''(iii) The individual has appropriate credentials and has attained recognized expertise in the applicable medical or legal field.

''(iv) The individual was not involved in the initial adverse coverage decision or any other review thereof.

''(C) INDEPENDENCE REQUIREMENTS.—An individual described in subparagraph (B) meets the independence requirements of this subparagraph if—

''(i) the individual is not affiliated with any related party,

''(ii) any compensation received by such individual in connection with the binding arbitration procedure is reasonable and not contingent on any decision rendered by the individual,

''(iii) under the terms of the plan, the plan has no recourse against the individual or entity in connection with the binding arbitration procedure, and

''(iv) the individual does not otherwise have a conflict of interest with a related party as determined under such regulations as the Secretary may prescribe.

''(D) RELATED PARTY.—For purposes of subparagraph (C), the term 'related party' means—

''(i) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(ii) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(iii) the institution at which the medical care involved in the coverage decision is provided,

''(iv) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

''(v) any other party determined under such regulations as the Secretary may prescribe to have a substantial interest in the coverage decision .

''(E) AFFILIATED.—For purposes of subparagraph (C), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(5) ALLOWABLE REMEDIES.—The remedies which may be implemented by the arbitration panel shall consist of those remedies which would be available in an action timely commenced by a participant or beneficiary under section 502, taking into account the administrative remedies exhausted by the participant or beneficiary under section 503.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to adverse coverage decisions initially rendered by group health plans on or after the date of the enactment of this Act.

TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to patient freedom of choice.'';

and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

''A group health plan shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2000 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

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 Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury 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 such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) 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.

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Bipartisan Consensus Managed Care Improvement Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(C) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection (a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

The CHAIRMAN. Pursuant to House Resolution 323, the gentleman from New York (Mr. HOUGHTON) and the gentleman from Michigan (Mr. DINGELL) will each control 30 minutes.

The Chair recognizes the gentleman from New York (Mr. HOUGHTON).

Mr. HOUGHTON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I, together with my colleagues the gentleman from South Carolina (Mr. GRAHAM), the gentleman from Tennessee (Mr. HILLEARY) and the gentleman from Nevada (Mr. GIBBONS) rise to offer an amendment in the nature of a substitute to the Norwood-Dingell bill, and I will make this really quite short, this introduction of mine. I am an original cosponsor of the Norwood-Dingell bill.

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I absolutely support what it is trying to do. It is thoughtful; it corrects a wrong which has been around since the beginning of the health maintenance organizations. And all three gentlemen who are supporting this and promoting it are superb legislators and believers in health care reform.

But I have only one problem with the bill in that what it does, it slides over another very, very important issue. What it does, frankly, is to open a huge gap for those who are simply providing the money to fund these plans.

So while supporting the concept and the aim of the Norwood-Dingell bill, because of this huge void in funding, we almost surely will, in effect, be hurting the people we are trying to help. And I say this autobiographically from my experience in the business field.

So I think it is irresponsible for us to ignore this issue in this great wave of enthusiasm for this bill. Despite the emotions of the day, if we do not do something, and I feel that it will be appropriate through our amendment, it will come back to haunt us.

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

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Chairman, I rise in opposition to this well-intentioned but, I think, flawed substitute. There are three deficiencies in the substitute which I believe compel its rejection and the adoption of the underlying Norwood-Dingell-Ganske bill.

First is that this substitute usurps States' rights and States' causes of action with respect to tort law. One of the pieces of wisdom of the regulatory system in the United States is that different States have the authority to set different standards of care and different causes of action according to their State law. Each of our several States is very different. There are different needs of the people, there are different legal problems, and we recognize this by recognizing the fact that tort law causes of action typically, and

sometimes exclusively, come from State law.

This substitute creates one single Federal cause of action, and I believe that one-size-fits-all approach is inappropriate to solving the problem that is before us.

The second defect is that this substitute does not provide full relief for people who are wronged. The limitation on damages is a very meaningful limitation on damages. For example, by tying the limitation to a multiple of economic damages, what about the case of a person who is a stay-at-home parent who does not have a job that pays in remuneration, but pays in psychic rewards, and that person is severely harmed by the actions of a managed care company. The damages that person would be able to recover would be significantly limited by this amendment, and I believe that is another reason for its rejection.

Finally, the cause of action has some technical flaws in it which could exclude some managed care decision-makers from accountability. By creating the requirement that the decision-maker both have the authority to make the final decision and exercise that authority, there are certain decision-makers and certain decisions which would be exempt from accountability under this process.

So although I congratulate the author for frankly offering a substitute that moves much closer in the direction of the underlying bill, I believe for these three reasons it should be rejected; and I urge the defeat of the substitute.

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN. The Chair would ask Members to refrain from using cell phones and other telecommunications devices on the floor of the House.

Mr. HOUGHTON. Mr. Chairman, I yield 5 minutes to the gentleman from South Carolina (Mr. GRAHAM), my great friend.

Mr. GRAHAM. Mr. Chairman, I thank the gentleman for yielding me this time. I would like to say I have thoroughly enjoyed working with the gentleman from New York (Mr. HOUGHTON) and the other two Members who are Norwood-Dingell cosponsors on trying to bring some common sense reform to a very important issue.

Where are the American people? The American people, whether one is Republican or Democrat alike, believe HMOs should be sued when they hurt people. The American people believe one should be able to choose one's own doctor even if one has to pay more money out of their own pocket. The American people believe that one should not have to call the insurance company before one can take a kid to the emergency room, and they should not be able to deny treatment and payment because one did not call them.

The American people are very much for a lot of the reforms in this bill. The American people are also for limiting our tort system in a way that keeps people in business. The American people are very much for common sense legal reform. That is what this bill does.

Here is the question of the 29 Republicans who have voted ''no,'' and here is the question to the Democratic Party: What if we kept the health care in Norwood-Dingell the same? What if we did not change it one word? What if we gave all of the patient protections that Norwood-Dingell give the American people? What would my colleagues do if we asked them to move a little bit toward the American business community by giving them a chance to keep their employees with health care in the area of liability?

My question is, can we tear down the legal wall that unfairly protects HMOs from liability and keep people in the health care business? Yes, we can, if people will work together. The answer will be no if we continue on this confrontational track.

What do we do differently? We do nothing different in health care. Here is what we do in liability. I address my friend, the gentleman from New Jersey (Mr. ANDREWS), and his comments. We keep it at the Federal level. Do my colleagues know why we keep it at the Federal level? Because uniformity is helpful in controlling costs.

ERISA is a Federal law that protects employees' retirement benefits. If one has a claim under ERISA for one's retirement, one does not go to 50 different States. We do not let 50 different States write 401K plans. One goes to Federal court, and one has their day in Federal court because it is a Federal law that is uniform to make sure employers who do business in more than one State can have one set of rules to live by so that they know the rules of the road. We give a uniform forum to the people who may be aggrieved, and we give them a fair day in Federal court.

Mr. Chairman, I say to my colleagues, if Norwood-Dingell passes the way it is today, here is what is going to happen in corporate America. If one can be sued as a multi-State business in 50 different States with 50 different legal theories of holding people accountable in the health care industry, we are going to have lawyers meet with the corporate board and say, you are going to be chasing jury verdicts all over this country. Get out of this business. This is voluntary on your part; you do not have to do it.

You are going to spend more time in State court on lawyer fees than you are going to spend on health care. If we allow 50 different theories of being sued, we are going to not only tumble down the liability wall, we are going to tumble down the benefits that go to the people who need it the most, and that is the employees.

What do we do in this bill? We limit damages in two areas. Economic damages are fully recovered.

Let me say this to the gentleman from New Jersey (Mr. ANDREWS). I have represented housewives, people who do not have the traditional job. Let me tell my colleague, if we put down what it cost to run a family, we can add up some serious damages, because people who stay at home and take care of families have a job, and we can turn that into money as a lawyer, because I have done it. One can get one's full range of damages under this bill, but we are not going to let people make up numbers called pain and suffering beyond a half a million dollars to keep people in business.

Punitive damages are taken off the table. If we leave that as a form of damages, the cost of premiums are going to go through the roof. Punitive damages helps no one have a better quality of life except the lawyer who puts the money in their pocket, and I have been a lawyer seeking punitive damages.

Mr. Chairman, we can have common sense legal reform that gives people a fair day in court, that allows businesses to be sued, but in a uniform manner with a national standard so that they do not get out of this business chasing 50 different juries.

If we want to help patients keep the health care the same, if we want to help business, give them a chance to understand the rules of the road no matter where they do business; give them some commonsense legal protection so that they do not get sued to death.

Mr. Chairman, this bill as currently written is going nowhere. With some common sense changes, it can become the law of the land and people can have the health care they deserve and paid for; they can have their day in court, and people like the gentleman from New York (Mr. HOUGHTON) who have been in business and offered employee benefits can continue to do that if we will work together.

Mr. BROWN of Ohio. Mr. Chairman, I yield 4 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I indeed thank the gentleman for yielding me this time, and I would like to take a moment to talk about the gentleman from New York (Mr. HOUGHTON) and the gentleman from South Carolina (Mr. GRAHAM), not only two good friends, but two cosponsors of our bill, and I want both of them to know how much I appreciate the work they have done with us. The gentleman from New York (Mr. HOUGHTON) knows that we have spent many hours trying to, within our bill, reach accommodation with him.

I will just submit for the RECORD a CRS report that agrees that the changes that he has worked so hard to get in our bill we were able to do that and accommodate him.

CONGRESSIONAL RESEARCH SERVICE,
LIBRARY OF CONGRESS,
Washington, DC, October 5, 1999.

To: Hon. Charlie Norwood, Attention: Rodney Whitlock.

From: Kimberly D. Jones, Legislative Attorney, American Law Division.

Subject: Legal Analysis of Whether the Amendment in the Nature of a Substitute To H.R. 2723 offered by Representatives Norwood, Dingell, Ganske and Berry Addresses Concern Raised by Representative Houghton.

This memorandum is in response to your request for a legal opinion whether concerns raised in regard to H.R. 2723 by Representative Houghton in a document provided by your office have been addressed by a substitute amendment being offered by Representatives Norwood, Dingell, Ganske and Berry (Substitute Amendment). H.R. 2723 would amend Section 514 of ERISA to prevent ERISA's preemption provision from interfering with a state law that seeks to recover damages for personal injury or wrongful death resulting from acts connected to or arising out of an arrangement regarding ''the provision of insurance, administrative services, or medical services'' by a group health plan. In addition, the bill establishes standards of internal review and creates an external review process. Under the bill, no punitive damages may be awarded if the defendant complied with external review in a timely manner, as defined under the bill. It bars from review those decisions denying coverage for items specifically excluded from the plan.

In a document provided by your office, Representative Houghton raises a number of concerns with H.R. 2723. The first concern is that the liability clause in Section 302(a)(1) of H.R. 2723 shows ''no connection between wrongdoing and who is sued.'' Section 302(a)(1) states:

(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan . . ., or

(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

Specifically, Representative Houghton's letter expresses concern about the potentially broad definition of the term ''any person'' and the potential activities that could be grounds for a cause of action under the bill. Representative Houghton also expresses concern about the bill permitting a suit based on any act of the plan, whether ''good or bad.''

The language of section 302(a)(1) is the same in both H.R. 2723 and the substitute amendment. Therefore, both would allow claims under state law. The potential parties to a suit and the basis of a suit would be determined by state law. Ultimately, the participant or beneficiary would have to satisfy the elements of a state law claim and meet the standard of proof required to prevail under state law.

Another concern raised by Representative Houghton is that state law may not provide an adequate remedy. Currently, many states have laws that allow only a ''natural person'' to be licensed as a doctor or to practice medicine. As a result, many states prohibit a corporation or similar professional entity from giving medical advice or practicing medicine.[1] In states where these corporate practice of medicine laws exist, HMOs (and other managed care plans) are legally prohibited from and are not considered to be practicing medicine or making medical decisions, even if they contract with licensed physicians to perform services on their behalf and/or make benefit decisions that affect the doctor's treatment. These laws could present an obstacle to HMO enrollees who seek to sue their HMO for medical malpractice or negligence. However, other state claims that do not address the standards for practicing medicine could be brought, i.e., negligent processing of a benefit, or ''bad faith'' denials. It should also be noted that some states have acted to remove the shield that managed care plans have against state medical malpractice claims. Texas, California and Missouri have enacted laws that would give patients the right to sue their managed care plan for injuries resulting from acts of the plan.

Another issue raised by Representative Houghton is that H.R. 2723 would allow an individual to go to court without exhausting internal and external review. H.R. 2723 states:

(3) FUTILITY OF EXHAUSTION.—An individual bringing an action under this subsection is not required to exhaust administrative processes [internal and external review] . . . where the injury to or death of such individual has occurred before completion of such processes.

The language of the substitute amendment states:

(e) FUTILITY OF EXHAUSTION.—An individual bringing an action under this subsection is required to exhaust administrative processes [internal and external review] . . ., unless the injury to or death of such individual has occurred before the completion of such processes.

The substitute amendment clarifies the language of H.R. 2723 to require a participant or beneficiary to exhaust internal and external review before commencing an action under state law, unless the injury or death has already occurred.

The final concern raised in the letter is the possibility that an employer may be liable for under H.R. 2723 for ''any exercise of discretionary authority including hiring the insurance company.'' Under H.R. 2723, no cause of action may be brought against an employer or plan sponsor (or its employees) which provides a group health plan. This provision also expressly prohibits a person from seeking indemnification from the employer or plan sponsor (or its employees) for damages awarded under the Act. However, the bill also includes an exception to these provisions where the employer or plan sponsor (or its employees) exercised its discretionary authority to make a benefits decision and the decision resulted in harm. The exercise of discretionary authority does not include the decision to include or exclude certain benefits from the plan, to provide extra-contractual benefits, or a decision not to provide a benefit while internal or external review is being conducted. The bill does not permit a cause of action under state law for failing to provide a benefit or service that is not covered by the plan.

Under H.R. 2723, it is possible that an employer who has a self-insured plan could be liable under a state cause of action. If the employer in the administration of the plan or the provision of benefits uses discretionary authority to make a benefits decision, it would fall under the exception to the employer protection provision of the bill. This is more likely to happen if the employer chooses to administer the plan itself. If the employer contracts with an insurance company to provide these benefits, the bill could be used to protect the employer if it did not exercise discretionary authority on a claims decision. It is less likely than an employer would be directly involved if the administration of the plan has been contracted to an insurance company. However, if the employer becomes involved in a claims decision it would be liable. Also, it could be argued that, although the insurance company made the decision, the company is an agent of the employer and acting on the employer's behalf. As the employer's agent, the argument could be made that the actions of the insurance company could be imputed to the employer. It is not clear if this argument would be successful.

The language of the employer provision in the substitute amendment is similar to H.R. 2723, except the term ''group health plan'' is included in the category of parties that may not be sued under this Act. The provision states, [Section 302(a)] ''does not authorize—(i) any cause of action against a group health plan or an employer or other plan sponsor maintaining the plan, or (i) a right to recovery, indemnity, or contribution by a person against a group health plan or an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under [Section 302(a)(1)]. The term ''group health plan'' is also included in the exception to the employer provision which states:

Subparagraph (A) shall not preclude any cause of action described in [Section 302(a)] against [a] group health plan or an employer or other plan sponsor (or against an employee of such a plan, employer, or sponsor acting within the scope of employment) if—(i) such action is based on the exercise by the plan, employer, or sponsor (or employee of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and (ii) the exercise by the plan, employer, or sponsor (or employee) of such authority resulted in personal injury or wrongful death.

The inclusion of the term ''group health plan'' would clarify the bill's application to fully-insured plans. The term ''group health plan'' is defined under ERISA 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.''[2] Therefore the employer provision would protect a group health plan from liability, unless it exercised discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue.

In a fully-insured plan, a company will contract with an insurance company to provide coverage for its employees. This company is known as a ''health insurance issuer'' under ERISA. The term ''health insurance issuer'' is defined under ERISA as ''an insurance company, insurance service, or insurance organization 9including a health maintenance organization . . .) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance. . . . Such term does not include a group health plan.''[3] In essence, in the case of a fully-insuredd plan, the plan and the health insurance issuer are two distinct entities. By including group health plans in the employer exception and special rule provisions of the substitute amendment, it is unlikely that the actions of the health insurance issuer will be imputed to the plan. However, a fully-insured plan

[1] Footnotes at the end of article.

could face liability if it exercises discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue.

In the case of a self-insured plan, the result is the same under both H.R. 2723 and under the substitute amendment. Where the employer assumes the risk of providing health insurance to its employees, the employer and the plan are for practical purposes the same. As such the acts of a self-insured plan could subject the employer to liability due to the high probability that the employer will have and use discretionary authority to make a decision on a claim for benefits covered under the plan or coverage in the case at issue.

KIMBERLY D. JONES,
Legislative Attorney.

FOOTNOTES

[1] D. Cameron Dobbins, *Survey of State Laws Relating to the Corporate Practice of Medicine*, 9 Health Lawyer 18 (1997). Approximately 15 states have corporate practice of medicine laws.

[2] 29 U.S.C.A. §1191b(a) (West Supp. 1999).

[3] 29 U.S.C.A. §1191b(b)(2).

The Houghton amendment would make insurers liable in Federal court rather than State court. That is sort of the bottom line. H.R. 2723 and every bill, incidentally, I have introduced on liability ensures we want them to face State liability.

I would just like my colleagues to consider a thought, consider this quote from Chief Justice William Rehnquist, and he says, and I quote, ''Congress should commit itself to conserving the Federal courts as a distinctive judicial forum of limited jurisdiction in our system of Federalism. Civil and criminal jurisdictions should be assigned to the Federal courts only to further clearly define and justify national interests, leaving to the State courts the responsibility for adjudicating all other matters.''

Should HMO liability be considered a national interest warranting Federal jurisdiction?

In the Federal courts today, there are 65 vacancies and the courts anticipate another 16 vacancies forthcoming. Twenty-two courts are considered to be emergency status, under emergency status. They do not have appropriate coverage from the bench to consider the cases before them. To this situation we are going to add a new Federal tort?

The Speedy Trial Act of 1974 requires the Federal bench to give priority to criminal cases over civil cases. In 1998, criminal case filings were up 15 percent. A single mother whose child needs constant care because of a decision made by an HMO will have to stand in line behind all of the drug dealers before she can try to hold the HMO liable for its action.

State courts are easier for patients to access. Almost every town in America has a State court. Federal courts are few and far between. States like Texas and Georgia and California already have moved to make insurers accountable for their actions. State courts are a more appropriate and accessible venue for personal injury and wrongful death.

Considering the problems that patients will have in accessing Federal court, it is hard to imagine that HMO liability meets the Chief Justice's definition of a national interest. It certainly does not meet the single mother's definition.

Like all politics, all health care really is local. H.R. 2723 holds insurers liable for their decisions that harm or kill someone in the most appropriate venue: State courts.

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My dear friend, and I do mean that sincerely, my dear friend, the gentleman from South Carolina (Mr. GRAHAM), he knows Frogmore, South Carolina, is a long way from a Federal court. You just cannot get there from here. We just need to do this at home. We also need to consider that the companies that do have a business in all 50 States, my goodness, they have to deal with 50 States now. Because you have a business in all 50 States does not preempt you from ever going into State court.

What about slip and fall? That happens every day. They have to be ready in every State. I am not even going to ask Members to vote against my friends, just vote for H.R. 2723 intact on the next vote.

Mr. Chairman, I include for the RECORD the following statement on physician pathology services:

It is the intent of this legislation that the access to care subtitle apply to clinical pathology and specialized clinical pathology services. However, I am aware that the language may not be specific enough on this particular issue. Therefore, when we go to conference with the Senate, I am willing to work to further clarify this issue by including clarifying language on access to clinical pathology and specialized clinical pathology services in sections 111 and 112 of this legislation

It is the intent of this legislation that the access to care subtitle apply in the same manner to clinical pathology and specialized clinical pathology services as it would to other specialty medical services in this legislation.

It is my intention that when we go to conference with the Senate that I will work to further clarify this issue by including explicit language on access to clinical pathology and specialized clinical pathology services in section 114 of the legislation.

CHARLIE NORWOOD.

Mr. HOUGHTON. Mr. Chairman, I yield 1½ minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, I appreciate those kind comments from my friend across the river in Georgia. We agree on most everything.

One thing I am not going to do when this is over, go practice dentistry. I promise the Members that today. I appreciate all these doctors wanting to rewrite this liability section, but let me ask one question of my friends on the other side. Are they suggesting that if a fiduciary mismanages the retirement benefits of a company or employees, that they should be sued in State court? Is that what they are telling us?

Under current law under ERISA, if there is a mismanagement by the fiduciary of the employees' retirement benefits, is it the gentleman's belief that State court is the proper place to sue?

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. GRAHAM. I yield to the gentleman from Georgia.

Mr. NORWOOD. The gentleman wins. I am not a lawyer. I am not sure. I just know when one has liability under our bill, it has to be in State court.

Mr. GRAHAM. The reason the gentleman cannot answer the question, Mr. Chairman, if we had that as a rule, every 401(k) plan in America would fold, because nobody in their right mind is going to offer these benefits so they can be sued in 50 States under 50 different theories of plan management.

The reason we have this law at the Federal level is to encourage employers to offer health care and retirement benefits so they know what the rules are, and they cannot be nickeled and dimed in every State.

This is an emotional topic from the plaintiff's point of view and from the business point of view. If Members want to destroy health care, allow 50 different theories of liability. People are going to get out of the business.

Mr. HOUGHTON. Mr. Chairman, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Chairman, the Commission on Health Care Dispute Resolution, formed by the American Bar Association, the American Medical Association, and the American Arbitration Association, issued a draft report in 1998 recommending the use of alternative dispute resolutions for medical insurance disputes.

The Houghton-Graham substitute amendment allows this, using binding arbitration as an alternative option for a patient to appeal the decisions of their health insurers, and follows the standards set by the commission, which include independent and impartial arbitrators with sufficient medical or legal expertise, appropriate credentials, and who have no conflicts of interest.

Additionally, the arbitration process must include a fair de novo determination, the opportunity to submit evidence, have representation, and make oral presentation. The health insurer must also provide all records and provisions of the plan relating to the matter.

Arbitration is a voluntary option to operate in lieu of court. Some people just do not want to go to court. Because arbitration is voluntary for the patient to choose, it will not take away from the patient's right to sue in court, but instead, adds a choice to the accountability process. I think we should expand choice for patients who are harmed by wrongful decisions. The Norwood-Dingell bill does not offer this choice.

Mr. Chairman, I urge Members to support the Houghton-Graham substitute.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, we have indeed been making history since we started this debate last evening. Americans do not have to wait for their State to catch up in protecting them when they become ill, in protecting their interests. If there is hurt, then HMOs are going to have to withstand the scrutiny that doctors and hospitals withstand right now.

I applaud the efforts of the gentleman from New York (Mr. HOUGHTON). There are a tremendous amount of similarities between what he wants to do and what is in the Dingell-Norwood bill, no doubt about it. I detect, if I may, and I hear the fears portrayed by my good friend, the gentleman from South Carolina (Mr. LINDSEY), from the proponents of this substitute.

But I also hear the fears and the anxiety of actual human beings who have to deal with the bureaucratic maze that is in front of them when they are ill. If I have to err, if I have to make a mistake, I believe, in good faith, we should make it on the side of the patient.

What that means is that all the things that we agree upon in similar pieces of legislation should not be shortstopped because we cannot agree on where that limit is if one has to go to court. There are built-in processes right within this legislation internally that protect us from those fears and those anxieties which Members have expressed.

That is why I cannot vote for this substitute, but I applaud the gentleman's efforts.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from California (Ms. PELOSI).

Ms. PELOSI. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I rise in opposition to the Houghton-Graham substitute and in support, strong support, of the Dingell-Norwood legislation. I commend both of those gentlemen for their courageous leadership.

Nothing, I think, speaks more eloquently to the need for their proposal than the case of my constituent, Stephen Parrino, from San Francisco. Stephen was diagnosed with a brain tumor. His HMO referred him to Loma Linda Medical Center, which successfully removed the tumor.

Stephen's treating physician then ordered him to undergo proton beam therapy no later than 2 or 3 weeks following the operation, but Stephen's HMO refused to pay for the therapy, saying that it was experimental, unapproved, and not medically necessary. For those reasons, it did not fall within the managed care guidelines.

After repeated calls to the claims reviewer, Stephen was told that the HMO would ask for a second opinion. Seven weeks after surgery was completed, the second opinion came back. It was medically necessary. But it was now too late. Two weeks later, Stephen was informed his brain tumor had spread; it had reoccurred to the same place, and spread to the rest of his body, including his lungs. He subsequently brought suit against the HMO in State court, but claiming ERISA preemption, the HMO had the action removed to the U.S. District Court, which dismissed his case. With no remedy against the HMO, Stephen Parrino ultimately died as a result of the tumor.

Mr. Chairman, this story has been told over and over again in our country, of desperately sick people who thought they had access to the best health care in the world, and who find themselves at the mercy of the managed care bureaucrats in a judicial system that provides them with less assistance than they need and no compensation after the damage has been done.

We have a responsibility to stop this. Health care consumers must be able to hold their health care plans accountable and get lifesaving care. That is why the American Psychological Association writes that the Norwood-Dingell bill is the only legislation that holds HMOs accountable for negligent acts.

Mr. Parrino's HMO did not provide him with the remedy to save his life. His family has no remedy against that HMO.

Mr. HOUGHTON. Mr. Chairman, I yield 1 minute to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, I would like to address the case previously mentioned on the floor. It is a very emotional topic.

Under our bill, they would have a legal remedy. They would have a wrongful death claim brought in Federal court. They would get a full range of what has been lost: the future wages, past wages, past medical bills, the entire package that goes with a wrongful death claim, plus a half a million dollars for pain and suffering, which in a wrongful death claim is very hard to get anyway. They would get that whole range. The liability wall would come down.

Let me just make this one statement. I am asking every member of this House who has voted for products liability reform, where we limit damages, just like we do here, to ask themselves, are they being honest with themselves? What is the deal, here? If someone gets hurt by a machine, we are entitled to limit damages, but if they get hurt by an HMO, for some strange reason and they go through the roof, 280 people in this House have voted for liability reform just like we have today, including the gentleman from Iowa (Mr. GANSKE) and including the gentleman from Georgia (Mr. NORWOOD).

They were willing to limit damages then, but not now. Why?

Mr. HOUGHTON. Mr. Chairman, I yield 4 minutes to the gentleman from Tennessee (Mr. HILLEARY).

Mr. HILLEARY. Mr. Chairman, I am proud to be in the House today as a coauthor and principle cosponsor of this legislation, the Houghton-Graham-Hilleary-Gibbons substitute to the Norwood-Dingell bill.

Our substitute would clarify and close the loopholes that presently exist, in our opinion, in the liability section of the base bill before us. I, like the drafters of the base bill, do believe that some sort of accountability mechanism must exist in order to improve today's managed care plans. I support holding managed care plans that make negligent decisions accountable in a court of law.

However, the bill ignores to a serious level, I believe, concerns about the potential liability that employers will face. This problem must be resolved or literally millions more Americans will join the ranks of the uninsured.

I know that adding millions of Americans to the ranks of the uninsured is absolutely not the intent of anybody on the other side, or who supports the Norwood-Dingell bill. They do not mean to expose innocent employers to liability, I am quite sure. However, the language they use to protect the employers does not achieve their goal, and therefore, we will try to correct it in our substitute.

Under the base bill, a business cannot be sued if they use discretionary authority in making coverage decisions. The problem is that the phrase ''discretionary authority'' is, in my opinion, much too broad.

Let us first guess what is meant by ''discretionary authority.'' What if an employer sets up a clerical system that simply provides information on coverage decisions? Can that employer be sued under the base bill? Yes, it could be, under discretionary authority.

What if a plan simply selects a third-party administrator or a certain type of health care plan. Can they be sued? Yes, under discretionary authority.

What if an employer reverses the decision of a plan on behalf of an employee? Could they be sued? Shockingly, possibly, yes, under the phrase ''discretionary authority.'' It is too broad.

With discretionary authority, we are, in reality, creating a system where lawyers can find loopholes to go after innocent companies. We cannot accept such loopholes that allow innocent businesses to be dragged into court just because they have the deepest pocket, which in turn incentivizes businesses to drop health care policies for their employees.

Our substitute plugs this loophole. Under this substitute, only the business that has direct participation in making the sole, final decision of the plan is liable. Those are the key words, ''Sole and final decision.'' The loophole is closed. This will force the people in

charge of the plan to make a good decision or be on the wrong end of monetary damages.

Meanwhile, innocent employers, which had nothing to do with the decision on health care, will not be forced into court, as is the case with the base bill.

I truly commend the gentleman from Michigan who supports the Norwood-Dingell bill and our great friend, the gentleman from Georgia (Mr. NORWOOD). We appreciate how he has pushed this issue, pushed the issue of patient protections in health care, accountability in managed care. In my opinion, every option on the floor today has the fixes to these problems, in one way or another.

In my view, part of that accountability must include having one's day in court, if one happens to be an employee who has been wronged. Three of the options we have considered today have that as a possible option, but we cannot let a legislative vehicle which fixes these problems also be used to create unlimited lawsuits, even against employers that had nothing to do with the health care decision.

Our substitute leaves Norwood-Dingell's patient protections intact, but closes the loopholes in the liability section.

This is the size of the Norwood-Dingell bill, a pretty thick bill. This is the size of the changes that we make to Norwood-Dingell. There are very few changes that we make. We just consider those closing those loopholes to the base business that might be an innocent bystander in this situation.

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Everybody here that I know of is interested in the same thing, trying to get more patient protections into the law of the land, but we just believe in different solutions to the problem. Vote for our substitute.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from Michigan for yielding me this time.

Mr. Chairman, I have been rather interested about the attacks on discretionary authority. Of course, I am not a lawyer, but I took a minute, and I tried to look up what in the world are they hanging their hat on. I mean, all discretionary authority really means is that an employer can make an independent decision. He has the power to do that about a health care plan.

What we do in this bill with the discretionary authority, we say that it is about a claim for benefits covered under the plan. That is what they have the authority to do. We are saying, ''do not use your authority to go in and deny care under this claim if it is a benefit in your claim, and you have to answer to that if you kill somebody.'' It is pretty simple.

I say to the gentleman from South Carolina (Mr. GRAHAM) I am all for limiting liability. Now, he knows that. That is why we have limited liability in our bill once one gets passed external review. I thought that it would make good sense. There is great limitation of liability at the State level. We see about half the States have really good punitive. Half the States, and sometimes not the same ones, have very good limitations on noneconomic. I think I am for limiting liability.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished 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. Chairman, let me thank the distinguished gentleman from Michigan for this time and his patience and his leadership on this legislation, along with the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Arkansas (Mr. BERRY).

This has not come about overnight, and I think it is important to emphasize that because I have the greatest respect for the gentleman from New York (Mr. HOUGHTON). We have worked together. We understand the value of bipartisanship.

But on the floor of the House today, I have heard doctors maligned, I have heard unions maligned, I have heard lawyers maligned. I thought it would be best if someone got up and spoke about the American people, spoke about the young man that is joining us, children, or little Steve Olson that I spoke about yesterday, the little 3-year-old who needed a brain scan and was denied that by his HMO; or 11-year-old Paige Lancaster who for a long time had headaches, and her brain tumor grew for 4 years because her HMO denied her the service; or maybe Phyllis Cannon, a woman who died because of a lack of the ability to get the service she needed because of the HMO.

Although the intentions are good for this amendment, I believe that we will respond to the American people, and we will not malign them if we pass straight up the Norwood-Dingell bill that allows the patient-physician relationship to be the relationship that so many physicians who our Members of Congress have spoken about, the singular relationship of trust and respect and knowledge, so that that patient will have the ability to get the care that they need.

My good friend who is on the Committee on the Judiciary knows what this amendment does. This is the back door of tort reform. This gives one a single Federal action, and it closes the door to those citizens located in Oklahoma, in Texas, and Georgia who can go to their State courts. It is the same thing as the reform on the class action.

Mr. Chairman, the only bill that will respond to the American people is the Norwood-Dingell act. Save our children. Pass the Norwood-Dingell health reform package.

Mr. Chairman, today I rise to voice my strong opposition to the three substitute amendments to H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act. H.R. 2723 amends current law to establish new patient protections, set nationwide standards for health insurance, and expand medical liability. The measure establishes basic standards for utilization review (i.e., establishing guidelines for how a plan reviews the medical decisions of its practitioner). In instances where the insurer and practitioner disagree about a patient's treatment, the insurer must disclose the reason for the negative coverage decision and inform the patient of his right to appeal. The bill establishes basic standards for the internal appeal process. If the internal appeal upholds the coverage denial, the patient may request an external review. The bill allows any decision involving a medical judgment to be appealed; however, if a benefit is specifically excluded from a health plan contract, it may not be appealed.

The measure expands health plan tort liability by permitting state causes of action under the 1974 Employment Retirement Income Security Act (ERISA; P.L. 93–406) to recover damages resulting from personal injury or for wrongful death for any action ''in connection with the provision of insurance, administrative services, or medical services'' by a group health plan. The bill prohibits insurers from retaliating against a patient or provider based on that individual's use of the review or appeals process and establishes other whistleblower protections.

The bill also includes a number of provisions designed to protect patients' rights and ensure access to health care. Specifically, the measure: Lifts so-called ''gag rules'' to allow free and open communications between patients and doctors in order for the patient to make fully-informed decisions about the best course of treatment; requires insurers to provide coverage, without prior authorization, for emergency care if a ''prudent layperson'' would consider the situation an emergency (resulting in serious injury or death); requires health plans and insurers to allows patients to choose their own primary care professional from the plan or insurer's network; requires HMOs to provide direct access to a participating physician that specializes in obstetrics and gynecology (OB–GYN) and allows parents to designate a pediatrician as a child's primary care provider; allows patients who have an ongoing special condition to have continued access to their treating specialist for up to 90 days in cases where the provider is terminated from the plan or if the plan is terminated; requires HMOs to provide a referral to a specialist for patients with conditions that require ongoing treatment; and requires health plans to disclose information to that patients are able to learn what their plan specifically covers, including benefits, doctors, and facilities, in addition to information on premiums and claims procedures.

In my home state of Texas, we already have effective laws that addresses this concern. The Health Care Liability Act, codified as Tex, Civ. Prac. & Rem. Code Ann. §§ 88.001–88.003 (West 1998) allows an individual to sue a health insurance maintenance organization, or other managed care entity for damages proximately caused by the entity's failure to exercise ordinary care when making a health care treatment decision.

In upholding portions of this forward thinking law that allows injured patients to bring suits for damages against health insurers for substandard quality medical care, District Judge Vanessa Gilmore wrote, ''[I]n light of the fundamental changes that have taken place in the health delivery system, it may be that the Supreme Court has gone as far as it can go in addressing this area and it should be for Congress to further define what rights a patient has when he or she has been negatively affected by an HMOs decision to deny medical care . . . .

''If Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that ensures every patient has access to that care.'' Corporate Health Insurance v. The Texas Dept. of Insurance, 12 F. Supp. 2d, 597 (S. Tx. 1998). I could not agree more.

The three amendments made in order, appropriately called poison pills, would kill the bipartisan crafted Norwood-Dingell Bill. The first amendment, the Boehner bill would allow no new lawsuits, while the Norwood-Dingell measure would provide patients relatively open ability to sue in state courts. This is not acceptable. A patient's right to sue to address the denial of care by HMO is at the heart of Norwood-Dingell.

The second amendment, the Coburn-Shadegg amendment, is a wolf in sheep's clothing. It permits patients the right to sue. Should we applaud? I think not. Upon careful reading one finds that patients, under the Coburn-Shadegg amendment, can sue in either state or federal court, but not both, and would limit non-economic damages to $500,000.

The Graham-Houghton measure does not attempt to hide its attack on a patient's right to sue. It would limit damages in most cases to $250,000 and limit suits to federal court. This is outrageous. Think of the economic hardship that a family would endure if they have a loved one who is permanently and catastrophically disabled as a result of an HMO's negligence. To cap damages to $250,000 at a time when health care costs continue to rise smacks of callous indifference on the part of the sponsors of this measure.

These amendments would deny patients legal redress when he or she has been negatively affected by an HMOs decision to deny medical care. The first lawsuit to cite Texas' pioneering HMO liability law, filed against NYLCare of Texas, shows why the measure needed to be passed, according to physicians. HMOs here and around the country have argued that they shouldn't be liable for medical malpractice because they only determine insurance coverage and don't make medical care decisions. But the Texas suit, filed in district court in Fort Worth on Oct. 19, charges that a decision by NYLCare's reviewers to end hospital coverage for a suicidal patient led to his death. Despite his psychiatrist's objections, the patient did not protest the HMO's decision to release him from the hospital, and, shortly after discharge, he killed himself. ''HMOs may say otherwise, but they are quite clearly practicing medicine,'' said Robert G. Denney, MD, a Fort Worth psychiatrists familiar with the case. The lawsuit could spark interest in many state legislatures and Congress, where legislation similar to Texas' HMO liability law failed this year but is expected to be reintroduced.

Only Texas and Missouri have passed such laws, and Missouri officials reported that no suits have been filed yet under their 1997 law. Meanwhile, psychiatrists said a victory in Texas could help reverse massive cuts in mental health services in the past decade, as employers and managed care companies imposed tight coverage limits. ''HMOs and behavioral health companies are really going to take notice of this case because it's going to change how they manage their care,'' Dr. Denney predicted. At the time of filing, defendants in the lawsuit wouldn't comment on the case. In addition to NYLCare, which was acquired in July by Aetna U.S. Healthcare, the suit names Merit Behavioral Care Corp., which allegedly made the coverage decision as a subcontractor for NYLCare. Merit was acquired in February by Magellan Health Services, now the nation's largest behavioral health care provider.

Look at the Fort Worth patient, 68-year-old Joseph W. Plocica, who became suicidal after he was diagnosed with prostate cancer and lost his job of 11 years. Plocica was admitted to a mental health facility in late June by psychiatrist Harold Eudaly Jr., MD. About a week later, according to the lawsuit filed, Gary K. Neller, DO, a psychiatrist working for Merit in Dallas, told Dr. Eudaly by telephone that Plocica had ''used up his [hospital] days,'' even though the HMO's limit had not been reached.

Upon discharge, Plocica went home, drank a half gallon of antifreeze that night and died of the effects eight days later. ''This case appears to be very strong and raises some serious questions about promises made by the HMO,'' said Donald P. Wilcox, general counsel of the Texas Medical Association. In a TV ad for NYLCare 65, the Medicare product that Plocica enrolled in, the HMO asserts that, ''Some health insurance companies limit hospital days. NYLCare 65 will give you as many hospital days as your doctor will authorize,'' according to a transcript filed with the lawsuit. Wilcox added that since Plocica was covered by Medicare, the case will not be affected by the Employee Retirement Income Security Act of 1974, which shields self-insured companies from state actions.

It's no surprise that the first lawsuit under the Texas liability law involves mental health services, because ''the managed care industry has been arbitrarily cutting benefits,'' said Jefferson Nelson, MD, president of the Texas Society of Psychiatric Physicians. Nationwide, spending for behavioral health care benefits in the past 10 years has fallen by 54%, to $69.61 per person, compared with a 7.4% drop for general health care benefits, according to a 1997 study by the Hay Group for the National Association of Psychiatric Health Systems.

Although some states have passed mental health parity laws requiring coverage at the same levels as other care, the Hay Group found that by 1997, more than half of health plans had imposed limits on mental health hospital stays, typically 30 days. Coverage decisions are not typically made by behavioral care companies under contract to HMOs. Their reviewers ''constantly second-guess complicated cases that take a great deal of clinical judgment,'' said Houston psychiatrist Bernard Gerber, MD. When the HMO stops hospital coverage, patients often refuse to pick up the bill because they lack the funds to pay for the hospital stay and often want to be released, as in Plocica's case, Dr. Denney added. Such cases are ''frightening for psychiatrists because the liability rests with them,'' said Joanne Ritvo, MD, a Colorado psychiatrist and chair of the managed care committee at the American Psychiatric Association. The Texas lawsuit ''is one of the first cases to expose what is under the rock'' in managed mental health care.

Critics of the Texas law predicted an avalanche of HMO suits. With only one lawsuit filed under the Texas law, which went into effect in September 1997, there is hardly the avalanche of claims that some HMOs predicted when the measure was being debated, said Fort Worth attorney George Parker Young, who represents the Plocica family in the suit.

In other states where no such laws are on the books, there is little legal redress for patients suffering from negligent medical or reckless decisions made by their health insurance plans. Take for instance, Steven Olson—a once healthy, thriving two-year old child. After falling on a stick while hiking with his parents, two-year old Steven was rushed to the emergency room where he was treated. His mother returned him a week later because he was in great pain. He was treated for meningitis and sent home. Steven continued to complain about pain, but despite his parents' protests, the HMO doctors refused to perform a brain scan, even though it was a covered benefit. Steven eventually fell into a como due to a brain abscess that herniated. He now has cerebral palsy. An $800 brain scan would have prevented this tragedy.

In an even more tragic case, a woman attempted to switch doctors when it became clear that her original doctor would not fully examine a growing and discolored mole on her ankle. Paperwork and bureaucracy resulted in a six-month wait. Once the women finally visited a second doctor, she was immediately sent to a dermatologist who determined that the mole was a malignant melanoma. The woman died one year later.

Mr. Chairman, under the current federal law, many patients whose lives have been devastated or destroyed by negligent or reckless decisions made by their health insurance plans cannot go to court to obtain appropriate remedies under state law. The federal law—the 1974 Employee Retirement Income Security Act (ERISA)—was originally intended to protect the interests of employees covered by pension and health benefit plans offered by their private-sector employers. But the law is not being used as a shield against state tort liability by HMOs and other health insurers who claim that ERISA preempts state lawsuits against health insurers who cover private sector employees. Based on rulings of some courts, participants in ERISA-covered employee health plans are deprived of the protections afforded by the state common law of negligence and medical malpractice and state wrongful death statutes.

Although the courts do not all agree, many patients injured or killed by negligent or even deliberately reckless decisions of their HMO or other ERISA-covered health insurers have been unable to sue their health plan for damages. Injured patients and their families are limited to a narrow federal remedy under ERISA, which covers only the cost of the procedure that the plan failed to pay for, but does not include compensation for injuries or death

resulting from the denial of a medical treatment.

Mr. Chairman, this year, it should be a top priority of Congress to remove the ERISA preemption. Legal accountability for health insurance plans that make life-and-death decisions about medical care must be a part of any ''Patients' Rights'' bill that passes the Congress. Requiring plans to be legally accountable forces them to suffer consequences when they deny care on the basis of cost and harm results. If health plans are not accountable to patients for their decisions when harm results, they have no financial incentive to make appropriate medical decisions in the first instance.

Mr. Chairman, this is a historic time to stand up for the rights of patients. I ask my Colleagues to join with me in rejecting these poison pill amendments. I urge my Colleagues to support the bipartisan Norwood-Dingell measure which would take away the ERISA shield health insurers currently hide behind.

Mr. HOUGHTON. Mr. Chairman, I yield 3 minutes to the gentleman from Nevada (Mr. GIBBONS).

Mr. GIBBONS. Mr. Chairman, I thank the gentleman from New York for his willingness to share a little bit of his time for us folks.

What we are trying to do today is simply avoid a catch-22 provision which we are all knowingly pushing this country toward. Truly, if one looks at the Houghton amendment, it is the most balanced approach to the whole question we have got here today. For those of us who talk about patient reform, needed patient reforms, and HMO reforms, let me say that I agree with my colleagues. That is why I and all the colleagues who have joined on in this amendment are cosponsors of H.R. 2723, and we preserve those patient reforms. We do not change them at all.

But let me say that the 1.2 million constituents that I have in the Second Congressional District of Nevada sent me here to make this bill a little better. They sent me here to try to make the Norwood-Dingell better by adopting this substitute.

We have heard a lot of claims go about today about, yes, we are closing the door to States' lawsuits, that people will not have the chance, if they are in California, Texas, or Georgia, or whatever, to address those legal remedies that they have. Well, what about the other 44 States who do not have those same provisions?

By passing this bill without a uniform common approach to this law, we have shut the door to the citizens of those other 44 States. We are denying them the access to have and to seek damage and remedies that maybe some of these States do not have that we grant, that we allow, that we give this uniform approach under this bill here today.

Let me tell my colleagues a little bit about why we need to control the cost in this. If we look at the overall rise in health care, and I am sure the gentleman from Georgia (Mr. NORWOOD) knows about the rise in health care premiums, and I think it looks like double digit and has been double digits for a number of years.

In fact, in Nevada we just took a survey, and 12 percent of the employers, in the last year, said they have dropped their health care coverage for employees because of the continual rise in premiums. That survey also showed that 49 percent of those employers would also drop their health care coverage if these premiums continued to rise.

What we are trying to do here is to get to the issue of controlling the cost by giving them uniformity and certainty about damages that they have to estimate in their payment of premiums that continually rise, that put them out.

Let me say that for every 1 percent of premium increase, approximately 400,000 people around America go off of the insured roles on to the uninsured.

What we are doing here, Mr. Chairman, of course, is trying to give certainty to our employers that they know what their exposure to liability is. We all know that punitive damages cannot be insured, that this comes out of pocket of the employer. That is why we take punitive damages off the table. That is why we give a uniform approach to liability, to the remedies that are here. That is very important in this bill.

I would encourage all of my colleagues to support this amendment because I think it gives uniformity to a much needed piece of legislation.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Maryland (Mr. HOYER).

Mr. HOYER. Mr. Chairman, I thank the distinguished gentleman from Michigan (Mr. DINGELL), the ranking member, who is the senior Member of this House, for yielding me this time.

His father introduced health care legislation long before I knew anything about what Congress was doing. He has followed in that distinguished tradition.

I congratulate the gentleman from Georgia (Mr. NORWOOD) for his courage, his commitment, his focus to ensuring that patients and families and doctors had the opportunity to provide the medical care that the patients needed.

I rise in opposition to this amendment offered by one of the most distinguished and conscientious and honest Members of this House, the gentleman from New York (Mr. HOUGHTON) and the gentleman from South Carolina (Mr. GRAHAM).

I say to the gentleman, with all due respect, that we stand on the edge of an opportunity to pass historic legislation. This amendment will undermine that, not because this amendment, per se, is inherently bad, but because this amendment raises very complicated issues that, frankly, could have been raised in another way and could have been considered, in my opinion, much more straightforwardly and honestly as an amendment to the bill as opposed to a substitute to the bill.

I am reminded somewhat of what we did on campaign finance reform, not what the gentleman is doing, but the procedure that is being followed.

I urge my colleagues who have come this far to ensure that we complete this historic effort with the Norwood-Dingell bill and reject this amendment.

Vote overwhelmingly to pass this legislation. Let it go to conference where it will be worked on by, not only the Senate and the House, but by the President as well.

We will have an opportunity this year to do something that the American public will say is the best thing that we have done this year in ensuring that patients and doctors have the right and the opportunity to provide health care that the patients and doctors believe is necessary, not some third party. Defeat this substitute.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Chairman, first, I would like to salute all the Members that have worked so hard to bring forward the Dingell-Norwood bill. I would like to say some things today that really will remind us of some of the greatest things that have happened in this Chamber in the past chapters of American history: when a Congress and a President put together Social Security, when a Congress and a President put together Medicare.

In our day and our time, we, too, can do something noble. The American people are really pleading with us. They are saying to us in our town hall meetings, wherever we gather in our congressional districts all over the country, fix the ills in this system. There are parts of it that are broken. We need access. We need fairness. We want our physicians, our doctors, that sacred relationship between a patient and a doctor. We want the doctor to make the calls.

There is interference in the system, and we know what we need to do. The Patients' Bill of Rights is the bill that the American people genuinely support. We know that.

There is politics of special interests here that take amendments and debates one way or another. But I am convinced that the American people still respect access to the courts, not overuse of the courts, but access to the courts, and that they want the laws to be enforceable ultimately if that is where it has to go.

We can cast a vote that is going to keep faith with the American people. I believe that when they come back to judge us, that this will be the yardstick by which they will measure Members of the 106th Congress.

I ask my colleagues to defeat the substitute. There is no substitute for the Norwood-Dingell bill. Let us pass the Patients' Bill of Rights and do ourselves proud in this Congress.

Mr. HOUGHTON. Mr. Chairman, I yield 5 minutes to the gentlewoman from Missouri (Mrs. EMERSON).

Mrs. EMERSON. Mr. Chairman, before I even begin my formal remarks, let me say that the Houghton substitute incorporates all of the good in good work, the excellent benefits, the excellent changes in the health care delivery system that Norwood-Dingell has. It only changes the liability portion. Let me say that again. The entire Norwood-Dingell bill stays intact except for the liability provision. I just thought I ought to say that in response to the remarks of the gentlewoman from California (Ms. ESHOO).

Let me also say, Mr. Chairman, that, since I have been in Congress, I have had to intervene on behalf of many, many of my constituents, one of whom has been denied or was denied health care access when she had to have a hysterectomy. At least three doctors told her she had to have a hysterectomy.

This 43-year-old cafeteria worker from New Madrid was denied coverage and denied coverage and denied coverage. Her coverage said she can only have a uterectomy. She said, ''Well, if this is the only thing I can have, I will take this.'' But she had it, and she had pain and suffering, and she was even worse off after she had the uterectomy.

She went back to the three doctors, two of whom by the way were part of her health plan, one of whom was an outside doctor. All three doctors said once again, if she did not have a hysterectomy immediately, this woman is going to die. But the plan argued, ''No, she had a uterectomy. She does not need further surgery,'' even though it was obvious she was still suffering and was in great pain.

□ 1530

And only after I intervened and I threatened the plan with exposure to the news media did they finally relent and say, okay, go ahead. Well, my colleagues all know that that should not happen. Plans should not be threatened by Members of Congress in order to provide needed services to our constituents. But this has happened on many occasions. And for all the good health plans out there, there are some bad ones.

And let me say, as a former lobbyist for a small business and also as a former lobbyist for the insurance industry, that plans should be held liable in a court of law for acting irresponsibly and providing health care to consumers. I say that. But it should be responsible liability.

And let me say that after talking with employers in my district as well as a very, very close personal friend of mine who was both a trial attorney and a Taft Hartley Trust Fund attorney that I think the liability language in Norwood-Dingell does not protect labor unions or employers who provide quality health care coverage for their employees.

Let me give my colleagues an example. Let us say Joe Smith is denied coverage by his HMO. He is in a life-threatening situation and his doctor recommends experimental surgery; and because the HMO does not cover experimental medical practices, his coverage is denied. Now, the employer at this time inserts himself in the process because Joe is a long-time employee, his life is threatened; and, quite frankly, he wants to give Joe help. So the HMO grants Joe coverage because the employer has said I want Joe covered.

Now, another situation comes up with a different employee where the employer says, I am going to stay out of this and let the HMO do its job. So that coverage is denied. However, in this case the employer is liable because he acted out of compassion in the very first case.

This same thing happens on a daily basis with Taft Hartley Trustees each and every day. They grant coverage, where maybe they should not have granted coverage, but they did it out of compassion, and under Norwood-Dingell they would expose themselves to liability because of this compassion.

Now, Mr. Chairman, I have a couple of questions I would like to address to the gentleman from New York (Mr. HOUGHTON), if I might. It is my understanding that the Houghton substitute has added language now to section 302 of the liability provisions that make sure that companies and unions who do intervene on behalf of their employees are not held liable.

Mr. HOUGHTON. Mr. Chairman, will the gentlewoman yield?

Mrs. EMERSON. I yield to the gentleman from New York.

Mr. HOUGHTON. I would say to the gentlewoman, Mr. Chairman, that she is correct, we have added language that ensures that employers and unions who intervene on behalf of a patient in one circumstance are not held liable for actions committed and decisions made directly by the plan. Furthermore, employers and unions are not held liable for not intervening on behalf of their patients.

Mr. EMERSON. So, then, it is also my understanding that one of the key differences between Norwood-Dingell and the Houghton substitute is that Houghton clarifies that employers and unions cannot be held liable if they did not make the decision to deny medical care.

Mr. HOUGHTON. That is right.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from Washington (Mr. INSLEE).

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

Mr. INSLEE. Mr. Chairman, we should reject this amendment and pass the underlying bill. We should do it because America knows one thing in this debate with certainty. The amendment would divide this chamber. The Norwood-Dingell bipartisan would unite it.

This is a bipartisan bill, intended to unite us across the aisle. And the one thing we should know for sure, bills that unite us are superior to those that divide us. And if we think about why we are here, it is Congress, and Congress, by its meaning, is coming together. That is an American value.

If we look at the five values, and I encourage my colleagues to do this some day, carved on the bar of the House, there are five values: peace, justice, liberty, tolerance, and union. Let us vote for union today, union to do something meaningful for patients. It is what America wants.

Mr. DINGELL. Mr. Chairman, I yield myself 30 seconds for a colloquy with the distinguished gentleman from Georgia.

Mr. Chairman, I would like to engage my colleague to clarify the scope of the bill. I would say to my colleague that it is my understanding that our objective today here is to improve the delivery of health services, including medical, dental, and vision benefits for millions of Americans.

I also understand there is no intention for the provisions of this bill, including the claims provision of section 301, to govern other lines of insurance, such as disability income insurance or long-term insurance. Is that correct?

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. DINGELL. I yield to the gentleman from Georgia.

Mr. NORWOOD. The gentleman's understanding is exactly correct, Mr. Chairman.

Mr. DINGELL. Reclaiming my time, Mr. Chairman, I fully agree with my good friend.

Mr. Chairman, I yield 1 minute to the gentlewoman from Ohio (Mrs. JONES).

(Mrs. JONES of Ohio asked and was given permission to revise and extend her remarks.)

Mrs. JONES of Ohio. Mr. Chairman, I keep hearing the only difference between Houghton and the Norwood-Dingell amendment is that it only changes the liability. It only changes the liability. When a lawsuit is brought, the only thing that matters is liability. No liability, no lawsuit, no damages. Why penalize the American public by restricting their ability to seek damages?

The other thing that does not seem to want to be discussed on this floor today is the issue that someone who may be a victim of a violation of a claim or denial of a claim may be suing the doctor, may be suing the hospital, and the plan. The lawsuit against the doctor is in State court, the lawsuit against the hospital is in State court, the lawsuit against the plan should be in State court. Why require American citizens to go into Federal Court on the plan and the State court on the doctor and State court on the hospital?

Again, it only changes the liability. That is it, everybody. Liability. Keep it in State court. Support Norwood-Dingell.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentlewoman from California (Ms. WOOLSEY).

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

Ms. WOOLSEY. Mr. Chairman, after fighting for almost 2 years, this House is finally poised to pass meaningful managed care reform. The American people want us to do this, and I am delighted that this House is rising to the occasion. We are almost there.

We have been hearing some stories, though, about how HMO reform will make the sky fall. I want my colleagues to know that in my State of California our governor, Governor Gray Davis, recently signed landmark legislation that will provide HMO participants with major consumer protections and give health decisions back to 20 million patients and their doctors.

Now Californians have HMO accountability. Now Californians have a fair, timely, external grievance process. It should be an eye opener for all of us here today, because California, a large and diverse State, in fact with the population and the economy of a country, has patients first when they think of health care.

Mr. HOUGHTON. Mr. Chairman, I yield 2 minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, where common ground exists, let me explain it. We are on the verge of doing something positive, but we are about to blow it. This bill, according to CBO, costs $7 billion to the Treasury. We have to work somehow to make that up.

Let me say this about liability and be as direct as I know how. 280 Members of this body have voted in the products liability area to limit damages, even economic damages, and change every law in every State and trump every court lawsuit anywhere in the country because they thought it was good for business and fair to plaintiffs.

We have passed the Cox amendment that would limit damage recoveries if medical malpractice occurred because we want to lower the cost of medicine and still give people a fair day in court.

Let me say this to my friends on the other side. We have a nice young man here who has probably a sad, bad story to tell. I want to help to make sure these things never happen again by getting the health care that people need. I do not want to drive people out of ERISA coverage. ERISA is designed at the Federal level to encourage people to have retirement plans and health care plans.

What have we done in the past? If somebody gets hurt by a doctor, this body was willing to say nationally that a plaintiff could only get this much money for the good of medicine. If somebody was blown up by a product, and I have had those cases, and I can show my colleagues files that would make them sick to their stomach, emotional things happen in lawsuit situations. I can show my colleagues product liability cases, but this House was willing to say this is all a plaintiff gets for the good of the Nation.

My colleagues, we are going to blow it if we do not reform the liability measure to keep it so people have a fair day in court but we do not drive well-meaning people out of business. It costs $7 billion already. This is the one area we have shown in the past we were willing to limit recovery for the greater good.

And I do not want to discount the fact that health care needs to be improved, but I am a lawyer and I know what we are setting up with a 50-State lawsuit form. We are going to drive people out of business.

Mr. DINGELL. Mr. Chairman, I yield 3 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, we are coming to the end of a long debate. We are coming to the end of 5 years of work.

This bill, the Norwood-Dingell bill, is not about the gentleman from Georgia (Mr. NORWOOD), nor is it about the gentleman from Michigan (Mr. DINGELL), the gentleman from Iowa (Mr. GANSKE), the gentleman from New York (Mr. HOUGHTON), or the gentleman from South Carolina (Mr. GRAHAM). It is about the people out in the country.

I want to tell a story about this little boy right here who is tugging on his sister's sleeve before he received HMO care. One night his mother found that he had a temperature of 104, 105. He was really sick. She phoned her HMO. The HMO said she could take him to one hospital, but only one, and that if she went to another one they would not pay for it. His mom asked where it was. And the person said, I do not know; find a map.

Well, it was a long ways away. And halfway there, 30-some miles into the drive, with more than that to go, they were passing one emergency room after another, one pediatric care after another, and this little boy is sick. But his mom and dad, they are not doctors; they do not know how sick. Before he gets to that emergency room, he has a cardiac arrest. His mom is trying to keep him alive and his dad is driving him there, and they pull into the emergency room and his mom leaps out and says, save my baby, save my baby. And a nurse comes out and starts resuscitation and they save his life.

But they do not save all of this little boy. Because of that HMO's medical judgment and decision, making him go 70 some miles instead of to the nearest emergency room, he ends up with gangrene of both hands and both feet. And this is that little boy after his HMO care.

The Norwood-Dingell bill would have prevented that. We do not want lawsuits; we want to prevent this. This little boy has a big heart, and he is going to do just fine. And his mama and dad, who are here today, they are making a place for him and making sure that he gets the kind of care he needs. But this little boy, if he had a finger and we pricked it, it would bleed. He is not an anecdote.

□ 1545

We need to fix this problem so that these cases do not happen. This little boy has met a lot of my colleagues today, and I encourage others to meet him. His name is James Adams.

I will tell my colleagues what we need to defeat this last substitute. We need to get a big vote for the Norwood-Dingell bill, and we need to send it to the conference. And instead of calling it the Talent bill, I have a suggestion. Let us call this bill the James Adams bill. Vote for the Norwood-Dingell bill. Vote against the substitute.

Mr. HOUGHTON. Mr. Chairman, I yield 1 minute to the gentleman from Tennessee (Mr. HILLEARY).

Mr. HILLEARY. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, I am sitting here, and I am very conflicted about the fact that this young man is here today. I think the reason I am conflicted is because I think it borders, but probably does not go over, but borders exploitation of his condition.

But in a way, on final analysis, I guess I am glad that our friend the gentleman from Iowa (Mr. GANSKE) brought this up and really focuses exactly on what this is about. And it is about this young man.

We only have so much money in this country to focus on health care, and we should focus every bit of it that we can on young men like this one sitting right here. The bill that is the base bill here, in my opinion, and I am an attorney who has never tried a case in my life, but I believe I could drive a Sherman tank through that discretionary authority in the base bill.

So much money is available and that is it to help this young man. Now, if we can get to that deep pocket, which is that base company that contracts with that HMO, a good portion of that money available for this young man is going to go out the door to trial lawyers, who I do not malign. But if we have a choice between that limited funding of where that money should go, it seems to me that money should not go to the trial lawyers, it ought to go to young men like this young man right here.

I urge a vote for the substitute.

Mr. HOUGHTON. Mr. Chairman, I yield 30 seconds to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, I can show my colleagues cases of people that have lost their lives, lost their limbs in product liability suits that were treated by a doctor who was drunk. This House has in the past limited damage recoveries not because they are mean but because they want to keep people in business and lower the cost of medicine.

This young man, under this bill, would have a full range of damages available to him to treat him in the future to make him as best he can be in terms of damages.

What my colleagues are doing is they are not helping him. They are taking

people with health care coverage and for no good reason letting 50 States with unlimited damages take his mom and dad out of the health care market for no good reason.

Mr. DINGELL. Mr. Chairman, I yield myself 3 minutes.

(MR. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Chairman, this has been a long and exciting debate. It has been, I think, one of the finest I have had the privilege of seeing. I want to pay tribute to all of my colleagues on whatever side of the issue they might have been. It has been a strong and vigorous debate, but it has not been one which has been bitter or acrimonious. It is a real credit to the sincerity of the Members on both sides of the issue and it reflects great credit on this institution.

Now, my dear colleagues, if we defeat the substitute, we will move to vote on final passage. If we send this legislation to the other body for a conference, its final success is not assured. But I can tell my colleagues we have done our job and have done it well. We will pursue and try to see to it that the conference is completed to give this House and this Congress and this people a piece of legislation in which they may be proud and in which they will know that we have again made the HMOs of this country responsive to the needs and wishes of the people.

Members of both parties are concerned that if we vote for this legislation, we will not observe the customary budget requirements. I offer my colleagues firm assurance that we will, in this process, observe the customary budget requirements.

I have a letter from the President here in my hand, which I will insert into the RECORD, saying that we will do so and that the legislation will be paid for and offer my promise that that also will be so and that I will do everything that I can to see that nothing comes out of conference which does not pay the cost of the legislation.

I do not want to say anything bad about any piece of legislation. I am sure they have all been offered sincerely. I want to pay a particular word of compliment to my good friend the gentleman from New York (Mr. HOUGHTON). He is a great gentleman, and he is a man which I much admire and respect.

I also want to say a word of thanks to my good friends the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) and to their fine staff and to that of ours who have worked so hard to bring us to where we are. There are many here who deserve great credit for what it is that we have accomplished today, and I want them to know that this legislation is something which is good.

Many members on both sides of the aisle worked to make this day happen. Along with Dr. NORWOOD and Dr. GANSKE, several other Republican members labored long and hard. And on the Democratic side, I'd be remiss if I didn't mention MARION BERRY and my other good friends in the Blue Dogs, the cochairs of the health care task force, FRANK PALLONE, EVA CLAYTON, and CHRIS JOHN, and, of course, SHERROD BROWN, the subcommittee ranking member, and the other tireless Commerce Committee Democrats. We were well served by very capable staff, including Bridgett Taylor, Amy Droskoski, and Karen Folk of the Commerce Committee Democratic staff, and numerous excellent staffers from the personal offices of all involved on both sides of the aisle.

The remarkable thing is that the House has moved to a point where we now have agreement on all things save the question of litigation. But we have an example of what litigation means in matters involving HMOs in Texas under similar proposals of law, and that is that in 2 years, 4 million people have been involved in five lawsuits.

The total cost of those programs is less than 13 cents a month per subscriber. That tells us the system works, not at excessive costs but in a fashion which affords rights which have been denied to HMO subscribers and to allow them to be heard and get redressed for grievances and to get the abuses and the concerns which confront them adjusted.

I urge my colleagues to vote against the amendment. I urge my colleagues to support the bill.

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN. The Chair must ask all Members to refrain from alluding to any guest who might be on the floor of the House.

Mr. HOUGHTON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I want to thank the gentleman from Michigan (Mr. DINGELL) for his courteousness, the dean of our House, a very distinguished man, a great and dear friend.

This is the final vote to keep Norwood-Dingell intact and yet save the caregivers. I understand that the American people are pleading for something like this, and we are also.

I wish, as my friend from Maryland has said, that this had been an amendment. But it just was not. It was in the form of a substitute. I have no control over that. But I can only talk from personal experience that the Norwood-Dingell bill means that the health care is now going to be provided at a very scary cost.

My colleagues have got to believe me. They may not agree with me. They may be able to tear some of my statements apart. But having lived through this process and taking a look at what is now available, the basic thrust of my argument is absolutely right, no question about it.

The problem is that these people who have had problems, such as the gentleman from Iowa (Mr. GANSKE) has indicated earlier, if they do not have any health care, they cannot be helped at all.

I worked for many, many years, more than I would like to recount, for a company that was one of the first five in the country to offer health care to its employees. And I never thought in terms of employers or employees. We were members of the same corporation. I really believe that these people felt that we treated them correctly.

But as I looked over that plan, and if I put on my other hat and I was now a businessman, I would have to change my thinking. I could not stand the liability provision hanging over my head. And I would do a couple of things.

One of them might be to just give individual grants to employees, but that would not be good. We would not have the pooling. Many people would not have the money when they needed it. But the problem that I would have in being exposed to the liabilities, no matter how you want to define them, is they would be so great I could not continue the present plan as it is.

Now, let me just say one other thing. We have heard from people who care very much about this. We have heard from lawyers. We have heard from doctors. I would like in pleading here, as others have, to plead for the employees and employers of corporations and the small companies who are going to be dramatically affected unless something can be done to refine this bill.

Mr. Chairman, I yield back the balance of my time.

Mr. DINGELL. Mr. Chairman, I yield such time as he may consume to the distinguished gentleman from Texas (Mr. STENHOLM).

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

Mr. STENHOLM. Mr. Chairman, I rise in support of H.R. 2723.

Mr. Chairman, I rise in support of the Bipartisan Consensus Managed Care Act, offered by Representatives CHARLIE NORWOOD and JOHN DINGELL. While I do have some remaining concerns with some of the provisions in this legislation, I believe that Dr. NORWOOD and Mr. DINGELL have made a sincere effort to work with me and others to address the legitimate concerns with their bill. Whenever issues were brought to their attention, they took the time to consider these suggestions and worked to resolve them. I commend both the Members and their very capable staffs for their diligent efforts to develop bipartisan, meaningful managed care reform. I am pleased that they have been able to put together a bill which is much improved from the legislation considered by the House during the 105th Congress.

Our health care system poses a challenging area of public policy. I believe that is it important that we try to strike a balance between the rights of patients, the duties of physicians, the operations of insurance companies, and the ability of employers to provide health insurance for their employees. One of the most difficult issues to address throughout this debate has been the matter of liability. If a health plan's actions cause harm to a patient, the plan should be held accountable. I believe that the internal and external appeals processes included in this bill will enable patients to get the care that they need and therefore preclude

the need for litigation. In fact, this bill clarifies that a patient must go through an external appeals process before going to court unless they already have suffered an injury or death. Furthermore, this bill includes provisions which ensure that employers will not be subject to liability unless they specifically act as an insurer and decide that a specific enrollee shall not receive a certain benefit that is covered. I have long supported tort reform, and I certainly do not want to see an increase in litigation. I believe that the limited scope of this bill's liability provisions make lawsuits a last resort that is available only in egregious cases where all other avenues have been exhausted.

I believe that the managed care plans in my district, First Care, offered by Hendrick Health System, and HMO Blue, offered by Abilene Regional, are doing a good job. I hope that the Bipartisan Consensus Managed Care Act will highlight the work of these responsible plans. In fact, the bill contains a number of provisions that these managed care plans already are using to provide better care for their patients.

I am disappointed that the majority party did not allow the sponsors of this legislation the opportunity to pay for their bill. I believe that it is extremely important that we follow the budget rules that require us to pay for the legislation we pass. I continue to oppose any legislation that would use any of the budget surplus until we have an overall budget plan that protects Social Security and Medicare. I know that the authors of this bill agree with this position and offered a proposal to pay for the costs of the bill. The only reason that this bill is not paid for is because the majority leadership prevented the authors of the bill from doing so. I am voting for this bill today with the understanding and expectation that provisions paying for it will be added in conference. I am pleased to that the President has indicated he will not sign it unless its costs are fully offset by the conference committee.

Even if we pass this legislation to ensure patients have rights in their health care, there is still much work to be done. The rising cost of health care and the growing number of uninsured citizens in our nation are alarming. In addition to giving patients who already have access to health care the ability to have a say in their health care decisions, we also have an obligation to work to see that everyone has access to health insurance.

There are many valid and difficult issues to resolve as we seek to improve our health care system. H.R. 2723 isn't the final answer but it moves us in the right direction. I urge my colleagues to support the Norwood-Dingell bill.

Mr. DINGELL. Mr. Chairman, I yield such time as he may consume to the distinguished gentleman from Illinois (Mr. COSTELLO).

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

Mr. COSTELLO. Mr. Chairman, I rise in opposition to the substitute and in strong support for the Norwood-Dingell bill.

Mr. Chairman, I rise today in strong opposition to the process imposed in the House today by the Republican leaders. Once again the Republican-led Congress has made in order a rule they know will defeat the bipartisan Norwood-Dingell bill, the only bill that could provide real managed care reform for 32 million Americans. This is the Republicans clever way of fooling the public into thinking they would like to pass a real managed care bill.

Mr. Chairman, the rule does not allow the bipartisan Norwood-Dingell bill to be offered in its original form and then links it with another poorly crafted bill that will deny access to the 32 million uninsured individuals in the lowest income bracket. This scheme is unacceptable, the Republican Leadership should be ashamed.

The ''access bill'' that will be tied to the real managed care bill is for the healthiest and wealthiest of individuals. By expanding Medical Savings Account (MSAs), the access bill discourages preventive care, and undermines the very purpose of insurance. When we voted on the Kennedy-Kassebaum Health Insurance Portability Protection Act in 1996 I supported the MSA demonstration project. However, this demonstration project turned out to be a failure. Of the 750,000 policies available only 50,000 have been sold. In my own Congressional District in Southwestern Illinois my constituents do not have access to these policies.

This access bill and the rule is just another attempt by the Republican-led Congress to undermine a bipartisan bill that could provide relief for millions of Americans. I am outraged that the Rules Committee denied Representative DINGELL's request to offer an amendment to pay for this legislation. As a general rule the Republican leadership demands that legislation not bust the budget caps imposed in 1997. While the Norwood-Dingell bill was not expected to require additional spending, the Congressional Budget Office estimated it would cost $7 billion. Representative DINGELL offered to offset the bill so that Members like myself who wish to protect Social Security could cast their vote in support of real managed care reform while ensuring the Social Security Trust Fund would not be touched.

As a cosponsor of the Bipartisan Consensus Managed Care Improvement Act—legislation strongly supported by doctors and by the American Medical Society and the Illinois State Medical Society—I believe it is the only real reform bill that will provide a comprehensive set of consumer rights that includes guaranteed access to emergency care and specialists, choice of providers, and strong enforcement provisions against health plans that put patient's lives in jeopardy. I am pleased the bill protects our small business owners by excluding businesses from liability if they do not make the decisions. This bill contains provisions that create safe harbors to ensure that no trial lawyer will accuse an employer of making a decision by simply choosing what benefits are in a plan or providing a patient benefit not in a plan. I am encouraged by the State of Texas who gave their citizens the right to sue HMO's for the past two years. In that time there have only been four cases filed.

I urge my colleagues to oppose this rule and support real managed care reform legislation. Vote for the bipartisan Norwood-Dingell legislation.

Mr. DINGELL. Mr. Chairman, I yield 3½ minutes to the gentleman from Georgia (Mr. NORWOOD) who has worked long and hard on this matter and shown extraordinary skill, ability, dedication, and energy. And those are characteristics I have seen in the gentleman from Iowa (Mr. GANSKE).

Mr. NORWOOD. Mr. Chairman, well, it is almost over. I think it has been a great 2 days, frankly. There are so many good ideas and so many good people in here, all of whom have brought the most interesting points of view to this debate. I am proud of this House. I agree with the gentleman from Michigan (Mr. DINGELL) that it has been a very civilized, correct type of debate.

Mr. Chairman, I have had the strangest feelings. This has been going on for me for a long time. I woke up today and I felt, well, it must be May 1969. The 101st Airborne Division was ready to take Hamburger Hill in a place far away in Vietnam. It had been their tenth try. They had to fight on bad ground. And they had to win.

That division one more time locked and loaded and went straight uphill to take Hamburger Hill, and that day they won for America.

I feel like we are running uphill our tenth time today, and we are going to get to the top of the mountain, and we are going to do it for America.

I have tried, interestingly enough, for 4 years to make this a partisan debate. I did everything I could do, I think, to try to get the Republicans to take this issue. This is such an important issue to America, so important to so many people. Each one of us, each member of our families, each one of our constituents, every American is what this issue really was all about.

I realized this year that we will not succeed that way, that for us to change the law in this country to protect our patients, we have to do it in a bipartisan fashion. That is the only thing that will work. That is the only thing that will really give us the new law that we need.

I am asking my colleagues today, do not vote for this because they are a Republican, do not vote for this because they are a Democrat. That is not what this is about. I want them to vote for this bill, I want every one of them to vote for this bill today as an American.

Let us show this country that on issues of this high quality and importance for the American people, we are going to come out of this House. And we are going to produce a good bill. We are going to conference, and we are going to face an uphill battle.

Everybody knows that. We are going to go to conference and listen to my friend the gentleman from New York (Mr. HOUGHTON) and the gentleman from South Carolina (Mr. GRAHAM) and the gentleman from Tennessee (Mr. HILLEARY) and others, and we are going to try to make it even better. And we can do that, and we can do that if we work together.

I mean, everything maybe does not have to be bipartisan, but today's vote is an American vote. I ask every one of my colleagues, if they possibly can, vote for this bill today. And if they cannot, I respect them. And their opinion is important. But if you can, do.

□ 1600

Mr. Chairman, I thank my colleague, an interesting hard-working gentleman, a man that will tell it straight, and, boy, do I admire that. I thank the gentleman from Iowa (Mr. GANSKE) for his hard work. I thank the gentleman from Oklahoma (Mr. COBURN). As my colleagues know, we are going to pass a bill out in an few minutes that the gentleman from Oklahoma wrote, or he certainly helped write. He will probably fuss about me saying that, maybe one or two things. But I thank the staffs in our offices, all of our offices that have worked so hard.

Everybody, cast that American vote.

The CHAIRMAN. The time of the gentleman from Georgia (Mr. NORWOOD) has expired.

Mr. HOUGHTON. Mr. Chairman, have I any time left?

The CHAIRMAN. The gentleman from New York has 1 minute remaining.

Mr. HOUGHTON. Mr. Chairman, if the gentleman from Georgia would like another minute, I will yield him the balance of my time.

The CHAIRMAN. The gentleman from Georgia is recognzied for 1 minute.

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from New York for yielding this time to me, but I will tell my colleagues I am sort of tired of hearing myself talk. It has all been said, and it has all been done, and what we need to do now is mount the top of Hamburger Hill.

Mrs. CHRISTENSEN. Mr. Chairman, and my colleagues, while the Houghton-Graham amendment is a bit more reasonable than the previous two, and I think is an attempt at promoting a compromise—I still must oppose it.

I will admit that as a physician, I may be biased on this issue. Why should I as a physician be liable to be sued for a decision that was made by an HMO plan I work for, but the plan only be subject to arbitration.

This will not bring the kind of accountability necessary to make sure that plans act in the best interest of the health of the patient, and not just on cost.

Once again I must restate, that a lot of work and compromise went into crafting the bipartisan Norwood-Dingell bill. No one got everything they wanted in the bill. In fact, I am particularly disappointed that my own managed care bill—to ensure access to managed care plans for residents and physicians living and working in medically underserved areas—was not included in the Dingell-Norwood bill.

However, in spite of this, I still say that it is the best managed care reform bill that we could get because it addresses, in a comprehensive way, the problems that the corporations will not address without legislation.

So while my friends, Mr. HOUGHTON and Mr. GRAHAM may mean well in offering their substitute, they don't go far enough.

The Norwood-Dingell bill is the only proposal that offers real managed care reform. Let us not amend it. Let us vote for the Norwood-Dingell-Ganske bill and against any and all amendments.

Mr. CLAY. Mr. Chairman, I rise in opposition to the Houghton amendment. This amendment is no different than the Coburn substitute. It makes it so difficult for an individual to bring a lawsuit that in effect there is no right to sue. Only if an individual can jump over the high hurdles that this substitute puts up, can anyone receive a modicum of redress.

Under Houghton, an individual has to prove three key points. First, that a person who had sole final authority exercised that sole final authority. Second, that that person failed to exercise ordinary care in making an incorrect determination. And third, that the denial was the proximate cause of the injury of death. In most health plans, it is unclear who has the final authority and individuals will be hard pressed to know and prove who was the person who actually denied their care.

Houghton furthermore, requires that the court give the plan's decision substantial weight. This means that there is a presumption that the plan was right. Individuals and courts will be hard pressed to override this presumption. Only in the most egregious cases will there ever be any relief.

Most of the other provisions in Houghton are similar to the Coburn substitute. Both of these substitutes make it so difficult to bring a suit that only a few individuals will ever be able to meet its tough standards. This isn't what the American people want. The American people want a reasonable way to hold health plans accountable. Americans deserve the same protection against health plans that they have when they buy a car or go to the supermarket. Oppose the Houghton substitute.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. HOUGHTON).

The question was taken; and the Chairman announced that the ayes appeared to have it.

RECORDED VOTE

Mr. DINGELL. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 160, noes 269, not voting 5, as follows:

[Roll No. 489]

AYES—160

Aderholt	Deal	Hilleary
Archer	DeLay	Hoekstra
Armey	DeMint	Houghton
Baker	Dickey	Hulshof
Ballenger	Dreier	Hunter
Bartlett	Duncan	Hutchinson
Barton	Dunn	Hyde
Bateman	Ehlers	Isakson
Bereuter	Ehrlich	Istook
Bilirakis	Emerson	Jenkins
Bliley	English	Johnson (CT)
Blunt	Everett	Johnson, Sam
Bono	Ewing	Kelly
Brady (TX)	Fossella	Kingston
Bryant	Fowler	Kolbe
Callahan	Gallegly	Kuykendall
Calvert	Gekas	Largent
Camp	Gibbons	Latham
Canady	Gillmor	LaTourette
Cannon	Goode	Lazio
Castle	Goodling	Lewis (CA)
Chabot	Goss	Lewis (KY)
Chambliss	Graham	Linder
Chenoweth-Hage	Green (WI)	Lucas (KY)
Coble	Greenwood	Lucas (OK)
Coburn	Gutknecht	McCrery
Collins	Hansen	McHugh
Combest	Hastert	McInnis
Cooksey	Hastings (WA)	McKeon
Crane	Hayes	Metcalf
Cubin	Hayworth	Mica
Cunningham	Hefley	Miller (FL)
Davis (VA)	Hill (MT)	Miller, Gary
Myrick	Salmon	Thomas
Nethercutt	Sensenbrenner	Thornberry
Northup	Shadegg	Thune
Nussle	Shaw	Tiahrt
Ose	Shays	Upton
Packard	Sherwood	Vitter
Pease	Shimkus	Walden
Pickering	Shuster	Walsh
Pitts	Simpson	Wamp
Porter	Skeen	Watkins
Portman	Smith (MI)	Watts (OK)
Pryce (OH)	Smith (TX)	Weldon (FL)
Radanovich	Souder	Weldon (PA)
Ramstad	Spence	Weller
Regula	Stearns	Wicker
Reynolds	Stump	Wilson
Riley	Sweeney	Wolf
Rogan	Talent	Young (AK)
Rogers	Tancredo	Young (FL)
Rohrabacher	Tauzin	
Ryun (KS)	Taylor (NC)	

NOES—269

Abercrombie	Farr	Matsui
Ackerman	Fattah	McCarthy (MO)
Allen	Filner	McCarthy (NY)
Andrews	Foley	McCollum
Bachus	Forbes	McDermott
Baird	Ford	McGovern
Baldacci	Frank (MA)	McIntosh
Baldwin	Franks (NJ)	McIntyre
Barcia	Frelinghuysen	McKinney
Barr	Frost	McNulty
Barrett (NE)	Ganske	Meehan
Barrett (WI)	Gejdenson	Meek (FL)
Bass	Gephardt	Meeks (NY)
Becerra	Gilchrest	Menendez
Bentsen	Gilman	Millender-McDonald
Berkley	Gonzalez	Miller, George
Berman	Goodlatte	Minge
Berry	Gordon	Mink
Biggert	Green (TX)	Moakley
Bilbray	Gutierrez	Mollohan
Bishop	Hall (OH)	Moore
Blagojevich	Hall (TX)	Moran (KS)
Blumenauer	Hastings (FL)	Moran (VA)
Boehlert	Herger	Morella
Boehner	Hill (IN)	Murtha
Bonilla	Hilliard	Nadler
Bonior	Hinchey	Napolitano
Borski	Hinojosa	Neal
Boswell	Hobson	Ney
Boucher	Hoeffel	Norwood
Boyd	Holden	Oberstar
Brady (PA)	Holt	Obey
Brown (FL)	Hooley	Olver
Brown (OH)	Horn	Ortiz
Burr	Hostettler	Owens
Burton	Hoyer	Oxley
Buyer	Inslee	Pallone
Campbell	Jackson (IL)	Pascrell
Capps	Jackson-Lee (TX)	Pastor
Capuano	Jefferson	Paul
Cardin	John	Payne
Carson	Johnson, E. B.	Pelosi
Clay	Jones (NC)	Peterson (MN)
Clayton	Jones (OH)	Peterson (PA)
Clement	Kanjorski	Petri
Clyburn	Kasich	Phelps
Condit	Kennedy	Pickett
Conyers	Kildee	Pombo
Cook	Kilpatrick	Pomeroy
Costello	Kind (WI)	Price (NC)
Cox	King (NY)	Quinn
Coyne	Kleczka	Rahall
Cramer	Klink	Rangel
Crowley	Knollenberg	Reyes
Cummings	Kucinich	Rivers
Danner	LaFalce	Rodriguez
Davis (FL)	LaHood	Roemer
Davis (IL)	Lampson	Ros-Lehtinen
DeFazio	Lantos	Rothman
DeGette	Larson	Roukema
Delahunt	Leach	Roybal-Allard
DeLauro	Lee	Royce
Deutsch	Levin	Rush
Diaz-Balart	Lewis (GA)	Ryan (WI)
Dicks	Lipinski	Sabo
Dingell	LoBiondo	Sanchez
Dixon	Lofgren	Sanders
Doggett	Lowey	Sandlin
Dooley	Luther	Sanford
Doolittle	Maloney (CT)	Sawyer
Doyle	Maloney (NY)	Saxton
Edwards	Manzullo	Schaffer
Engel	Markey	Schakowsky
Eshoo	Martinez	Scott
Etheridge	Mascara	Serrano
Evans		

Sessions	Sununu	Vento
Sherman	Tanner	Visclosky
Shows	Tauscher	Waters
Sisisky	Taylor (MS)	Watt (NC)
Skelton	Terry	Waxman
Slaughter	Thompson (CA)	Weiner
Smith (NJ)	Thompson (MS)	Wexler
Smith (WA)	Thurman	Weygand
Snyder	Tierney	Whitfield
Spratt	Toomey	Wise
Stabenow	Towns	Woolsey
Stark	Turner	Wu
Stenholm	Udall (CO)	Wynn
Strickland	Udall (NM)	
Stupak	Velazquez	

NOT VOTING—5

Fletcher	Kaptur	Traficant
Granger	Scarborough	

□ 1622

Mrs. MCCARTHY of New York and Messrs. BACHUS, MANZULLO, SANFORD, KASICH, CROWLEY and PETRI changed their vote from ''aye'' to ''no.''

Messrs. CRANE, CHABOT and ADERHOLT and Mrs. NORTHUP changed their vote from ''no'' to ''aye.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. FLETCHER. Mr. Chairman, on rollcall No. 489, I voted in the machine but it did not record my vote. I voted ''aye.''

Ms. ROYBAL-ALLARD. Mr. Chairman, I rise today in support of the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act of 1999 and in support of effective use of the National Practitioner Data Bank.

Unfortunately, the Republican leadership, in restricting the debate on managed care reform, has prevented many promising ideas from being discussed, including an amendment I submitted to the Rules Committee about the National Practitioner Data Bank. The purpose of my amendment was to encourage health care providers to use the existing National Practitioner Data Bank. This would allow health consumers to make accurate and informed decisions about their health care.

We've all read about these terrible stories where doctors, whose licenses have been suspended by one state, to relocate to another state and start their harmful medical practices all over.

The National Practitioner Data Bank was established as part of the Health Care Quality Improvement Act of 1986 to try to prevent this from happening.

The purpose of the data bank is simple: to help prevent incompetent doctors, dentists, or other practitioners from moving from one state to another without a state discovering their previous history of unethical or incompetent medical practice.

The data bank contains information on malpractice payments, licensure actions taken by state medical boards, professional review actions taken by hospitals or HMOs, actions taken by the Drug Enforcement Agency, and Medicare/Medicaid exclusions.

Information is made available only to registered entities such as state licensing boards, professional societies, HMOs, PPOs, and group practices.

Hospitals are required to query the NPDB when hiring medical staff and at least once every 2 years for those already on staff or having clinical privileges.

However, other health care entities may consult NPDB but are not required to.

My amendment would have encouraged the use of NPDB by health plans and HMOs in order to give consumers confidence that bad actors are not employed or covered by their health plan. The amendment simply stated, that in the ''Patient Access to Information'' section of the bill, along with a doctor's name and address and availability to new patients, an HMO or a health care plan must indicate whether the National Practitioner Data Bank has been consulted—essentially, whether a background check has been done on the doctors in their list. The amendment did not require HMOs or health plans to consult the data base.

The fact is, more and more Americans are now covered by HMOs.

Many have little choice in the matter—80% of small businesses and over 50% of large businesses offer one and only one health care plan to their employees.

In the past, most of us were able to choose a family doctor or a specialist because someone we knew or trusted—a relative, a family friend—recommended them to us.

Under most HMOs, we are handed a list of participating doctors and told these are the only doctors we can pick.

Yet we may have no idea who they are—it may be a list of complete strangers.

Are they licensed? Has their license been suspended in another state? Has another state taken a disciplinary action? Have they been sued for malpractice in the past? If so, was it an aberration or is it a regular occurrence?

It seems the very least we should expect is that our health care plan or HMO has run a background check on these doctors. These are legitimate questiions the health plan or HMO should know the answer to.

Practically speaking, I had hoped such disclosure would serve as an incentive for health plans and HMOs to check up on who they are hiring, or who they are including in their list of covered physicians. My amendment would not have done everything, but it would have represented a small step forward in the area of consumer access to information that will help us move ahead for a more open health care system with access to the information people need to make informed medical decisions.

I urge my colleagues to pass the Norwood-Dingell bill today to begin the long process of reforming our health care system, expanding coverage, and bringing quality health care to all our people. I hope that we can move quickly in the near future to discuss ways of making the National Practitioner Data Bank effective, and to consider related legislation to prevent medical malpractice and give consumers the confidence that unethical or illegal practitioners are not hiding out in the medical system, waiting to prey on their next unsuspecting patients.

Mr. CUMMINGS. Mr. Chairman, an historic American tale teaches us the traits necessary to follow the road to your dreams—a brain, a heart and courage. Today, we must use these traits to knock down the GOP Substitutes that are roadblocks placed on our path toward making the American people's dream of a meaningful patients' bill of rights a reality.

As lawmakers, we have a duty to use our brains and hearts, and to have the courage:

To knock down GOP roadblocks to expanded access to specialists who have the requisite expertise to treat patients;

To knock down GOP roadblocks to ensuring that individuals have access to emergency care, without prior authorization, if a ''prudent lay person'' deems it an emergency;

To knock down GOP roadblocks to increased access to prescription drugs through participation of plan physicians and pharmacists in the development of any drug formulary;

To knock down roadblocks to prohibiting gag rules that would allow patients to be informed of all of their treatment options; and

To knock down roadblocks to holding health plans accountable for decisions about patient treatment that result in injury or death.

To knock down roadblocks to allowing provisions, as requested by the Democratic leaders on the bill, in the bipartisan managed care legislation that would ensure that the Social Security Trust Fund is protected by including revenue offsets.

These GOP roadblocks have been placed to steer us down an alternate route filled with hidden, poisonous traps and leading to a dead end, with no real access for the 837,000 Marylanders and 44 million nationwide who are uninsured.

So, I urge my colleagues—use your brain, listen to your heart, and have the courage to pass the managed care reform the American people have mandated.

Knock Down the GOP substitutes and support the Norwood-Dingell bill.

Mr. CROWLEY. Mr. Chairman, I rise today in support of H.R. 2723, the Bi-partisan Consensus Managed Care Reform Improvement Act of 1999 and against any attempts to weaken its provisions. I also want to express my dismay at the political maneuvering by the Republican leadership to defeat this bipartisan legislation before it even came to the floor.

Mr. Chairman, the American public needs our help. All too often, a constituent will contact my office at the end of their rope. They, or someone in their close family, will have received a devastating medical diagnosis. They attempt treatment, only to have their insurance company deny coverage—coverage they are entitled to! Our constituents are facing a declining quality of care and have basic medical decisions being made not by qualified medical professionals, but by insurance plan administrators. As United States Representatives, we cannot allow this to continue.

Quality health care is a right, not a privilege. Those who have coverage by a Health Maintenance Organization deserve better than bureaucratic decisions. Additionally, access to health care is something that should be available to all Americans, not just those who can afford it. I am proud to be a cosponsor of the Norwood-Dingell bill which extends patient protections to the 161 million Americans who are covered by private health plans. Norwood-Dingell will make health plans accountable, offer more protections for women and children and prohibit gag rules. Overall, the Norwood-Dingell bill provides comprehensive reform which assures individuals of emergency services coverage; access to specialty care; chronic care referrals; ob/gyn services; continuity of care' access to clinical trials; access to prescription medications; internal and external appeals processes plus a utilization review; anti-gag and provider incentives; payment of health claims in a timely manner; paperwork simplification; and importantly, insurer liability—giving patients the right to sue over

insurance made treatment decisions that result in injury or death.

The three substitutes do not provide the comprehensive reforms contained in H.R. 2723. The Boehner substitute fails to cover all privately insured Americans. It leaves out millions in the individual market. Additionally, its external appeals process does not provide for an independent and timely appeal. The Boehner substitute does not provide for access to specialty care. It provides for clinical trials for cancer victims, but not for those suffering from other debilitating diseases, such as multiple sclerosis. And finally, the Boehner substitute does not allow patients to hold their plan accountable if it causes injury or death. It allows HMOs to remain immune from accountability for their actions.

The Coburn substitute grants sweeping judicial powers to private medical review bodies to determine harm and proximate cause, with no rights or due process requirements for the patient. The finding by the entity would not be subject to challenge or appeal, but would become legally binding in all judicial venues. Additionally, the Coburn substitute purports to add an untested federal remedy to the current range of judicial remedies under both ERISA and state law for cases involving patient injury. But the substitute would effectively give managed care companies a complete shield against any further medical malpractice cases under state law. Finally, the Coburn substitute only permits actions against individuals who have the authority to make the final determination of coverage. This provision could shield from liability a utilization review company under subcontract to the HMO, thereby undercutting any incentive to ensure better utilization review procedures.

Lastly, here is the Houghton substitute, which is basically Coburn-Shadegg revisited. It would strike the Norwood-Dingell state court accountability and put in its place a very limited and untested federal cause of action. The Houghton substitute does not allow for punitive damages at all, even compensatory damages are unavailable if the external review agrees with the HMO. The Houghton substitute in effect creates yet another system for hearing these claims by also allowing for binding arbitration.

Mr. Chairman, the only true Patient's Bill of Rights is contained in the Norwood-Dingell Bi-Partisan Consensus Managed Care Improvement Act. I urge all my colleagues to put aside the partisanship and the political maneuvering and institute reforms that will help the majority of Americans.

Mr. LEVIN. Mr. Chairman, I rise in strong support of the Dingell-Norwood ''Patients' Bill of Rights'' legislation.

Well, here we are again. More than a year has passed since the last time the House debated HMO reform. Last year the decision before the House was between the half-hearted, watered-down approach offered by the House Leadership and a strong, enforceable patients' bill of rights that would empower patients and allow health care professionals to perform their jobs without interference from the health insurance bureaucracy.

The choice before the House is the same today. We can vote for real HMO reform by voting for the Dingell/Norwood bill or we can vote for something much less. Medical decisions should be made by doctors and patients, not by insurance companies. In addition, HMO's must be held accountable when their decisions cause a patient's injury or death. A right without an enforceable remedy is no right at all.

The story of one of my constituents, Timothy, painfully illustrates the importance that this House pass the right reform package. After an accident at work, Timothy developed a rare nerve disorder, Reflex Sympathetic Dystrophy. People with this disease experience extreme pain when their skin is blown or even touched. If the condition is diagnosed and treated within the first few weeks, the patient can usually expect great relief and often complete remission of the disease.

Reflex Sympathetic Dystrophy is treated with special injections given by an anesthesiologist. Both Timothy's primary care physician and orthopedist agreed that this treatment was needed.

When Timothy went for treatment he was told his managed care plan would not cover the injections. He was told that the HMO was not confident that his condition warranted treatment and an appointment would be made to get a second opinion.

The appointment did not occur for 3 months! By that time it was too late for treatment. Timothy was in constant agony. Some months later, Timothy had a massive heart attack and died. His cardiologist found no sign of heart disease, and suspected that the heart attack was directly related to the stress and pain caused by his condition—a condition that may have been cured with prompt medical treatment.

Today we have a chance to do what the Congress failed to do last year and give the American people a strong, enforceable Patients' Bill of Rights. Vote for real reform and support Dingell/Norwood.

Mr. EVANS. Mr. Chairman, I rise to express my strong support for H.R. 2723, the Bipartisan Managed Care Improvement Act of 1999.

Today, Democrats and Republicans have joined together to advocate for reforms that will restore control over medical decisions to patients and doctors and make the health care system more responsive for all Americans.

The Bipartisan Managed Care Improvement Act institutes meaningful, common sense reforms of managed care. It will ensure that people may seek care in emergencies without having to wait for prior authorization from an insurer. It will guarantee that patients who need specialized care will have access to appropriate specialists. It will improve the quality of care for women and children, allowing women to see obstetrician/gynecologists without referral and ensuring that children can see pediatricians as their primary care physicians and pediatric specialists if necessary.

This bill establishes real accountability for health insurance companies when they make medical decisions, accountability that has been lacking under ERISA. With a strong, two-stage process of internal and external appeals for denial of care, patients will now have recourse to challenge decisions and have their cases resolved by an independent board of health professionals. And in those extreme cases when a patient suffers injury or death due to denial of care by a health plan, patients and their families will have the same access to state courts for damages that is currently available to all patients whose plans are not covered by ERISA.

I am also proud that H.R. 2723 will help people in the most dire of situations receive coverage for routine care during clinical trials. This issue was brought to light for me by a constituent, LaDonna Backmeyer, who is bravely fighting a rare form of cancer, renal leiomyosarcoma. LaDonna has participated in a clinical trial at a National Cancer Institute-designated Comprehensive Cancer Center, and under the bill, the costs of routine care during a clinical trial would be covered. I want to thank LaDonna for educating me, for inspiring all of us with her courage, and for being willing to speak out for the need for reform of our health care system.

At its core, this bill is about giving back control over medical decisions to real people and their doctors, and restoring faith in the American health care system as the best in the world. I urge my colleagues to vote for H.R. 2723 and to enact these critical reforms.

Mr. COYNE. Mr. Chairman, it is time for Congress to act on the Bipartisan Managed Care Improvement Act. American families have already waited far too long for us to pass these common-sense consumer protections.

Over half of American workers are not given a choice of health insurance plans by their employer. Under current law, many of those workers and their families have no place to turn if they are harmed or killed by their HMO's decisions.

The consumer protection bill we are currently debating would guarantee basic health rights for these workers. If this bill passes, families will know they can see specialists when they need to, appeal unfair denials, and seek emergency care when they experience severe pain. Doctors will be free to tell their patients all the options and to make medical decisions without fear of retribution from health plans. Health plans will be accountable if they make medical decisions, just as doctors are now.

Some would suggest that this bill undermines our long-held goal of health coverage for all Americans. They say that if we don't let HMOs reduce the quality of health care, health insurance will be too expensive for families to afford. They would have us believe that a health insurance plan that protects basic health care rights is out of reach for the average American. That is wrong. It is our responsibility to find a better way to help the uninsured than telling them to buy bad health coverage, coverage which may not be there when they need it.

I urge my colleagues to join me in supporting this important legislation. By enacting this legislation, we will make sure that health insurance coverage is worth having. Once we have done that, I hope we can work together on a bipartisan basis to extend that coverage to every American.

Mr. SANDLIN. Mr. Chairman, I rise in strong support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 introduced by Representatives Norwood and Dingell. This is the only bill that would enact consumer protections through responsible health care reform.

The Norwood-Dingell managed care bill provides Americans with many important patient protections such as access to needed health care specialists; access to emergency room services when and where the need arises; assurance that doctors and patients can openly discuss treatment options; an external, third-

party appeals process for service denials; access to personal medical information; legal redress for injury or death due to the denial of care covered under a managed care plan. I am a cosponsor of H.R. 2723 because it will provide comprehensive and enforceable protections that American's health care consumers demand and deserve.

By 1997, more than 80 percent of privately insured Americans were enrolled in managed care plans-up from just 13 percent in 1987. As we increase access to health care, we must not allow unqualified parties to make critical decisions about patient treatment. Patients needed to feel confident that their doctors are giving them all necessary information, without concern of retaliation by a health insurance provider.

Insurance bureaucrats want to tell patients they know medicine better than their doctors. Let's tell them they do not. The Norwood-Dingell bill would prohibit health plans fro silencing any health care professional from advising a patient about the patient's health status or available treatment, regardless of whether the plan covers such a treatment or care.

Americans also deserve access to emergency care services. Let me give an example of why this protection is so important. Jess Reed suffered a stroke at home. He was rushed to the closet hospital. The HMO insisted he be taken to another hospital, causing a 2–3 hour delay in treatment. Delay seriously exacerbated his condition and prevented full recovery from his stroke. The Norwood-Dingell bill would require health plans to cover the emergency care of a ''prudent layperson'' in any hospital emergency room, without prior authorization.

Another reason I support the Norwood-Dingell bill is to assure patients access to necessary prescription drugs. Prescription medications should not be one-sized-fits all. For plans that use a formulary, Norwood-Dingell provides that beneficiaries must be able to access medications that are not on the formulary when the prescribing physician dictates.

One of the most important distinctions in this debate is whether or not we truly hold health plans accountable. Opponents of real accountability argue that patients who have been unfairly denied health care should be limited to external appeals. But external reviews is simply not enough to protect patients against the worst managed care abuses. Accountability is the ultimate deterrent and is an essential last resort when all else fails. Only legal accountability gives injured patients what they need to ensure that managed care does the right thing and puts patients first. And only Norwood-Dingell ensures legal accountability. Such accountability exists in all other sectors of our society, yet we continue to exempt health plans.

Health plans are not currently held accountable for decisions about patient treatment that result in injury or death. Currently, ERISA preempts state laws and provides essentially no remedy for injured individuals whose health plans' decisions to limit care ultimately cause harm. If the plan was at fault, the maximum remedy is the denied benefit itself. Norwood-Dingell would remove ERISA's preemption and allow patients to hold health plans accountable according to state law. However, plans that comply with an external reviewer's decision may not be held liable for punitive damages. Additionally, any state law limits on damages or legal proceedings would apply.

My home State of Texas was the first State in the Nation to pass a patient protection act. But because many large employers insure their workers themselves, giving them Federal protection from State insurance laws under ERISA, only about 25 percent of Texans are covered by the act. It is fundamentally unfair to deny this group of individuals the rights my State has afforded to all other Texans who do not belong to an ERISA health plan. Norwood-Dingell would allow Texas' liability laws and patient protections to apply to all Texans.

The liability provision in Norwood-Dingell also protects employers from liability when they were not involved in the treatment decision. It explicitly states that discretionary authority does not include a decision about what benefits to include in the plan, or a decision not to address a case while an external appeal is pending or a decision to provide an extra-contractual benefit.

Now, I have heard a great deal of rumbling about the impact of Norwood-Dingell on health care costs. During the debate in the Texas Capitol, business and insurance groups routinely warned that costs would skyrocket. In fact, Texas' health insurance premiums continue to trail the rest of the country even though our fellow Texans enjoy some of the most stringent patients' rights laws in the country. Opponents said, repeatedly, that holding HMOs accountable for harming patients would provoke a flood of lawsuits. The reality is that no more than five suits have been filed since the law took effect in September 1997.

Instead of defending good, comprehensive, enforceable patients' rights legislation to insurance bureaucrats, we should be firing some questions of our own at the insurers. If managed care is supposed to make health care more affordable and therefore more available, why is it that, as HMO penetration increased in Texas, the percentage of working uninsured increased proportionately? Other than skyrocketing CEO compensation, where have all the millions of dollars in profits gone?

Mr. Chairman, it's time to stop the insurance companies from putting profits above patients. I urge my colleagues to vote for H.R. 2723, the Norwood-Dingell bipartisan managed care reform bill.

Mr. POMEROY. Mr. Chairman, I rise today in support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999.

Mr. Chairman, I believe that this legislation would ensure genuine accountability of health plans and put patient care ahead of profits. Today Congress has an historic opportunity to take steps to ensure that doctors and patients are in charge of health care decision-making.

I do have serious concerns, however, that the spending offsets originally designated in this legislation were not permitted under the rule. Managed care consumer protections must be enacted, but not while spending the surplus generated by the Social Security trust funds. While I support this legislation today, I certainly hope that spending offsets can be designated during the conference process, and I will not support a conference agreement that does not do so. Congress can and should ensure both quality health care and a secure retirement income for our nation's seniors.

Ms. KILPATRICK. Mr. Chairman, I rise today in strong support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act, also referred to as the Norwood-Dingell Act. We must help the poor, the uninsured, and all American citizens, in obtaining more accessible and more affordable health care. Over 60 percent of the U.S. population and over 75 percent of insured employees were covered by some form of managed care in 1997, and the numbers are growing. H.R. 2723, the Bipartisan Managed Care Improvement Act would enact important changes that are necessary to improve managed care.

Individuals should be assured that if they have a health emergency, the necessary services will be covered by their plan. The Bipartisan Consensus Act states, individuals must have access to emergency care, without prior authorization, in any situation that a ''prudent lay person'' would regard as an emergency. Patients with special conditions must have access to providers who have the requisite expertise to treat their problem. This Act allows for referrals for enrollees to go out of the plan's network for specialty care if there is no appropriate provider available in the network for covered services. It provides a process for individuals to select a specialist when they are seriously ill or require continued care by a specialist. It provides direct access to ob/gyn care and services, as well as access for children to pediatric specialists. The Bipartisan Consensus Act provides special protections for pregnancy, terminal illness, and individuals on a waiting list for surgery. The Act prohibits plans from gagging doctors regarding the discussion of treatment options with their patients. Consumers have the right to know all of their treatment options. In addition, patients should be protected against disruptions in care due to a change in plan or a change in a provider's network status.

The Bipartisan Consensus Act provides for a strong and efficient review process, using the insurer's internal appeals process, while ensuring that a health professional performs the review. If the patient is denied care in a decision by the plan's internal appeals process, they can then appeal to an external review body that is independent of the health plan. This review process should ensure excellent care, as grievances are effectively reviewed.

The Republican Health Care Access Bill does not improve health care access to those who most need improved access to health care. It does not improve the affordability of health care unless you have the extra cash to pay up front. It does not help our poor. It digs into our social security surplus by an estimated $48 billion over ten years. It does not improve access to preventative health care.

The Bipartisan Consensus Act protects patients and strengthens assurances that managed care programs will improve access to emergency care, specialists and doctor information on treatment options. Furthermore, the Act provides for an improved review process that works with current insurers' appeals processes. The Act is supported by doctors. It is supported by patients. And I support it. I urge my colleagues to join me in voting in support of the Bipartisan Consensus Managed Care Improvement Act. We must protect the health care needs of our patients and constituents, preserve social security, and ensure adequate access to health care for the poor.

Mr. FILNER. Mr. Chairman, I can't believe how beholden to special interests the majority is. We are presented with a bipartisan bill,

H.R. 2723, which is supported by the American Medical Association and 300 other organizations, yet the Republican leadership is trying to sink it.

Our bill offers vital patient protections in a way that has been shown to not raise costs. H.R. 2723 will return control of our health care to physicians. We, as patients, will have access to specialists and an appeals process. And managed care operations will be held accountable for any decisions that endanger our health. These important provisions must be embraced, not feared. Mr. Speaker, I urge support for H.R. 2723.

Mr. LARSON. Mr. Chairman, I rise today in support of a Patient's Bill of Rights. I had hoped, however, that an amendment version of Connecticut's Patient's Bill of Rights could have been considered. Unfortunately, the debate here has been hamstrung by the rules of the House, which makes it nearly impossible to have a policy debate on the issues, and prevents amendments from being offered that would enable the legislative process to respond to the primary concerns of patients.

In Connecticut, the Legislature demonstrated that if you work in a bi-partisan manner you can write legislation that is balanced, and gets to the heart of the matter, which is the protection for the patent, and thus, provide the care that is needed. Moreover, what most people don't understand is that under current law, HMOs can already be sued.

The vote today should be about a Patient's Bill of Rights, but in many respects it is about the tactical differences between various partisan proposals.

I remain committed to the fundamental principle that has guided me, which is that doctors and patients should determine how patients are treated and cared for, not bureaucrats. I have always tried to level the playing field for patients, and so has Connecticut.

The HMOs should be held accountable and liable for their actions without opening a Pandora's box of unlimited litigation. Companies in my home state of Connecticut have operated under the Connecticut law and are to be commended for their compliance. Connecticut has demonstrated that it can work.

Managed care is not without its problems, and we will need to work toward the goal of improvement. Fortunately, there are many fine people who represent the insurance industry who are working every day toward the goal, so that we can improve the health care delivery, control costs, and help the patient and family in time of need.

Ms. RIVERS. Mr. Chairman, while I plan to cast my vote today in favor of the protections given by the Patients Bill of Rights, I am greatly concerned with the partisan politics that have worked great mischief in the preparation of this proposal. Specifically, I condemn the House majority's manipulation of the rules process to exclude the funding mechanism advanced by the bipartisan sponsors of this bill. In light of this indefensible action by the opponents of the Patients Bill of Rights, H.R. 2723 comes before the House without compensatory new revenues or budget offsets attached to it. In short, it is unclear where the dollars to implement this bill will come from. And, inevitably, the cynical and strategically constructed attack of ''spending social security money'' will be leveled against those who vote in support of these protections. I cannot emphasize enough how dishonest, manipulative, and irresponsible the House majority strategy is. It puts a serious initiative support by the majority of Americans at risk for no other reason that partisan politics. This is among the most shameful things I have witnessed during my time in Congress.

I am voting yes on H.R. 2723 because I support the protections contained in it. I am not voting in favor of invading the Social Security Trust Fund. I have made a practice of voting against unfunded proposals, sham emergency spending, and budget gimmicks of all types. In this particular case, I firmly believe the Senate will not behave in the egregious manner of the House. I believe the Senate will attach appropriate funding to this bill before it returns to the House. If that is done, I will happily vote to send H.R. 2721 on to the President for his signature. If it is not done, I will unflinchingly vote against it.

Mr. DAVIS of Florida. Mr. Chairman, I rise today in strong support of the Bipartisan Consensus Managed Care Improvement Act, H.R. 2723. I commend Congressmen DINGELL and NORWOOD for putting aside partisan rhetoric and developing a bipartisan compromise designed to provide strong patient protections and to ensure that managed care companies are held accountable for their decisions.

As a member of the Florida House of Representatives, I played an active role in writing the Florida law on managed care. I remain a strong supporter of our managed care system of health care, but I believe that changes are needed to the current system to make the insurance companies accountable to their patients and that medical professionals rather than insurance companies' bureaucrats are making decisions on health care treatment.

The Norwood-Dingell bill provides strong patient protections, many of which have already been implemented in states throughout this country, including my home state of Florida. I applaud these very needed protections. However, the focus of this bipartisan bill is by far its emphasis on holding managed care companies accountable for medical treatment decisions through a new independent review process and providing patients access to state courts to ensure the enforcement of the decisions of the independent review panel. The Norwood-Dingell bill is the only option available to this House that will remove the preemption currently given to managed care health plans covered under the Employee Retirement and Security Act (ERISA).

Throughout the debate on managed care reform, we have all heard extensive arguments about the impact that providing patients the right to hold their health plans accountable will have on monthly premiums. I do not believe, however, that monthly health insurance premiums will significantly increase as a result of passage of the Bipartisan Consensus Managed Care Improvement Act of 1999. The liability provisions contained in this legislation are very similar to those included in a law passed by the State of Texas. In the two years since the enactment of their managed care law, Texas has experienced only minor increases in health insurance premiums.

We have also heard that if we pass any liability provisions our court dockets will explode as patients rush to sue their managed care plans. Again, I refer to the experience in Texas—where in the last two years only five lawsuits have resulted from their law allowing patients to hold their managed care plans accountable. Let me repeat that statistic, from over four million Texans who are covered by health maintenance organizations (HMOs) only five lawsuits have been filed as a result of the Texas managed care law.

I think it is commendable that unlike the tactics in this body, the Texas Legislature rose above partisan politics and worked in a bipartisan manner to ensure the safety of their citizens participating in managed care plans.

I urge my colleagues to think of our constituents who are being denied treatment for very serious illnesses. I urge you to think of our constituents who are seriously injured or die as a result of an insurance company clerk either denying or delaying necessary medical treatment.

I strongly urge my colleagues to support meaningful managed care reform. Support the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act.

Mrs. MINK of Hawaii. Mr. Chairman, I rise to express my support for H.R. 2723, the ''Bipartisan Consensus Managed Care Improvement Act of 1999.''

Everyone should feel confident and assured that their managed care organization will fulfill what is perceived by the general public to be basic and reasonable health coverage in times of need. However, what patients consider reasonable, has often been called unjustified or unnecessary by health plans. These frequent disputes have resulted in a stream of cases where patients and their families are forced to jump through hoops, chase carrots, and fight tooth and nail, for benefits they felt they outright deserved in the first place. This is wrong.

H.R. 2723 establishes basic rights for patients when dealing with managed care organizations and will help to restore public confidence and trust in their doctors and health care professionals. The bill will facilitate patients' access to care, improve doctor-patient relationships, provide patients with defined rights to appeal coverage denials, and hold health plans accountable for erroneous coverage decisions that have adverse effects on patients' health.

First, the Bipartisan Consensus Managed Care Improvement Act tears down barriers to health care access. The bill requires plans to improve access by providing coverage for services that the general population commonly feels to be the most basic of benefits but plans often fail to provide. These benefits include: emergency care in any hospital emergency room, including outside of the health plan, and without prior authorization; access to specialists for patients with special conditions; access to outside specialists if none are available in the plan; the option of going outside of the plan for care as long as the patient agrees to pay any additional costs; and permitting patients with special conditions to have continued access to their specialists when the plan terminates the specialists or the plan is terminated.

The bill further improves access by eliminating prerequisites of going through a gatekeeper before seeing certain specialists. Specifically, women will have direct access to Ob-Gyns and children could have pediatricians as their primary care providers. This will eliminate the burdensome and often unnecessary step of visiting a general practitioner for something that should obviously be handled by one of these specialists.

Furthermore, H.R. 2723 will facilitate patients' access to the latest health care treatments. It requires health plans to: allow patients to participate in clinical trials while the health plan pays for routine patient costs associated with the trials; and provide access to medications that are not on the plan's drug formulary when it is prescribed by a physician.

Second, the bill would restrict certain managed care plan practices that interfere with doctor-patient relationships. Health plans would be prohibited from: restricting health professionals from advising a patient about a treatment option regardless of whether the plan covers the treatment; providing doctors with incentives to limit medically necessary services; and from retaliating against health care professionals who advocate on behalf of patients or disclose information about quality of care to regulatory or accrediting agencies. Freeing doctors and health professionals from these pressures imposed upon by health plans will enable them to practice medicine as it should be, without outside intervention.

Third, the bill would provide patients with appeal rights when coverage for treatment is denied. Health plans would be required to meet certain guidelines when considering treatment authorizations and provide patients and their families with specific appeal options. If coverage is denied, the bill provides for internal appeal processes involving a health professional, who was not involved in the original decision, followed by an external appeals process based on objective standards of professional medical practice. The bill sets time limitations on how long the plan can take to render a decision in each step of the appeal process and requires that the reasons for the denial be communicated to the patient. Patients and their families are too often bewildered by the complex procedures they must endure to obtain coverage for care they thought was included in their health care insurance. These new rights will provide relief to all families in these situations and will accelerate the appeals process.

Finally, the bill would enable patients who are wrongfully denied care by health plans governed by the Employee Retirement Income Security Act (ERISA) to sue their plan for damages. Persons in such situations currently may only sue to recover the cost of the care but not for damages. It is time that health plans be held accountable for the adverse effects their decisions have on patients' health and lives.

I have always felt that health plans should not impede access to health care but rather they should facilitate it. H.R. 2723 will provide patients with the basic rights necessary to assure that they are treated fairly when dealing with managed care organizations. No one in the United States should ever again be forced to face managed care organizations without these rights and I urge immediate passage of H.R. 2723, the ''Bipartisan Consensus Managed Care Improvement Act of 1999.''

Mr. MORAN of Virginia. Mr. Chairman, I rise in strong support of the Dingell-Norwood bill and in opposition to the substitute alternatives. I am not going to address the specifics of the bill because I am confident my colleagues will do a good job of that but instead I want to just share with you the kind of trauma that I hope this bill will address.

I received a letter from one of my constituents, a police officer in Alexandria, who was compelled to write about her problems with her own managed care company. ''The entire ordeal was hideous.'' she wrote. Kris Gulden suffered a spinal chord injury in an accident which resulted in paralysis below the waist. After the accident, Kris began the grueling work of occupational and physical therapy that can make such a difference in quality of life. Her therapists told her that her hard work was paying off and that more therapy could continue to make a difference. Unfortunately, her managed care company disagreed. They refused to extend the standard 90 days of coverage through their internal appeals process because it was a ''quality of life issue'' and not a ''life and death issue.'' Kris appealed as many times as she could through the managed care organization's internal appeals and then had no further recourse.

Fighting over late bills and arguing with the managed care company became the focus of her life when she should have been focusing on exercise and therapy that would have made her stronger. Fortunately, Officer Gulden has a compassionate employer in the City Manager of Alexandria who helped her deal with the unpaid bills, and a compassionate family and community who helped her raise additional money for further therapy. But she wrote because she doesn't want to see the same thing happen again to anyone. ''It's ridiculous that what most prevented me from getting better was my HMO.'' she wrote:

> Not being able to walk, not being able to stand up to take a shower, living with abnormal bowel and bladder function . . . in general, living with a disability is a walk in the park compared to what they put me through. Truly, dealing with them has been the worst part of this whole ordeal.

Finally, the most important point of Kris' letter was to say that ''I am vehemently opposed to any compromise on the Patient's Bill of Rights.'' I close by asking my colleagues to do what Kris, and so many of our constituents like her wish. I urge you to support the Dingell-Norwood bill without amendment.

Mr. VENTO. Mr. Chairman, I rise today in support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. I'm pleased to have joined as a cosponsor of this measure, which acknowledges that all Americans deserve a strong standard of protection in managed care and other health insurance programs.

There is general agreement that managed care reform should address the fundamental concerns of all American families that have health insurance. Access to specialty care, emergency care, clinical trials and continuity of care are just a few of the widely lauded provisions of this proposal. In addition to these core access provisions, H.R. 2723 will also ensure that medical judgments are made by medical experts.

Although managed care has played an important role in helping to efficiently utilize finite health care resources, managed care policy needs more balance and accountability. It is time for Congress to remove the current ERISA shield and permit the judicial system process to hold health care plans fully responsible for their negligent decisions and actions whether intra stat or interstate health insurance.

Mr. Chairman, meaningful reform should include meaningful protections. Only a national policy can address the deficiencies of current law, which leaves too many patients without adequate recourse. While critics portray this legislation as the precursor to a proliferation of capricious lawsuits, I have more faith that the American public and legal system which are interested foremost in timely and appropriate medical care, not litigation. We need not invent a new medical police force, rather just permit the time tested legal system and rights of the individual to reasonable due process.

Health care consumers should have aces to necessary medical treatment, as well as objective remedies if a health plan decision is alleged to cause harm. During a time of unprecedented prosperity, H.R. 2723 reaffirms that equity and quality should be the unquestioned foundation of our health care system. I urge my colleagues to support this sound managed care reform proposal encompassed in the Dingle-Norwood measure and as we defeat the gauntlet of amendments and detours to sound health insurance finally vote to pass the base bill, the patients healthcare bill of rights.

Mr. McGOVERN. Mr. Chairman, I rise today in strong support of the Norwood/Dingell Bipartisan Consensus Managed Care Improvement Act.

Today we are debating a very simple issue: whether we will provide the proper protection for patients who pay good money for their health insurance. We have all heard the horror stories from patients, doctors, nurses and employers about the need to improve basic HMO coverage. This bill will do that.

We are addressing basic rights that patients should receive from their health plan—the right to appeal to an external review panel, the right to have access to a gynecologist or other specialist, and the right to hold an HMO accountable for its decisions. The Norwood/Dingell bill provides the strongest patient protections and holds HMOs accountable for their actions, just like doctors. The Republican amendments offered today are insurance protection bills and do not protect the patient.

The bottom line must not dictate the amount or quality of car a patient receives. Profit margins should not dictate whether an injured person can go to the emergency room or visit a medical specialist. This bill will ensure that patients receive the best care and coverage from their HMO. We owe our constituents nothing less.

Mr. Chairman, I urge my colleagues to support this bill, vote against the poison pill substitutes and vote for Norwood/Dingell.

Mr. BENTSEN. Mr. Chairman, I rise today to express my strong support for H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 or the Patient's Bill of Rights, that is sponsored by Representative NORWOOD and Representative DINGELL. Today, we will consider four different approaches to reform managed health care plans. I am a strong supporter and co-sponsor of H.R. 2723 because I believe that this bill provides essential consumer protections to all Americans. I urge my colleagues to reject all three versions of the Republican Leadership sponsored legislation, and vote for the real Patients' Bill of Rights.

Today, there are more than 160 million Americans enrolled in managed care plans, such as Health Maintenance Organizations (HMOs). Of these enrollees, approximately 125 million Americans are enrolled in managed care health plans that are governed by federal law, the Employee Retirement and Insurance Security Act (ERISA). Under ERISA,

these Americans cannot seek legal remedy if their health plans denies or delays access to care. In a time when many Americans believe that their health plans are arbitrarily denying care and services, the Norwood-Dingell bill would ensure that health plans must provide an appeals process to their decisions. Under the Norwood-Dingell bill, patients would be guaranteed the right to seek both an internal and external appeals process with a deadline for decisions to be made. If both of these appeals are denied, consumers would have the right to hold their plans accountable for their decisions through a legal case in our court system. In my state of Texas, where a state law has been in effect for two years, our experience has been that these external reviews have been decided on behalf of consumers in 50 percent of these cases, while the rest of these cases have been decided on behalf of the health plans. We have also seen that very few consumers have decided to use their new right to sue, with very few lawsuits filed to date.

The Norwood-Dingell bill provides critical reforms that patients need. It guarantees that decisions will remain in the hands of doctors and nurses, not insurance companies. It guarantees access to specialists and ensures that doctors and nurses can talk freely with patients without interference from their health plans. The Norwood-Dingell bill also prohibits the use of financial incentives to limit medical care. The Norwood-Dingell bill also ensures that patients can seek care in emergency rooms without prior approval and when they are suffering severe pain.

I would like to highlight one main difference between these bills. The Norwood-Dingell bill also includes an important provision to ensure that all Americans can enroll in cutting-edge cancer clinical trials if they need them. As the sponsor of legislation to ensure that Medicare beneficiaries can enroll in cancer clinical trials, I believe we must guarantee this right to ensure that patients have access to the best, most-advanced care. As the Representative for the Texas Medical Center, where many of these cancer clinical trials are conducted, I believe that this guarantee must be included as any consumer-protection. The Norwood-Dingell bill would require managed care plans to pay for the routine costs associated with cancer clinical trials.

I wish to be clear why I opposed the House Rule that was imposed by the Republican majority on this bill. This rule was fatally flawed in many respects. Most important was its failure to include offsetting provisions to pay for the costs associated with this bill. This is important because it would ensure that this bill if fully paid and would not add to the on-budget deficit. I will be supporting final passage of H.R. 2723 in order to ensure that this federal uniform consumer protections will be provided to managed care enrollees. I am pleased to note President Clinton's letter of October 7 in which he states that he will not sign a bill whose costs are not fully offset. Indeed, it is my hope during the conference process that these offsetting provisions can be added to this necessary bill. It is my understanding that the Senate bill on managed care reform legislation already includes these offsetting provisions and therefore this issue could be addressed as part of the conference process.

I also opposed the rule because it linked final passage of H.R. 2723 to another bill, H.R. 2990, a bill providing new tax deductions for health care costs. Although I support many provisions included in H.R. 2990, such as providing 100 percent tax deductibility for health insurance costs for self-employed persons, yesterday I opposed H.R. 2990 because of several provisions included in H.R. 2990 such as Association Health Plans (AHPs). These AHPs plans would not be subject to state insurance regulations or to the federal ERISA law. I am concerned that we would be establishing a loophole for employers to create health insurance plans without adequate regulations and solvency standards. Although I will support final passage of these two combined bills if the Norwood-Dingell bill remains in tact, I want to express my strong concern that this tax legislation should not have been linked to the Patient's Bill of Rights, I would have preferred that these two bills were considered separately, on their own merits. However, we in the House of Representatives will not have this option.

I urge my colleagues to reject the three Republican alternative bills and vote for the Bipartisan Managed Care Improvement Act.

Mr. DIXON. Mr. Chairman, I rise in strong support of H.R. 2723, the Dingell-Norwood Bipartisan Consensus Managed Care Improvement Act of 1999, and in opposition to the substitute amendments being offered. I am proud to be a cosponsor of this important legislation, which will protect consumers in managed care plans.

I have heard from many residents of California's 32nd Congressional district as they become increasingly skeptical of the motives behind the treatment decisions made by their health plans and fearful of the consequences of those decisions. Fortunately, the accountability provisions in the Dingell-Norwood bill will allow patients to hold health plans liable when a decision about patient treatment results in injury or death. At the same time, the bill protects employers who provide health insurance from liability when they are not involved in medical treatment decisions.

The Dingell-Norwood bill ensures that health care decisions are made by medical experts, not insurance company administrators. The bill offers protection important to my constituents, including access to needed health care specialists, assurance that doctors and patients can openly discuss treatment options, and access to a timely internal and external appeals process when a health plan denies or delays doctor-prescribed care.

Mr. Chairman, the Dingell-Norwood bill is an excellent, bipartisan response to the problems facing health care consumers. The substitute measures masquerading as patients' rights legislation which will be offered by opponents of this bill do not offer Americans the patient protection they are asking for in their managed care plans. The House cannot squander this chance to pass meaningful managed care reform legislation; it is essential that we pass the Dingell-Norwood bill and reject any attempt to weaken its important provisions.

Mr. CAPUANO. Mr. Speaker, I rise in support of The Bipartisan Consensus Managed Care Improvement Act of 1999 sponsored by Representatives NORWOOD and DINGELL. This bill modeled after the Democratic Patient Bill of Rights, would ensure strong patient protections for people enrolled in Health Maintenance Organizations.

I strongly oppose efforts by the Republican leadership to dictate the debate by promoting a rule that is designed to kill the Norwood-Dingell reform bill. I urge my colleagues to oppose the rule as it attaches the Quality Care for the Uninsured Act to the managed care bill. While I support its intent to reduce the number of Americans who are currently without health insurance, the tax breaks contained in the legislation benefit the wealthy and would have little effect on working Americans who have no health insurance. According to the General Accounting Office, more than 32 million of the uninsured fall within the 0–15 percent income tax brackets. These tax deductions would do nothing to help them. H.R. 2990 is a poison pill that must be defeated.

The Bipartisan Managed Care Improvement Act of 1999 stands in stark contrast to H.R. 2990. H.R. 2723 offers real managed care reform by providing a comprehensive, enforceable set of consumer rights. Under current federal law, patients covered by private employer-sponsored health insurance are barred from suing health plans for damages caused by wrongful denials. No other industry enjoys such legal immunity. H.R. 2723 would close this loophole by giving consumers the right to sue health plans in state courts for injuries and deaths caused by improper denials of care. Furthermore, the bill guarantees patients' access to such critical services as emergency care, specialty care, clinical trials, as well as obstetrician and gynecological services for women. The Norwood-Dingell reform plan also would allow patients to choose their health plans and ensure the continuity of care when people change jobs.

It is time for Congress to address the issue of managed care reform. I have heard time and time again from my constituents in Massachusetts who support these rational HMO reforms that are designed to hold these organizations accountable for bad decisions. The Norwood-Dingell proposal represents an important step in overhauling managed care and enabling patients and their doctors to regain control of critical medical decisions. Doctors and patients know best—not HMO bureaucrats. I urge my colleagues to vote in favor of H.R. 2723 and pass meaningful managed care reform.

Mr. DOYLE. Mr. Chairman, I rise today in strong support of true and meaningful managed care reform that H.R. 2723 provides to all Americans. On behalf of my constituents back in Western Pennsylvania, I am proud to say I am a cosponsor of this vital bipartisan legislation which confronts the real problems many families face with HMO's

My colleagues, supporting this bill is the only responsible choice for us to make certain that everyone in America has proper access to medical care, can see a medical specialist when necessary, and will ensure timely access to emergency room care.

The Bipartisan Managed Care Improvement Act guarantees medical decisions are made by qualified health care professionals, and not by insurance company bureaucrats. It returns to the American people that which has been denied for too long; the right to hold managed care companies accountable if they choose to make decisions regarding medical treatment.

Lately, there has been much concern expressed regarding employer liability provision in this bill. The overwhelming majority of employers rely on a third-party health plan to make medical decisions. Under our bill, only organizations that make negligent medical

treatment decisions on individual claims are subject to liability. Independent legal analyses have confirmed that employer liability allegations are simply a non-issue. Managed care and insurance company bureaucrats have to stop shunning responsibility and realize that if they choose to make harmful discretionary treatment decisions, they will be held accountable by the public.

Most importantly, our bill would help all American families, like my constituent Ellen Gasparovic, who was diagnosed with breast cancer, only to have her HMO refuse to pay to have the cancerous lumps removed from her chest. Fortunately, Mrs. Gasparovic is doing well today, but only after having to endure needless financial and emotional hardships, all because of the negligence of her HMO.

It is on behalf of my constituents in Western Pennsylvania that I urge my colleagues to support H.R. 2723, and defeat any attempts to weaken this much needed legislation.

Mr. SANDLIN. Mr. Chairman, the insurance companies are at it again. They are trying to deceive the American public and in the process are attempting to take away a fundamental right of each and every American.

Clearly, a right without a remedy is absolutely meaningless. The Norwood-Dingell bill comes down to one word—Fairness. This bipartisan bill guarantees patient protections such as the right to choose the doctor that best serves your needs; the right to have medical decisions made by physicians and their patients, not HMO bureaucrats interested in the bottom line; the right to know that our families will be able to use the emergency room when needed; the right to obtain the information we need to make informed decisions about our own medical care.

But what if our families are denied medical service? What if a delay in a service causes harm to our children, our spouses, our parents, our families? Where is the fairness then?

The Norwood-Dingell bill would allow patients (or the estates of patients) who are injured or die as a result of their health plan's denial of care to sue the health plan in State courts for damages. This is what the real world calls accountability. That's fairness.

As a strong supporter of local control, I support the Norwood-Dingell bill because, unlike the Coburn-Shadegg substitute, it will not override protections already enacted by the states. These protections in state laws are currently applicable to all non-ERISA employer-sponsored health insurance and to individually purchased insurance. It is not fair that these protections afforded by the states to their residents, do not have the force of law for everyone in the state. The Norwood-Dingell bill would restore those protections to everyone by removing the preemption provision in ERISA so that state laws prevail.

In contrast, Coburn-Shadegg would continue to preempt state liability law with respect to health plans and insurers. Rather than maintain the states' traditional role in regulating insurance by allowing state causes of action, Coburn-Shadegg creates an entirely new federal cause of action.

Mr. Chairman, federal courts are already overburdened, particularly in light of the fact that the Republican majority in the other body refuses to confirm President Clinton's nominations to the bench, creating more than 50 vacancies in the federal courts. In addition to this obstacle, patients seeking redress for injury or death will have to wait in line behind drug dealers and thieves because the Speedy Trial Act of 1974 gives criminal cases priority in the federal court docket. Those criminal cases should be given priority because that's where they belong—in federal courts. Liability suits against HMOs, however, belong in state courts.

In my home state of Texas, we have 372 state courts, but only 39 federal courts. Obviously, Coburn-Shadegg creates so many barriers to a trial that patients will never want to exercise the right we are trying to give them. The Norwood-Dingell bill is the only bill that restores states' rights and provides patients with real protections under the law.

Will there be a flood of litigation if Norwood-Dingell is enacted? Hardly. In Texas, we enacted a law in 1997 creating an external appeals process and allowing lawsuits against HMOs. In the two years since that law took effect, only five lawsuits have been filed against health plans in Texas. That's five lawsuits in two years—hardly an explosion.

And contrary to all the allegations, there is no employer liability in the Norwood-Dingell bill. Clearly, employers cannot be held liable for the decisions of insurance companies and/or the decisions of others. This bill does not create a new cause of action. It simply removes the provision of ERISA that protects insurance companies from being sued. It specifically states that employers cannot be held liable unless they exercise discretionary authority—in other words, if the employer acts like a doctor and makes a medical decision on an employee's claim for benefits covered under the plan, then the employer must accept the accountability that comes along with playing doctor.

I should point out that I have met with many representatives of the business community and I have repeatedly asked them to bring language to me that they believe would prevent employers from being sued. I assured them that I would work with Mr. DINGELL and Mr. NORWOOD to address their concerns. Not one of those people has taken me up on my offer. That is because there is no employer liability in the bill. Their answer instead is to oppose the entire bill and threaten Members who support Norwood-Dingell.

So why are the insurance companies so worried about the liability provisions of Norwood-Dingell? Because legal accountability will force HMOs to provide quality care, and some insurance company bean counters are afraid that might mean a smaller profit margin for them. They argue that Norwood-Dingell would force managed care plans to practice defensive medicine that would increase their costs and cause them to raise our premiums. This argument is ridiculous and actually underlines the need for reform. Norwood-Dingell specifically provides that plans are not required to cover any services beyond those provided in the contract. So with the liability provision in place, costs of care should not increase significantly as these costs are already covered by premiums. Care is being paid for, but not provided. Legal accountability will give HMOs the incentive to provide a quality of care that patients have every right to expect.

Mr. Chairman, I urge my colleagues to support the Norwood-Dingell bill and reject this disingenuous attempt by insurance companies to pull the wool over the eyes of the American people.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. PEASE) having assumed the chair, Mr. HASTINGS of Washington, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2723) to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, pursuant to House Resolution 323, he reported the bill, as amended pursuant to that rule, back to the House.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

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

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 275, noes 151, not voting 8, as follows:

[Roll No 490]

AYES—275

Abercrombie	Coburn	Gibbons
Ackerman	Condit	Gilchrest
Allen	Conyers	Gilman
Andrews	Cook	Gonzalez
Bachus	Cooksey	Gordon
Baird	Costello	Graham
Baldacci	Coyne	Green (TX)
Baldwin	Cramer	Greenwood
Barcia	Crowley	Gutierrez
Barr	Cummings	Hall (OH)
Barrett (WI)	Danner	Hall (TX)
Bateman	Davis (FL)	Hastings (FL)
Becerra	Davis (IL)	Hefley
Bentsen	Davis (VA)	Hill (IN)
Berkley	DeFazio	Hilliard
Berman	DeGette	Hinchey
Berry	Delahunt	Hinojosa
Bilbray	DeLauro	Hoeffel
Bilirakis	Deutsch	Holden
Bishop	Diaz-Balart	Holt
Blagojevich	Dicks	Hooley
Blumenauer	Dingell	Horn
Boehlert	Dixon	Hoyer
Bonior	Doggett	Hunter
Bono	Dooley	Hyde
Borski	Doyle	Inslee
Boswell	Duncan	Jackson (IL)
Boucher	Edwards	Jackson-Lee (TX)
Boyd	Engel	Jefferson
Brady (PA)	Eshoo	Jenkins
Brady (TX)	Etheridge	John
Brown (FL)	Evans	Johnson, E. B.
Brown (OH)	Farr	Jones (NC)
Callahan	Fattah	Jones (OH)
Canady	Filner	Kanjorski
Cannon	Foley	Kelly
Capps	Forbes	Kennedy
Capuano	Ford	Kildee
Cardin	Frank (MA)	Kilpatrick
Carson	Franks (NJ)	Kind (WI)
Castle	Frelinghuysen	King (NY)
Chambliss	Frost	Kleczka
Clay	Gallegly	Klink
Clayton	Ganske	Kucinich
Clement	Gejdenson	LaFalce
Coble	Gephardt	

Lampson
Lantos
Larson
LaTourette
Leach
Lee
Levin
Lewis (GA)
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (CT)
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McHugh
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Moran (VA)
Morella
Murtha
Nadler
Napolitano
Neal
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Phelps
Pickett
Pomeroy
Porter
Price (NC)
Quinn
Rahall
Rangel
Reyes
Reynolds
Rivers
Rodriguez
Roemer
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Rush
Sanchez
Sanders
Sandlin
Sawyer
Saxton
Schakowsky
Scott
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shows
Sisisky
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Spence
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Sweeney
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thornberry
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Vitter
Walsh
Wamp
Waters
Watt (NC)
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Wexler
Weygand
Wilson
Wise
Wolf
Woolsey
Wu
Wynn
Young (FL)

NOES—151

Aderholt
Archer
Armey
Baker
Ballenger
Barrett (NE)
Bartlett
Barton
Bass
Bereuter
Biggert
Bliley
Blunt
Boehner
Bonilla
Bryant
Burr
Burton
Buyer
Calvert
Camp
Campbell
Chabot
Chenoweth-Hage
Collins
Combest
Cox
Crane
Cubin
Cunningham
Deal
DeLay
DeMint
Dickey
Doolittle
Dreier
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Fossella
Fowler
Gekas
Gillmor
Goode
Goodlatte
Goodling
Goss
Green (WI)
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Hostettler
Houghton
Hutchinson
Isakson
Istook
Johnson (CT)
Johnson, Sam
Kasich
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
Lazio
Lewis (CA)
Lewis (KY)
Linder
Lucas (OK)
Manzullo
McCrery
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Myrick
Nethercutt
Ney
Northup
Nussle
Ose
Oxley
Packard
Paul
Pease
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Pryce (OH)
Radanovich
Ramstad
Regula
Riley
Rogan
Rogers
Rohrabacher
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Schaffer
Sensenbrenner
Shadegg
Shimkus
Simpson
Skeen
Smith (MI)
Smith (TX)
Souder
Stearns
Stump
Sununu
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thune
Tiahrt
Toomey
Upton
Walden
Watkins
Watts (OK)
Weller
Whitfield
Wicker
Young (AK)

NOT VOTING—8

Clyburn
Granger
Hulshof
Kaptur
Portman
Sabo
Scarborough
Shuster

☐ 1641

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. CLYBURN. Mr. Speaker, I was unavoidably detained in a meeting of the Committee on Standards of Official Conduct. Had I been present on the vote, I would have voted in favor.

Mr. SABO. Mr. Speaker, I was detained by the previously mentioned in a meeting of the Committee on Standards of Official Conduct. If I had been present, I would have voted ''yes.''

Stated against:

Mr. PORTMAN. Mr. Speaker, I was detained in a meeting with the Committee on Standards of Official Conduct during the vote on the Norwood-Dingell legislation. Had I been present, I would have voted ''no.''

Mr. HULSHOF. Mr. Speaker, I was detained in the very same meeting of the Committee on Standards of Official Conduct during the vote on the Dingell legislation. Had I been present, I would have voted ''no.''

PERMISSION TO HAVE UNTIL MIDNIGHT, FRIDAY, OCTOBER 8, 1999, TO FILE CONFERENCE REPORT ON H.R. 2561, DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2000

Mr. LEWIS of California. Mr. Speaker, I ask unanimous consent that the managers on the part of the House may have until midnight, Friday, October 8, 1999, to file the conference report on the bill (H.R. 2561) making appropriations for the Department of Defense for the fiscal year ending September 30, 2000, and for other purposes.

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

There was no objection.

LEGISLATIVE PROGRAM

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

Mr. MENENDEZ. Mr. Speaker, I yield to the gentleman from New York (Mr. LAZIO) for an explanation of next week's schedule.

Mr. LAZIO. Mr. Speaker, I am pleased to announce that we have completed legislative business for the week. The House will meet for a pro forma session tomorrow. Of course, there will be no legislative business and no votes tomorrow.

The House will meet again on Tuesday, October 12, at 12:30 p.m. for morning hour and at 2 p.m. for legislative business. We will consider a number of bills under suspensions of the rules, a list of which will be distributed to Members' offices tomorrow. On Tuesday, we do not expect recorded votes until 6 p.m.

On Wednesday, October 13, and the balance of next week, the House will take up the following measures which will be subject to rules: H.R. 1993, the Export Enhancement Act, and the Department of Labor, Health and Human Services and Education Appropriations Act. We also expect a number of appropriations conference reports to become available for consideration in the House early next week, but possibly throughout the entire week.

☐ 1645

Mr. Speaker, on Friday, October 15, no votes are expected after 2 p.m. I just want to wish all of my colleagues happy Columbus Day weekend, and pray that everybody has a safe travel back, and that they have an opportunity to celebrate the discovery of Columbus, that great Italian American.

Mr. MENENDEZ. Mr. Speaker, I thank the gentleman, and I would ask him if he would be able to answer a question or two about the schedule. We certainly all wish our colleagues a safe journey and a good Columbus day celebration.

Mr. Speaker, does the gentleman expect any late nights next week, in view of the schedule as the gentleman has announced it? And in terms of our effort to make this place family-friendly, does the gentleman expect any late nights next week?

Mr. LAZIO. If the gentleman will yield further, it looks as though we will have no late nights next week. We expect to have our business concluded relatively early.

Mr. MENENDEZ. I thank the gentleman. That would be helpful to our families.

We have heard about a November schedule from some of our colleagues on the other side who are wondering, and we are wondering, when that might be available to the minority so that Members can plan. If our expectation is to be here in November, we would like to know that schedule as well, if the gentleman would be so kind as to respond.

Mr. LAZIO. If the gentleman would continue to yield, Mr. Speaker, right now it is the expectation of the Speaker of the House that the House will adjourn October 29, so the target adjournment still is in this month. Of course, anything is possible as we struggle through these last few weeks in the appropriations cycle.

As soon as we have additional information, we would be happy to share it with the gentleman. Right now, the target adjournment date continues to be October 29.

Mr. MENENDEZ. We certainly all hope that we can achieve an agreement on our budgetary needs by that time.

But if not, and if there is to be a schedule for November that is already out there, we certainly would appreciate it as quickly as possible.

If I may ask the gentleman one last question, Mr. Speaker, is there a chance that Friday may be given away, in view of the schedule at this point, with only two stated pieces of legislation for the week? Does the gentleman expect that Friday may be given away?

Mr. LAZIO. I would say to the gentleman from New Jersey that Members should expect and plan on being in session on Friday. We have conference reports, appropriations conference reports, that need to be completed. That may include Friday. We expect it will include Friday. We have two votes scheduled. Members right now should plan to be in until 2 p.m. on Friday.

Mr. MENENDEZ. I thank my friend, the gentleman from New York.

ANNOUNCEMENT REGARDING AMENDMENT PROCESS FOR H.R. 1993, EXPORT ENHANCEMENT ACT OF 1999

Mr. DREIER. Mr. Speaker, today I sent a Dear Colleague to all Members informing them that the Committee on Rules is planning to meet next week to grant a rule for the consideration of H.R. 1993, the Export Enhancement Act of 1999.

The Committee on Rules may grant a rule which would require that amendments be preprinted in the CONGRESSIONAL RECORD. In this case, amendments must be preprinted prior to their consideration on the floor.

Amendments should be drafted to the version of the bill reported by the Committee on International Relations. Members should use the Office of Legislative Counsel to ensure that their amendments are properly drafted, and should check with the Office of the Parliamentarian to be certain their amendments comply with the rules of the House.

I join in extending happy Columbus Day to all of our colleagues.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF HOUSE CONCURRENT RESOLUTION 189

Mr. UNDERWOOD. Mr. Speaker, I ask unanimous consent to remove my name as a cosponsor of House Concurrent Resolution 189.

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

There was no objection.

HOUR OF MEETING ON TOMORROW

Mr. LAZIO. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 10 a.m. tomorrow.

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

There was no objection.

ADJOURNMENT FROM FRIDAY, OCTOBER 8, 1999, TO TUESDAY, OCTOBER 12, 1999

Mr. LAZIO. Mr. Speaker, I ask unanimous consent that when the House adjourns on Friday, October 8, 1999, it adjourn to meet at 12:30 p.m. on Tuesday, October 12, 1999, for morning hour debates.

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

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY NEXT

Mr. LAZIO. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday next.

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

There was no objection.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, 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 North Carolina (Mr. JONES) is recognized for 5 minutes.

Mr. JONES of North Carolina 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 gentleman from Indiana (Mr. HILL) is recognized for 5 minutes.

(Mr. HILL of Indiana addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

A MINNESOTA HERO DIES, BUT CONNIE EDWARDS' LEGACY WILL LIVE ON

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota (Mr. RAMSTAD) is recognized for 5 minutes.

Mr. RAMSTAD. Mr. Speaker, Connie Edwards taught physical education at Countryside Elementary School in Edina, Minnesota, for 14 years. Her fourth and fifth grade students loved her. She was a great teacher, a wonderful friend, and a true hero.

This past Wednesday Connie, who fought a courageous battle with ovarian cancer, left this Earth, but her spirit will live forever through the many young people whose lives she touched.

As Connie's good friend and former co-worker, Diane Morris, put it, and I am quoting, now, ''Connie had such a huge impact on so many people, from students to staff and the entire community. She had an energy that rubbed off on everybody. The school was her stage, and she shined.''

To show their affection and respect, Mr. Speaker, Connie's students, past and present, along with her staff members, fellow staff members, and parents of Countryside Elementary School, recently renamed the gymnasium in her honor. Despite her serious illness and treatments which left her weak, Connie Edwards visited Countryside School frequently during her extended sick leave just to be with her beloved students.

As recently as last Monday, two days before she died, Connie visited Countryside to cheer on her students during a district-wide cross-country race. Connie was mobbed by the students, who loved her so dearly.

Countryside principal Ken Hatch commented, and I am quoting again, ''There is no way in the world Connie should have been there. The courage and strength this woman had was astonishing. She displayed that right up to the very end. We loved her dearly and will miss her very much,'' concluded Principal Hatch.

Mr. Speaker, it is impossible to measure the great impact of Connie Edwards' life on Countryside's young people over the past 14 years. Connie's courage, energy, and spirit will live on in the hearts and minds of everyone who knew her. Connie was not only a dedicated educator, loyal friend, and role model, she was a true Minnesota hero.

You might be gone, Connie, but Countryside will never forget you. As your beloved students told you in that poem they wrote for you, ''Thank you, thank you for all you have done. Our lives are forever changed because of Connie Edwards, a special one.''

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Indiana (Ms. CARSON) is recognized for 5 minutes.

(Ms. CARSON 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 Ohio (Mr. BROWN) is recognized for 5 minutes.

(Mr. BROWN of Ohio addressed the house. His remarks will appear hereafter in the Extensions of Remarks.)

IN RECOGNITION OF THE LIFE OF SAMUEL C. GRASHIO

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington (Mr. NETHERCUTT) is recognized for 5 minutes.

Mr. NETHERCUTT. Mr. Speaker, I want to take a moment today to recognize the life of Samuel C. Grashio, who died this past Sunday in Spokane, Washington, my hometown, and a major part of the Fifth Congressional District of Washington.

Samuel Grashio was a retired Air Force Colonel and was a highly decorated World War II veteran. While many years have passed since that great struggle for peace, we still remember Samuel Grashio's escape from a Japanese prisoner of war camp during the Bataan Death March. He, along with many others, made that very difficult trek and survived. America's spirit was lifted by the courage that Sam and nine other soldiers showed by escaping the prison camp and for evading their captors in enemy territory for so long.

They continued their struggle for many months, alongside friendly Filipino guerillas who fought bravely to make sure that this group of Americans was able to survive.

Family and friends of Samuel Grashio remember him to be a man of great faith, great courage, and great patriotism. America will remember him for being our hero and our strength during World War II.

An article appeared in the Spokesman Review newspaper in Spokane after the death of Sam, and quoted in that article was a very close friend of mine, Seaton Daly, Senior, who has been a longtime Spokane lawyer and a great, great friend whose son and I, whose late son and I, were very, very close friends. We went through law school together and practiced law together for years.

Seaton said at the time of Sam's death that this was a great man of faith, Samuel Grashio, and he had as his priorities in life three influences: God, family, and country, in that order. He was a great man of stature in eastern Washington and nationally for his service in World War II, and he cultivated friends like Seaton Daly, Senior, who were lifelong friends, and who grieve as Sam passed away.

Sam Grashio led a wonderful life in service to our country. We certainly wish all of Sam's family well, and all of God's blessings in this time of reflection and mourning for them.

I must say, too often we do not recognize deeply enough those heroes who fought for freedom in World War II and have survived, many in this country, to this day as veterans and as proud veterans, and proud supporters of the freedom that this country so much enjoys.

Sam Grashio was one of those people. It is sad that he has passed away, but it is an honor for our community that he lived as long as he did and was able to enjoy not only the freedom he fought for, but the great, great benefits that this country offers to all of its citizens.

Mr. Speaker, I join many others in paying tribute and offering deep sympathy at the death of Samuel Grashio, as do many, many, in Spokane Washington and the State of Washington.

NATIONAL BREAST CANCER AWARENESS MONTH

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. TOWNS) is recognized for 5 minutes.

Mr. TOWNS. Mr. Speaker, we took the extraordinary action in the last Congress of creating an opportunity for States to provide health insurance to the children of the working poor. As we commemorate October as National Breast Cancer Awareness Month, we should take the opportunity to pass H.R. 1070 to expand Medicaid coverage to screen for breast and cervical cancer.

This bill will provide cancer screening for the mothers and grandmothers of the children that we covered under the child health initiative. These women are the waitresses, the domestic workers, and the farmers' wives who do not have the financial ability to take advantage of preventative cancer screenings.

Their low-paying jobs do not provide them with the insurance coverage that would cover the costs of breast and cervical cancer screenings, but they also make them ineligible for Medicaid. If they were unemployed or on welfare they would be covered by Medicaid, and thus receive the screening services.

Mr. Speaker, I cannot overstate the relationship between cancer screening and early detection. We all know that early detection saves the lives of women who are impacted by breast and cervical cancer. For example, the American Cancer Society estimates that of the 46,000 breast cancer deaths in 1994, 14,000 women, almost one-third, could have been saved with early detection. That means that approximately one in three women died needlessly.

□ 1700

That is why I fought so hard to convince the National Cancer Institute to maintain the age for mammography at 40 rather than pushing it back to age 50.

I am very pleased that, in 1997, NCI finally, finally agreed to restore their guidelines to the recommended biennial mammograms for women aged 40 to 49. This screening tool definitely needs to be readily available to women in this age group.

In fact, 29,000 women between the age of 40 and 49 are diagnosed with breast cancer every year. Of these 29,000, a disproportionate percentage will be African-American women, minority women. Particularly, black American women have a 25 percent higher mortality rate because their cancer is not detected early enough.

In addition to screening for breast cancer, H.R. 1070 will also provide reimbursement for cervical cancer screenings. Testimony before the Committee on Commerce also confirmed that cervical cancer is 95 percent treatable and curable if detected in time.

Working poor women are not receiving these screening services simply because they fall between the cracks of being too young for Medicare, not poor enough for Medicaid, and no access to commercial health insurance.

It is not often that we have a chance to save lives simply by improving access to prevention tools. Through the expansion of Medicaid coverage this month, we have that opportunity with H.R. 1070.

I would hope that my colleagues will support the inclusion of the important measure in whatever budget initiatives we enact this session. The working women of this Nation deserves a fighting chance against breast and cervical cancer.

In honor of National Breast Cancer Awareness Month, let us give them this chance by enacting H.R. 1070. That is the way to say ''thank you'' to people like Laura Brown and the Magic Johnson Foundation for all the work that they do.

Mrs. MORELLA. Mr. Speaker, October is Breast Cancer Awareness Month, and we have joined together tonight to urge our colleagues to work with us to increase funding for breast cancer research, treatment, and prevention, and to expand insurance coverage for screening and treatment. Each year, more than 180,000 new cases of breast cancer are diagnosed in the United States. One in eight women will develop breast cancer in their lifetimes, and it is the second leading cause of cancer deaths in women. Last year, about 46,000 of our grandmothers, mothers, aunts, nieces, sisters, cousins, dear friends, and colleagues died from this devastating disease.

Tonight, I will be receiving the Yetta Rosenbert Humanitarian Service Award from the Gloria Heyison Breast Cancer Foundation, Inc. at a special reception to launch Breast Cancer Awareness Month. In 1992, Marc Heyison created the Gloria Heyison Breast Cancer Foundation in love and honor of his mother, a breast cancer survivor. The Foundation also will be raising funds for The Check It Out Program presented by Suburban Hospital, the mobile mammography program at The George Washington University, and other programs that educate the public about the importance of early detection in breast cancer.

I mention this to highlight the role of organizations that advocate on behalf of breast cancer funding and education programs. Without organizations, such as the Gloria Heyison Breast Cancer Foundation, we would not have made the tremendous advances in funding for breast cancer research over the past decade.

Federal funding for breast cancer research totaled $91 million in 1993; it grew to $500 million in 1997. However, despite the increases in funding for breast cancer research and prevention in recent years, we still have few options for prevention and treatment. The National Cancer Institute received the highest funding increase of all of the institutes in last year's appropriations bill, and I hope that we will be able to make even greater strides in the Fiscal Year 2000 bill. I particularly thank Chairman John Porter for his leadership in working to bolster our federal investment in biomedical research, including breast cancer

research, as well as the members of his subcommittee.

Earlier this year, Congresswoman NITA LOWEY and I circulated a congressional letter urging the Appropriations National Security Subcommittee to provide $175 million for the peer-reviewed breast cancer research program at the Department of Defense, a letter co-signed by 225 of our colleagues. The peer-reviewed breast cancer research program has gained a well-deserved reputation for its innovation and efficient use of resources, with over ninety percent of program funds going directly to research grants. We must continue to increase our investment in this important program.

We must also work to better translate new research findings to clinical applications, both through a greater focus on clinical research and through technology transfer. As Chair of the Technology Subcommittee, I have been working to facilitate technology transfer between government agencies and the private sector. Efforts such as the ''missiles to mammograms'' project between the Public Health Service, the Department of Defense, the intelligence community, and NASA, are critically important in applying new technologies to the fight against breast cancer.

Access to mammography screening is another critical issue. The Congressional Caucus on Women's Issues had a major victory during the last Congress when the Balanced Budget Act included annual coverage for mammography screening under Medicare.

As of last year, the breast and cervical cancer screening program had provided more than 1.2 million breast and cervical cancer screenings, education, and follow-up services for low-income women across the country. While this program has been very successful, we must ensure that efforts are expanded to better reach disadvantaged and minority populations.

As an increasing number of mastectomies and lymph node dissections are performed as outpatient surgery, Congress should ensure that women receive the hospital care and insurance coverage they need. We must hold hearings and pass legislation to require health plans to provide coverage for a minimum hospital stay for mastectomies and lymph node dissection for the treatment of breast cancer. Congresswoman ROSA DELAURO and Congresswoman SUE KELLY have each introduced legislation that would provide 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer. I am a cosponsor and strong supporter of this critical legislation. Women and their doctors—not their insurance companies—should determine whether a shorter stay is sufficient.

These initiatives are just a few of the many important efforts underway to address the critical issue of breast cancer. For as long as I serve in Congress, I will continue to work with my colleagues on programs that will provide fuel for the hopes of patients and scientists alike and move us forward in the battle against breast cancer.

The SPEAKER pro tempore (Mr. PEASE). Under a previous order of the House, the gentlewoman from California (Ms. WATERS) is recognized for 5 minutes.

(Ms. WATERS. addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

REPORT ON H.R. 3037, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2000

Mr. YOUNG of Florida, from the Committee on Appropriations, submitted a privileged report (Rept. No. 106–370) on the bill (H.R. 3037) making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, and for other purposes, which was referred to the Union Calendar and ordered to be printed.

The SPEAKER pro tempore. Pursuant to clause 1, rule XXI, all points of order are reserved on the bill.

GENERAL LEAVE

Ms. PELOSI. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of the special order I am about to give.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

DEBT FORGIVENESS FOR THIRD-WORLD COUNTRIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentlewoman from California (Ms. PELOSI) is recognized for 60 minutes as the designee of the minority leader.

Ms. PELOSI. Mr. Speaker, today was a very historic day in this body, and Congress has finished its business at a reasonable time. I wish that many more of my colleagues were in town to hear our special order, because it addresses an issue that came up in our foreign operations bill the other day; and that is the issue of debt forgiveness in the developing world.

In the course of a debate on the legislative bill, an appropriations bill like the foreign operations bill, all we had was an hour on the rule and an hour on the bill, which is the regular order. But because so many Members want to express their support or their opposition to the legislation, the most any of us gets to speak is a few minutes if we are lucky if we are ranking member, or one or two if we are not.

The bill covers a wide range of issues. The foreign operations bill is the bill which funds our diplomatic efforts abroad. The pillars of our foreign policy are promoted in that bill: stopping the proliferation of weapons of mass destruction, promoting democratic values, growing our economy through exports, looking out for our national security, and the assistance that we provide for other countries is in the national interest of the United States.

So this is not about charity. It is about acting in our own self interest. It also, though, taps the well of generosity and concern that the American people have to alleviate poverty in the world and to make the world a safer place, promoting our democratic values, which are universal, so that the world is a safer place in which we can raise our children and our grandchildren.

That brings us to the point of, making the world a safer place means making the world a better place for all of the children of the world. I know my colleagues have heard me say the three most important issues facing this Congress are our children, our children, our children. By that, I mean, not only our children in America, but the fate of children throughout the world. They are affected by the economic well-being of the countries in which they live.

Many of the countries in the Third World, particularly in Africa, some in Latin America, mostly all in the southern hemisphere, have been burdened by debt that has been incurred by previous regimes. For instance, in South Africa, there is a heavy debt load that has been carried over from the apartheid government. Now this new government of the last few years has that burden to carry. How can they succeed with this drag on their economies? That is repeated over and over.

I think we have a responsibility in this area because, during the Cold War, the Soviets and the United States excerpted their influence on the continent of Africa. When the Cold War was over, we up and left, leaving the continent awash in weapons and, in many cases, burdened down by debt.

There is a movement afoot. This is not just a U.S. effort to alleviate this debt, this is an international issue. There is a movement afoot in the religious community. Bishop Desmond Tutu, the Nobel Prize winner from South Africa, was well-known to everyone in the world, I believe, a champion of reconciliation in South Africa, is part of something called the Jubilee, Jubilee 2000.

That is an effort to have debt forgiveness in the developing world so that these new emerging democracies can proceed to meet the needs of their people in terms of education and health and the well-being of their people, unburdened by debts, especially those incurred by previous regimes in their countries and not the democratically elected governments that prevail now.

In our foreign operations bill, there had been a request made by President Clinton for several hundred million dollars over a 3-year period to forgive debt in that region. During the debate, it was contended that, oh, forgiving debt in the Third World was just sending checks to these, what did they call them, turbans and tyrants, or something, so that they could then put this

money into Swiss banks and abscond with that money. That is not what we are talking about here. That is not what President Clinton was advocating.

So it was an unfortunate characterization of the purpose of debt forgiveness and the very important initiative that President Clinton was taking. He was doing it on behalf of our own country, but in conjunction with multilateral efforts that have been made by the G–7 and G–8 in order to alleviate debt in the Third World so that these economies could have a chance to prevail and these new democracies would be able to enjoy some of the benefits of democratic reform and market reform in their countries.

So when we ask for this debt forgiveness and this funding for the debt forgiveness, it is part of a multilateral effort which we are one part, and it is in conjunction with efforts that the people in these countries are taking to help themselves.

This is not about charity. It is about cooperation. This is not about something that is only for the benefit of the recipient. This is about initiatives that will redound to the benefit of the American people, both in providing markets for our goods, if we need a pragmatic reason, but also in addressing the concerns that we have about poverty throughout the world, starvation, famines that we would have come in at a later time and spend much more money, never be able to make for up for the human loss of the people that have died and the malnutrition of those who suffer from starvation.

Of course it would also prevent conflict. Any time that we can prevent conflict, I believe that that is our mission, mission of this great country.

I said in the course of the debate that, being from San Francisco and having the privilege to represent that magnificent area in this Congress, I wanted also, any chance I get, to share with my colleagues the message of Saint Francis, who is the patron saint of San Francisco. The song of Saint Francis is our anthem. Everyone is familiar with it, but I do not know if they know it is the song of Saint Francis. It begins: ''Make we a channel of thy peace. Where there is a darkness may we bring light. Despair, may we bring love. Hatred, may we bring love.''

Well, that is a big order, and we may not be able to do that, but we certainly can be a channel of God's peace to these countries. Helping these countries alleviate poverty and get on with the future and their economic well-being I think is a force for peace and promoting democratic values in those areas.

Therefore, this Jubilee effort, one that is undertaken by the people affected by it, as a way to help them unburden themselves of the debt and alleviate poverty, is very important one.

The President's initiative is a very wise one. The President says that these funds would be used to help alleviate the debt, forgive the debt if the government itself will spend the money on education and health care for the children, the people of their countries. That is a very important initiative. In fact, nothing is more important than that.

I do not think that most people in America need to be told how important it is for them to have disease controlled where it exists abroad so it does not come into our country. The environmental measures that this money could be used on to improve the health and the air that the people breathe in those areas prevents that pollution from coming into our country.

So, again, it taps the well of good intentions in our country, and it has a practical benefit to us. So, again, the Jubilee 2000 is a very noble effort, alleviating the Third World debt, forgiving it, because there is a good deal of talk about reducing and forgiving some, but we want to eliminate the Third World debt, which will be is a very important initiative that I believe a country as great as ours can cooperate with very readily. It is money very well spent.

Many of our colleagues are interested in this issue, but this being the end of the day, the end of the session for this week and the beginning of the Columbus Day weekend, we start today, and we will have other special orders on this subject, because there simply was not enough time to present the full enthusiasm that we have for this debt relief, debt forgiveness, elimination.

But I am pleased that a very distinguished leader in the Congress and the House of Representatives is here tonight. She has worked her whole life on the alleviation of poverty in our country and throughout the world. She has worked her whole life for economic justice issues. Fortunately for us, she is the Ranking Democrat on the Subcommittee on Domestic and International Monetary Police of the Committee on Banking, which is the committee of jurisdiction on the Third World debt. Our committee is the appropriating committee. The committee of the gentlewoman from California (Ms. WATERS) is the committee of authorization where this issue is being debated right now and an authorization bill is being prepared.

So I am very pleased to yield to the gentlewoman from California (Ms. WATERS), an international leader on this issue and a person well positioned to help very much promote the policy and the funding that President Clinton recommended.

Ms. WATERS. Mr. Speaker, I am very pleased and proud to join the gentlewoman from California (Ms. PELOSI) here on the floor this evening to talk about a subject that I believe is the number one issue confronting the world today.

□ 1715

I would also like to thank the gentlewoman for all of the years that she has put in not only on the issues of debt relief but on the issues of foreign affairs and foreign assistance and foreign relations.

The gentlewoman has become one of our premier experts, and she has provided leadership to this House. And it is because of the gentlewoman and the knowledge that she brings to these discussions that we are all able to advance and to move forward. So I truly appreciate everything that the gentlewoman has done and the gentlewoman's leadership in pulling together this time tonight for us to further talk about debt relief and these very poor countries who are depending on us to come to their aid and to their assistance.

I am so pleased and proud to be a Member of Congress at this particular time. Yes, there are many frustrating moments; and, yes, there are many disappointing moments, but I am here in this Congress at a time when I see both sides of the aisle coming together around debt relief. I am the ranking member on the Subcommittee on Domestic and International Monetary Policy of the Committee on Banking and Financial Services, but I serve on that committee with the chair of that committee, the gentleman from Alabama (Mr. BACHUS), a man who is obviously a Republican, and I am obviously a Democrat.

I am considered to be much more liberal; he is considered to be conservative. But when we hear the gentleman from Alabama (Mr. BACHUS) on this issue, and we see the work that he has brought to this issue, it really does make us proud that there are moments and there are periods in this great body of ours where we can put aside our philosophical differences and come together in the most humane fashion to do something good and send out the best messages from us to others about who we are and what we care about.

So the gentlewoman has referenced and referred to Jubilee 2000. This is a wonderful moment and a wonderful time. Just as I and the gentleman from Alabama have come together, and others from both sides of the aisle on the Committee on Banking and Financial Services, on the Committee on International Relations, on the Committee on Appropriations, all over the world various religious denominations have come together as well, and all of these nongovernment organizations, all of these nonprofit organizations, consumer-related organizations have come together all over the world to embrace debt relief.

We have all come to the point in time where we understand that it is absolutely illogical for us to think that many of these countries are able to repay debt that is owed to us and to others. Whether we are talking about bilateral or multilateral debt, many of these nations are spending a disproportionate amount of their revenue trying to make this payment, to the point oftentimes of starving the children and not being able to provide for health

care, not being able to have anything that approaches decent education systems.

So we sit here at a time when the economy is performing rather well, at a time when we are able to spread prosperity, and we are taking advantage of this time to say this is the time to do it. So we are moving forward and everybody is coming on board. As a matter of fact, we had some people who started out saying, well, we can do something; we can do a little bit of this, a little bit of that. And now we have more people moving toward 100 percent. The President of the United States, when he addressed the International Monetary Fund conference that was here in Washington, D.C., made us proud with his commitment to do 100 percent debt relief.

I know not everybody is there. And even on the appropriations subcommittee we do not have the money that has been allocated to the tune of what was asked for by this administration. But I am convinced that we are going to get there. One way or the other we are going to get there. I do believe there is enough of us who are focused, and we are focused on this issue, to be able in negotiations, that I know will take place no matter what has happened on our appropriations bill. I do believe that we will get to negotiations that will help us to understand that there must be more money for debt relief.

I know that there are those who make the argument that somehow we are taking all of the taxpayers' money to give to somebody else. And I think the gentlewoman made the point the other day that it is less than 1 percent.

Ms. PELOSI. It is 6.8 percent that is in the bill. If we did the President's request, it would be .8 percent. Less than 1 percent still.

Ms. WATERS. Less than 1 percent. And I think that should be said over and over again so that we can get rid of the notion that somehow we are bankrupting our country in order to make this very humane gesture.

We see pictures of children with extended bellies; we see pictures of people who live in remote villages who carry water for miles because they do not have running water. We saw, when we traveled to Africa, children in makeshift classrooms who have little in the way of books or materials but who want to learn. We see countries that are confronted with the problem of AIDS, such as we are seeing in Third World countries and in Africa.

Right next door to us, right in our own hemisphere, we see countries that are struggling to make sure that people just have one little piece of bread and maybe a little something to drink. Milk is out of the question for many of these children. So I do not think any of us can be proud that despite that which we do not have, and we would like to have for everybody, we have enough that we can share with these very desperate souls around the globe. And that is what we are all about in America.

One of the things that we are proudest of is the fact that we believe that we are spiritual people; that we believe in a higher being; that we worship in so many different ways, in whatever fashion. We feel it is important for us to worship. But central to all of that is the belief that we can share; that we can help out; that we can extend a helping hand. And how better to demonstrate that than through this wonderful Jubilee 2000.

And what a wonderful name for what we are doing. We are celebrating our humanity. We are celebrating that, no matter what the distances are around this globe, we are one people. We are one people, and we should all care about each other. So this debt relief is one of the most important actions that we can take.

We are going to send a message to Zambia, for example, who is spending one-third of its government revenue to servicing the debt. We are going to send a message to Mozambique, whose debt service payments in 1997 absorbed about half of all government revenue. We are going to send a message to Nicaragua, where over half of the government's revenue was allocated to debt service payments in 1997. We are going to send a message to all of these children that we care.

We are going to proudly attack the fact that almost 200,000 children die annually in Mozambique from preventable illnesses, such as malaria, measles, and respiratory infection; and only half of the rural population has access to safe water. So this is work that we can be proud of. This is work that everybody can take part in.

And, again, I thank the gentlewoman for her leadership, and I am proud to be a member of the House Committee on Banking and Financial Services offering some leadership in this area. And I look forward to the negotiations and the passage of the appropriations line item that will fully fund the bilateral debt relief and to using our leverage at IMF and the World Bank to make sure that we have multilateral debt relief and we work out all of the questions of how we are going to reap the benefit of the gold, through gold sales, in a way that will satisfy everybody and allay the fears about what it means to be involved in utilizing this possibility for helping to pay for this debt relief.

So I really do appreciate the gentlewoman's leadership.

Ms. PELOSI. Mr. Speaker, I thank the gentlewoman from California for participating in this special order this evening. But more important, I thank her for her leadership on this issue and the voice that she gives to the concerns that she expressed this evening. They are concerns that she has used every forum at her disposal to espouse this debt relief and poverty alleviation throughout the world.

I did want to reference the gentlewoman's comment about her chairman, the gentleman from Alabama (Mr. BACHUS), and his cooperation on this and also recognize the chairman of the full committee, the gentleman from Iowa (Mr. LEACH), who introduced a bill to provide debt relief to ensure that funds released go to anti-poverty programs, including education in the beneficiary nations.

So while we have been talking about some level of debt forgiveness all along, and in June the G–7 agreed to cancel up to 90 percent of bilateral debt, President Clinton upped the ante on the poor-country debt relief the end of September when he announced in his speech at the World Bank-IMF annual meeting that the U.S. would forgive 100 percent of the debts owed to the United States.

Of course, we have to have an act of Congress in order to do that. And, hopefully, this Congress will support the bipartisan efforts that have proceeded largely because of the efforts of the gentlewoman from California.

I wanted to just focus, because the gentlewoman brought up the excitement and the enthusiasm that the gentlewoman has for Jubilee 2000, and give a little background on it. We are part of the USA platform for the Jubilee 2000. But before I go into that, the religious community, as the gentlewoman mentioned, is very, very involved in this. In fact, on the subject of debt forgiveness, Pope John Paul, when he met with the President earlier this year, raised the issue when he met with President Clinton in St. Louis.

The Christian Science Monitor has editorialized about this by beginning, ''and forgive us our debts as we forgive our debtors.'' And they go on to say that, ''The rich predominantly christian industrial nations have had a hard time putting into practice the latter part of the Lord's prayer phrase in regard to the world's poorest countries.'' They said that at the end of April.

But since that time, with the action of the G–7 and the President's statement the other day, I think we are well on our way to a recognition that the only way that we are going to help these countries reach their fulfillment for their own people and their countries and in our own interest is to forgive the debt.

Jubilee 2000 springs from a biblical tradition. It calls for a jubilee year, and now we have one coming up, the Year 2000. In a jubilee year, slaves were set free and debts were cancelled. As a new millennium approaches, we are faced with a particularly significant time for such a jubilee. Many impoverished countries carry such high levels of debt that economic development is stifled and scarce resources are diverted from health care, from education, and all other socially beneficial programs to make debt service payments.

Imagine having to pay interest on the debt. They are not even paying down the principal; they are just paying interest on the debt instead of educating the children and giving them health care and, as the gentlewoman

said, providing some of the infrastructure necessary to even bring water into their villages much less their homes.

Much of the debt they carry is the result of ill-conceived development, flawed policies that creditors required of recipient countries in exchange for assistance, and shortsighted decisions by their own leaders. Many times these leaders were from previous regimes. So we have Democratic reform in some of these countries, and these new leaders and these fragile democracies are weighted down by debts incurred and funds used up by a previous regime, in many cases that they have ousted.

□ 1730

Much of the borrowing benefited only the elites in the receiving countries. Whereas, the burden of paying the debt is falling upon the most impoverished members of society. Recognizing that these debts are unpayable and exact a great social and environmental toll, the Jubilee 2000 USA Campaign calls for a time of jubilee and cancellation of the debts, and that would be definitive forgiveness of the crushing international debt in situations where countries burdened with high levels of human needs and environmental distress are unable to meet the basic needs of their people; definitive debt cancellation that benefits ordinary people and facilitates their participation in the process of determining the scope, timing, and conditions of debt relief, as well as future direction and priorities for a decent quality of life, definitive debt cancellation that is not conditioned on policy reforms perpetuate or deepen poverty or environmental degradation and acknowledge the responsibility of both lenders and borrowers and action to recover resources that were diverted to corrupt regimes, institutions and individuals.

And finally, establishment of a transparent and participatory process to develop mechanisms to monitor international monetary flows and prevent recurring destructive cycles of indebtedness.

So there is a vision about where these debt forgiveness can take these countries. There is knowledge about how we got to where we were and what we can do to make a difference. There is a plan of action well planned out. And there is an excitement about this that is building consensus in our country and throughout the world, developing a grassroots network, conducting this advocacy campaign. This Jubilee 2000 Campaign is about leadership.

Ms. WATERS. Mr. Speaker, will the gentlewoman yield?

Ms. PELOSI. I yield to the gentlewoman from California.

Ms. WATERS. Mr. Speaker, I thought since my colleague had given the background and history of Jubilee 2000 that I would just note some of the participants in this coalition that we have around the world on this very important issue. So I am going to call off a few of these names. Maybe I can get most of them in.

The supporters of the Jubilee 2000 Campaign in support of debt relief include the following:

The Pope
Africa Faith and Justice Network
Africa Fund
Africa Policy Information Center (APIC)
American Friends Service Committee
Bread for the World
Catholic Relief Services
Center of Concern
Church of the Brethren/Washington Office
Church World Service (CWS)/National Council of the Churches of Christ in the USA
Columban Justice & Peace Office
Conference of Major Superiors of Men
Episcopal Church
Episcopal Peace Fellowship
Evangelical Lutheran Church in America
50 Years Is Enough US Network for Global Economic Justice
Friends of the Earth (FOE)
Leadership Conference of Women Religious
Lutheran World Relief
Maryknoll Office for Global Concerns
Medical Mission Sister's Alliance for Justice
Mennonite Central Committee (MCC)
Missionary Oblates of Mary Immaculate
Nicaragua-US Friendship Office
OXFAM-America
Preamble Center
Presbyterian Church/USA
Sisters of Notre Dame de Namur
Sojourners
United Church of Christ
United Methodist Church
US Catholic Mission Association
Washington Office on Africa
Witness for Peace
African Methodist Episcopal Church
Church of the Brethren/General Board
Church Women United
Dominican Sister of Hope
Ecumenical Program on Central America & the Caribbean (EIPCA)
Fellowship of Reconciliation (FOR)
Interreligious Foundation for Community Organizations, Inc. (IFCO)
Lewis Metropolitan C.M.E. Church
Lutheran World Relief (LWR)
National Summit on Africa
NETWORK B A National Catholic Social Justice Lobby
Progressive National Baptist Convention
Rainbow-PUSH
RESULTS USA
Sister of Charity of St. Vincent de Paul/New York
Sisters of St. Joseph of Carondelet/Albany Province
Sisters of St. Joseph/Brentwood, NY Leadership Team
Sisters of Charity of Leavenworth
Swedenborgian Church/Social Concerns Education Committee
Unitarian Universalist Service Committee
United Methodist Church/General Board of Global Ministries
Washington Office on Africa

Is that not a wonderful coalition of people both in the United States and from other parts of the world who have joined hands in this great Jubilee 2000 celebration by putting substance in a real way to the word ''celebration in jubilee'' in this wonderful push that we have to relieve the debt of the world?

Ms. PELOSI. Mr. Speaker, that is a wonderful list.

I was taught by some of those organizations that my colleague has named, and we all have benefitted from their grassroots activism on it.

Many of those same organizations support, for example, microlending, which benefits alleviation of poverty among women and lifts up families and increases literacy rates, etcetera. So we are talking about new approaches, and that is what we need as we go into the new millennium.

My colleague listed those names, and I just wanted to reference two other points before we close here. And that is, I am going to quote my colleague as she joined the gentleman from Iowa (Mr. LEACH) and our own ranking member the gentleman from New York (Mr. LAFALCE) who has been a leader on this issue, too; the gentleman from Alabama (Mr. BACHUS) my colleague referenced, the chair of the subcommittee; and the gentlewoman from California (Ms. WATERS) in introducing the debt relief for poverty reduction act:

''Relieving the unsustainable debt burdens of the world's poorest countries is one of the foremost humanitarian and moral challenges of our time. Debt relief can also benefit the U.S. economy.''

So, again, it is helping us as we help others.

I want to also quote, this is a Jubilee Call for Debt Forgiveness. This pamphlet is put out by a statement by the Administrative Board of the U.S. Catholic Conference. This is the Catholic Conference of Bishops in the United States, the voice of the church in the United States, and it is the Catholic Campaign on Debt.

In here, among other things, the bishops say, ''The coming of the great Jubilee in 2000 offers us a time to make new beginnings and to right old wrongs. Pope John Paul, II, has called repeatedly for forgiving international debt as a sign of true solidarity. In this statement, we join our voice to his to inform the public about the moral urgency of the debt question and to offer some considerations about responding to it.''

So, as I said before, it is the vision, the knowledge, the plan of action, and the enthusiasm and excitement that is being engendered by this.

Again, this is in the context of these countries taking actions to help themselves. We must lend a helping hand. We cannot ignore the efforts that they are making, if not for political reasons or economic reasons that benefit the United States, but for the children.

Those of us who profess to value our religion know that the gospel of Matthew is one that we carry heavily on our shoulders, to feed the hungry and to minister to the needs of the least of God's brethren.

OXFAM is another organization that is in their pamphlet, Education Now: Breaking the Cycle of Poverty, talks about debt and education and it is much easier to have the education without the debt.

Ms. WATERS. Mr. Speaker, the gentlewoman mentioned and I failed to mention but I must underscore her recognition of the chairman of the full committee the gentleman from Iowa

(Mr. LEACH). I do not know if there could have been anyone else that could have executed this in the way that he has done.

As my colleague knows, the gentleman from Iowa (Mr. LEACH) is a highly respected Member of this House who has given leadership to that overall committee on many very important issues, none more important than this one. And it is because of his patience, it is because of the high esteem in which he is held in this House that he was able to work so well with all of these groups that make up Jubilee 2000.

So I would like to thank my colleague for the special recognition she has paid to him and to say on my behalf that the gentleman from Iowa (Mr. LEACH) probably will mark this success that we are going to have as one of the highlights of his career.

I know that he has done many things and he has been involved in many complicated pieces of legislation that have had far-reaching effects. But this molding and shaping and moving of debt relief for the world and the countries that need it so desperately will go down in history as one the most important efforts that he has made.

Ms. PELOSI. Mr. Speaker, I join my colleague in saluting the gentleman from Iowa (Chairman LEACH). I do not know where he is on total debt forgiveness, but I know that he is a champion of debt relief. I do not want to speak for him to associate him here with the Jubilee 2000. But he certainly has taken us a long way down the road.

Those of us who are concerned about this issue, as my colleagues knows, are very blessed to have him in this position that he is in because he understands financial institutions, international financial institutions, but he is also an expert on foreign policy and what is in the national interest of our country. So his two main committee assignments converge on this issue and his understanding of that will serve the poor people of the world well.

And the ranking member on the committee the gentleman from New York (Mr. LAFALCE) has a very clear understanding of the foreign policy implications. He understands the financial institutions. But he also understands the domestic situation in the United States. That is why I was so pleased that he joined the gentleman from Iowa (Chairman LEACH) and others of us to meet with representatives of the IMF, the World Bank, the Inter-American Development Bank, the Treasury Department to impress upon them how important the alleviation of poverty is to Congress in a bipartisan fashion.

I was very pleased with the comments that the gentleman from New York (Mr. LAFALCE) made that day, which the gentleman from Alabama (Mr. BACHUS) the ranking member made that day and the gentleman from Iowa (Chairman LEACH) to the representatives of the banks so that they knew that this thrust that we had about alleviating poverty and providing for the humanitarian needs should be the thrust of the actions of the international financial institutions in addition to the debt forgiveness.

This effort is bipartisan. It is bicameral. We have champions in the Senate, as well. And it now has the added benefit of the President of the United States weighing in very heavily on this issue, again speaking to the international financial institutions last week when they were in Washington.

It is also an international effort. It is ecumenical. All of the religions are joining in and working together. I cannot think of another issue that had such consensus across the board among so many divergent groups.

So where there is a will there is, hopefully, a way for us to do this; and in doing so, we will make a very serious difference.

Let us hear it. Bravo for Jubilee 2000 to use this landmark, this milestone, this date of the year 2000 for us to say, okay, we have talked about it a long time. We have nipped at the edges about it for a number of years. Now let us just put it behind us so that we and these countries can go into the next year, the next century, the next millennium with a chance of doing the right thing by the people and especially the children.

Ms. WATERS. Mr. Speaker, the gentleman from Massachusetts (Mr. FRANK) who really has been working on this for a long time, he preceded me and once was the chair of the subcommittee and he has been working very closely with the gentleman from New York (Mr. LAFALCE) working at some very important details of shaping and forming the final legislation in this effort. So I want to say bravo to them.

Once again, let me just conclude my remarks by saying bravo to my colleague for all the time and effort that she has spent even until tonight staying late to take this issue up. And, of course, she certainly did not have to add one more hour to her schedule.

Ms. PELOSI. Mr. Speaker, I thank the gentlewoman for that. I am glad that she mentioned the gentleman from Massachusetts (Mr. FRANK) because he is a champion on this.

There are many champions on the House on both sides of the aisle on this issue, and we are going to have to have another special order so that they can speak to the issue and, if not, that we can speak to their efforts. We are grateful to all of them for what they have done.

I thank the gentlewoman for joining me here this evening.

Mr. Speaker, in the spirit of ecumenism, of bipartisanship, and in helping the poor people of the world, as we help ourselves, I yield back the balance of my time.

☐ 1745

AMERICA'S DIGITAL FUTURE

The SPEAKER pro tempore (Mr. SIMPSON). Under a previous order of the House, the gentleman from Louisiana (Mr. TAUZIN) is recognized for 5 minutes.

Mr. TAUZIN. Mr. Speaker, I do not often do special orders, but something recently occurred that has caused me to come to the floor of the House today and to announce a very special project that will occur on Monday in Baton Rouge, Louisiana, at Louisiana State University.

And many of the Members of the House have recently seen copies of this map published in the local newspaper, The Hill, and the local newspaper, the Congress Daily and others in this area, and it is a map that indicates the U.S. Internet POPs, the points of presence of broadband hubs in America.

What is interesting about the map is that an awful lot of our country does not have the presence of an Internet, a broadband high-speed hub, located on their map. The map becomes more interesting when it is compared to a report that was recently published on the new economy index, an attempt by the Democratic Leadership Council to identify the States of our country where the high technology or digital economy has really arrived and is achieving great results for its citizens and the places around our country where the high technology economy, the digital economy, the Internet economy, however you want to call it, has yet to arrive and may be very slow in arriving.

The State new economy index ranked the States of America in terms of the high-technology connects, the connectivity of our people, of homes, of businesses, to the Internet and the presence of broadband capable structures that are going to allow those States and those economies to do well in the new millennium.

In that list of States are listed, of course, the real winners, the States where the high technology economy has really arrived and where high technology hook-ups, the connections to the Internet, the capacity of the systems are really very present. The top two States are Massachusetts and California. The lower States, the lower 25 States include Georgia, Hawaii, Kansas, Maine, Rhode Island, North Carolina, Tennessee, Wisconsin, Ohio, Michigan, Missouri, Nebraska, Indiana, South Carolina, Kentucky, Oklahoma, Wyoming, Iowa, South Dakota, Alabama, North Dakota, Montana, my own State of Louisiana, West Virginia, Arkansas and Mississippi. We are ranked 47th in Louisiana in high-technology connects.

Now why did I find that so alarming, and why this event in Baton Rouge next Monday?

I found it so alarming because, as chairman of the Subcommittee on Telecommunications, Trade, and Consumer Protection of the Committee on

Commerce, I have seen the high-technology economy at work in other parts of the country and around the world. I have seen how connecting to the Internet makes a difference in the education of children. I have seen how connecting to the Internet makes a business prosper or fail. I have seen the promise of the broadband technologies, in effect high-speed Internet connects, to an economy are going to make the difference between whether some economies succeed or fail.

And I have lived in the State of Louisiana that I love dearly and yet I know suffers from a high illiteracy rate and a need for children to be uplifted, an economy that desperately needs a connect to this high-technology economy; and yet I see these numbers that say we are 47th, and I see so many other States lingering near the bottom of this list.

And so on next Monday we have convened what might be the last big high-technology summit conference of this millennium where on October 11 in Baton Rouge we are going to feature such speakers as:

Bill Kennard, the Chairman of the Federal Communications Commission,

Robert Pitofsky, the chairman of the Federal Trade Commission,

Barry Diller, the chairman and CEO of USA Networks,

Charlie Ergen, chairman of Echostar Satellite Communications,

Bob Coonrod, chairman of the Corporation for Public Broadcasting,

Greg Maffei, the Senior Vice President of Microsoft,

Afshin Mohebbi, the President and CEO of Quest Communications,

Mike McCurry, former White House spokesman, now a cochairman with our own Susan Molinari of the broadband Coalition, an organization formed to try to make sure every part of America, not just the few States that have high-technology connects, but every part of America is brought together; that we do not have a digital divide in the new economy of the future; along with folks like Hal Krisbergh, chairman and CEO of Worldgate Communications, a company that is manufacturing equipment that can put every child in this country on the Internet on television without the necessity of a computer for about $5 a month rental, technologies that mean the difference between children being left behind, and businesses being left behind and economies being left behind or being a part of the new fast economy that is being described as the new economy of the new millennium.

This summit conference will be available to all of America on the Internet, and I want to tell you how you can log in, how you can tune in. If you are interested in knowing how critical it is for your homes and your businesses to be connected to the Internet and to be, more importantly, connected to the high-speed Internet of the future, the broadband services that are going to combine all the new economies on the Internet with the high-speed visual and audio and data services that are going to be available on those services. If you are interested, you can tune in. It will be broadcast live on the Internet all day long next Monday, and you can find it at www.mobiletel.com.

That site is connected to other ISPs or Internet service providers.

You can tune in, you can get a sense of how your State can do what Louisiana, I hope, will do, and that is start a major effort to connect every family, every business to this new economy and to the high speed Internet. Join us at www.mobiletel.com on Monday all day at LSU and learn what the future looks like for your State.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Ms. KAPTUR (at the request of Mr. GEPHARDT) for today on account of personal business.

Ms. GRANGER (at the request of Mr. ARMEY) for today after 3:30 p.m. on account of personal reasons.

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. TOWNS) to revise and extend their remarks and include extraneous material:

Mr. HILL of Indiana, for 5 minutes, today.

Ms. CARSON, for 5 minutes, today.

Mr. BROWN of Ohio, for 5 minutes, today.

Mr. TOWNS, for 5 minutes, today.

Ms. WATERS, for 5 minutes, today.

(The following Members (at the request of Mr. RAMSTAD) to revise and extend their remarks and include extraneous material:)

Mr. RAMSTAD, for 5 minutes, today.

Mr. TAUZIN, for 5 minutes, today.

Mr. NETHERCUTT, for 5 minutes, today.

ADJOURNMENT

Mr. TAUZIN. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 5 o'clock and 52 minutes p.m.), under its previous order, the House adjourned until tomorrow, Friday, October 8, 1999, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

4710. A letter from the Chief, Office of Regulations and Administrative Law, USCG, Department of Transportation, transmitting the Department's final rule—Special Local Regulations: Winston Offshore Cup, San Juan, Puerto Rico [CGD07 99–056] (RIN: 2115–AE46) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

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. YOUNG of Alaska: Committee on Resources. H.R. 748. A bill to amend the Act that established the Keweenaw National Historical Park to require the Secretary of the Interior to consider nominees of various local interests in appointing members of the Keweenaw National Historical Parks Advisory Commission; with amendments (Rept. 106–367). Referred to the Committee of the Whole House on the State of the Union.

Mr. YOUNG of Alaska: Committee on Resources. H.R. 1615. A bill to amend the Wild and Scenic Rivers Act to extend the designation of a portion of the Lamprey River in New Hampshire as a recreational river to include an additional river segment (Rept. 106–368). Referred to the Committee of the Whole House on the State of the Union.

Mr. YOUNG of Alaska: Committee on Resources. H.R. 2140. A bill to improve protection and management of the Chattahooche River National Recreation Area in the State of Georgia; with an amendment (Rept. 106–369). Referred to the Committee of the Whole House on the State of the Union.

Mr. PORTER: Committee on Appropriations. H.R. 3037. A bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, and for other purposes (Rept. 106–370). Referred to the Committee of the Whole House on the State of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. HANSEN:

H.R. 3035. A bill to designate certain lands in the State of Utah as wilderness, and for other purposes; to the Committee on Resources.

By Mr. SHUSTER (for himself, Mr. OBERSTAR, Mr. PETRI, and Mr. RAHALL):

H.R. 3036. A bill to provide for interim continuation of administration of motor carrier functions by the Federal Highway Administration; to the Committee on Transportation and Infrastructure.

By Mr. ANDREWS (for himself, Mr. GRAHAM, and Mr. OWENS):

H.R. 3038. A bill to amend the Fair Labor Standards Act of 1938 to clarify the exemption from the minimum wage and overtime compensation requirements of that Act for certain computer professionals; to the Committee on Education and the Workforce.

By Mr. BATEMAN:

H.R. 3039. A bill to amend the Federal Water Pollution Control Act to assist in the restoration of the Chesapeake Bay, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mrs. CHENOWETH-HAGE (for herself, Mr. YOUNG of Alaska, Mr. DUNCAN, Mr. DOOLITTLE, Mr. PETERSON of Pennsylvania, Mr. HILL of Montana, Mr. SCHAFFER, Mr. SHERWOOD, and Mr. HAYES):

H.R. 3040. A bill to require the appointment of the Chief of the Forest Service by

the President, by and with the advice and consent of the Senate; to the Committee on Agriculture.

By Mr. DEUTSCH:

H.R. 3041. A bill to provide for a demonstration project to allow certain organizations that provide care under Medicare to purchase home-care services from self-employed caregivers through home-care referral agencies; to the Committee on Commerce, and in addition to the Committee on Ways and Means, 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. GOODE:

H.R. 3042. A bill to designate the facility of the United States Postal Service located at 1031 Volens Road in Nathalie, Virginia, as the ''Susie A. Davis Post Office''; to the Committee on Government Reform.

By Mr. GREEN of Wisconsin:

H.R. 3043. A bill to amend title 10, United States Code, to direct the Secretary of the Army to establish a combat artillery medal; to the Committee on Armed Services.

By Mr. HILL of Indiana (for himself, Mr. DINGELL, Mr. FROST, Mr. DUNCAN, Mr. CRAMER, Mr. PASTOR, Mr. ROEMER, Mr. SCOTT, Mr. STUPAK, Mr. ETHERIDGE, Mr. BARRETT of Wisconsin, Mr. SANDLIN, Ms. HOOLEY of Oregon, Ms. CARSON, Mrs. TAUSCHER, Mr. LARSON, Mrs. JONES of Ohio, Mr. BAIRD, Mr. HOEFFEL, Mr. PHELPS, Mr. GONZALEZ, Mr. LUCAS of Kentucky, Mr. WU, and Mr. MOORE):

H.R. 3044. A bill to provide grants to local educational agencies to develop smaller schools; to the Committee on Education and the Workforce.

By Mr. LAZIO (for himself, Mr. BARRETT of Wisconsin, Mrs. KELLY, Mr. EHLERS, and Mr. MCHUGH):

H.R. 3045. A bill to amend title XIX of the Social Security Act to extend the authority of State Medicaid fraud control units to investigate and prosecute fraud in connection with Federal health care programs and abuse of residents of board and care facilities; to the Committee on Commerce.

By Mr. LEACH (for himself, Mr. LAFALCE, Mrs. ROUKEMA, and Mr. VENTO):

H.R. 3046. A bill to preserve limited Federal agency reporting requirements on banking and housing matters to facilitate congressional oversight and public accountability, and for other purposes; to the Committee on Banking and Financial Services.

By Mr. MATSUI (for himself, Mr. WELLER, Mr. ANDREWS, Mr. BENTSEN, Mr. GEJDENSON, Mrs. KELLY, and Mr. POMEROY):

H.R. 3047. A bill to amend the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to require plans which adopt amendments that significantly reduce future benefit accruals to provide participants with adequate notice of the changes made by such amendments; to the Committee on Education and the Workforce, and in addition to the Committee on Ways and Means, 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. MCCOLLUM:

H.R. 3048. A bill to amend section 879 of title 18, United States Code, to provide clearer coverage over threats against former Presidents and members of their families, and for other purposes; to the Committee on the Judiciary.

By Ms. MCKINNEY (for herself and Mr. ROHRABACHER):

H.R. 3049. A bill to cancel the bilateral debt owed to the United States by the heavily indebted poor countries, to prohibit United States funding of the International Monetary Fund until debt owed to the International Monetary Fund by the heavily indebted poor countries has been canceled, and for other purposes; to the Committee on Banking and Financial Services, and in addition to the Committee on International Relations, 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. SPRATT (for himself, Mr. SPENCE, and Mr. SKELTON):

H.R. 3050. A bill to provide for the posthumous advancement of Rear Admiral (retired) Husband E. Kimmel and Major General (retired) Walter C. Short on the retired lists of their respective services; to the Committee on Armed Services.

By Mr. UDALL of New Mexico (for himself, Mr. SKEEN, Mrs. WILSON, Mr. KILDEE, Mr. HAYWORTH, Mr. KENNEDY of Rhode Island, Mr. YOUNG of Alaska, Mr. GEORGE MILLER of California, and Mr. BECERRA):

H.R. 3051. A bill to direct the Secretary of the Interior, the Bureau of Reclamation, to conduct a feasibility study on the Jicarilla Apache Reservation in the State of New Mexico, and for other purposes; to the Committee on Resources.

By Mr. VITTER:

H.R. 3052. A bill to amend the Internal Revenue Code of 1986 to allow certain coins to be acquired by individual retirement accounts and other individually directed pension plan accounts; to the Committee on Ways and Means.

By Mr. WELDON of Pennsylvania (for himself and Mr. ANDREWS):

H.R. 3053. A bill to provide for assessments and contingency planning relating to emerging missile threats to the United States; to the Committee on Armed Services, and in addition to the Committee on International Relations, 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. WEYGAND:

H.R. 3054. A bill to support the fiscal year 2000 proposed budget; to the Committee on Banking and Financial Services.

H.R. 3055. A bill to support the fiscal year 2000 proposed budget; to the Committee on Banking and Financial Services.

By Mr. DEAL of Georgia:

H. Con. Res. 194. Concurrent resolution recognizing the contributions of 4–H Clubs and their members to voluntary community service; to the Committee on Education and the Workforce.

By Mr. LANTOS (for himself, Mr. SAWYER, Mr. LAHOOD, Mr. BURTON of Indiana, Mr. WAXMAN, Mr. CONDIT, Ms. DEGETTE, Mr. HOUGHTON, Mr. INSLEE, Mr. JACKSON of Illinois, Mr. LIPINSKI, Mrs. MYRICK, Mr. OXLEY, Mr. PACKARD, Mr. SCHAFFER, Mr. UDALL of Colorado, Mrs. MCCARTHY of New York, and Mr. SCARBOROUGH):

H. Res. 324. A resolution supporting National Civility Week, Inc. in its efforts to restore civility, honesty, integrity, and respectful consideration in the United States; to the Committee on Government Reform.

By Mr. LAFALCE (for himself, Mr. NETHERCUTT, Ms. DEGETTE, and Mr. WELDON of Pennsylvania):

H. Res. 325. A resolution expressing the sense of the House of Representatives regarding the importance of increased support and funding to combat diabetes; to the Committee on Commerce.

MEMORIALS

Under clause 3 of rule XII, memorials were presented and referred as follows:

261. The SPEAKER presented a memorial of the Legislature of the State of Louisiana, relative to House Concurrent Resolution No. 222 memorializing the United States Congress to continue to support and fund the United States-Asia Environmental Partnership, the Environmental Partnership, the Environmental Technology Network for Asia, and the Council of State Governments' State Environmental Initiative; to the Committee on International Relations.

262. Also, a memorial of the Legislature of the State of Louisiana, relative to House Concurrent Resolution No. 257 memorializing the Congress of the U.S. to limit the appellate jurisdiction of the federal courts regarding the specific medical partice of partial-birth abortions; to the Committee on the Judiciary.

263. Also, a memorial of the Legislature of the State of Louisiana, relative to House Concurrent Resolution No. 56 memorializing the United States Congress to appropriate sufficient funds to install lighting on Interstate Highway 10 and Interstate Highway 310 in the vacinity of the intersection of Jefferson Parish, and St. Charles Parish, Louisiana; to the Committee on Transportation and Infrastructure.

264. Also, a memorial of the Legislature of the State of Louisiana, relative to House Concurrent Resolution No. 266 memorializing the U.S. Congress to appoint a task force to close the Mississippi River Gulf Outlet; to the Committee on Transportation and Infrastructure.

265. Also, a memorial of the Legislature of the State of Louisiana, relative to House Concurrent Resolution No. 342 memorializing Congress to take measures which would allow receipients of Social Security benefits and other government benefits to marry or remarry without fear of losing or experiencing a reduction in such benefits or other adverse financial consequences; to the Committee on Ways and Means.

266. Also, a memorial of the Legislature of the State of Louisiana, relative to House Concurrent Resolution No. 284 memorializing the United States Congress to take such actions as are necessary to allow social security recipients born between 1917 and 1921 to receive an equal amount of social security benefits as those recipients born between 1910 and 1916; to the Committee on Ways and Means.

PRIVATE BILLS AND RESOLUTIONS

Under clause 3 of rule XII:

Mr. FLETCHER introduced A bill (H.R. 3056) for the relief of Margaret M. LeBus; which was referred to the Committee on the Judiciary.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 72: Mr. TOWNS.

H.R. 123: Mr. SHAYS and Mr. BATEMAN.

H.R. 218: Mr. REYES.

H.R. 303: Mr. FLETCHER, Ms. PELOSI, and Mr. GOODLATTE.

H.R. 354: Mr. BASS, Mr. GALLEGLY, Mr. SESSIONS, Mr. DOOLITTLE, Mr. MALONEY of Connecticut, Mr. TANCREDO, Mrs. BIGGERT, and Mr. BARR of Georgia.

H.R. 460: Mr. POMBO and Mr. BARCIA.

H.R. 688: Mr. KING.
H.R. 699: Mr. WEXLER.
H.R. 718: Mr. BALLENGER.
H.R. 721: Mr. BRADY of Texas.
H.R. 761: Mr. WEINER.
H.R. 864: Mr. STRICKLAND.
H.R. 1071: Mr. UNDERWOOD and Mr. COSTELLO.
H.R. 1103: Mr. FILNER.
H.R. 1180: Mr. HALL of Ohio, Mr. LATHAM, and Mr. BURTON of Indiana.
H.R. 1248: Mr. RAHALL and Mr. SANDLIN.
H.R. 1274: Mr. MCGOVERN and Ms. JACKSON-LEE of Texas.
H.R. 1285: Mr. LOBIONDO.
H.R. 1304: Mr. MORAN of Kansas and Mrs. EMERSON.
H.R. 1325: Mr. RAMSTAD.
H.R. 1329: Mr. SHERWOOD.
H.R. 1362: Ms. LEE.
H.R. 1389: Mr. DIAZ-BALART.
H.R. 1482: Mr. EVANS.
H.R. 1590: Mr. QUINN.
H.R. 1592: Ms. DUNN.
H.R. 1606: Mr. SHAYS.
H.R. 1640: Mr. BRADY of Texas, Ms. STABENOW, Mr. ABERCROMBIE, Mr. GONZALEZ, Mr. MENENDEZ, Mr. MEEKS of New York, Mr. LAMPSON, Mr. DOYLE, and Mr. LAFALCE.
H.R. 1644: Mr. EDWARDS.
H.R. 1708: Mr. BOYD, Mr. BARTLETT of Maryland, and Ms. STABENOW.
H.R. 1732: Mr. KIND and Mr. WATT of North Carolina.
H.R. 1754: Mr. HALL of Texas.
H.R. 1777: Mr. REYES.
H.R. 1785: Mr. FILNER, Mr. MCDERMOTT, and Mr. FRANK of Massachusetts.
H.R. 1870: Mr. DUNCAN, Mr. SCHAFFER, and Mr. MCHUGH.
H.R. 1987: Mr. ISAKSON, Mrs. NORTHUP, Mr. HERGER, Mr. HEFLEY, Mr. ROGAN, Mr. BURTON of Indiana, Mr. PICKERING, Mr. KNOLLENBERG, and Mr. PETERSON of Pennsylvania.
H.R. 1990: Mr. DOYLE and Mr. BACHUS.
H.R. 1998: Mr. WATKINS and Mr. MCINNIS.
H.R. 2059: Mr. FORBES.
H.R. 2068: Mr. VITTER.
H.R. 2100: Mr. TOOMEY.
H.R. 2106: Mrs. CAPPS.
H.R. 2121: Ms. WATERS, Mr. UDALL of Colorado, and Mr. LUTHER.
H.R. 2162: Mr. ROYCE.
H.R. 2221: Mr. DELAY.
H.R. 2247: Mr. STUMP.
H.R. 2282: Mr. ARMEY.
H.R. 2294: Mrs. LOWEY.
H.R. 2300: Mr. CHABOT and Mr. SHADEGG.
H.R. 2370: Mrs. LOWEY.
H.R. 2387: Mr. ETHERIDGE and Ms. LOFGREN.
H.R. 2418: Mr. SANFORD, Mrs. MINK of Hawaii, and Mr. LOBIONDO.
H.R. 2451: Mr. CALVERT.
H.R. 2463: Mr. THOMPSON of Mississippi and Mr. RANGEL.
H.R. 2500: Ms. PELOSI and Ms. MCKINNEY.
H.R. 2505: Mrs. TAUSCHER and Mrs. JONES of Ohio.
H.R. 2534: Mr. CALVERT.
H.R. 2539: Mr. ROHRABACHER and Mr. PACKARD.
H.R. 2541: Mr. WICKER, Mr. SHOWS, Mr. PICKERING, and Mr. THOMPSON of Mississippi.
H.R. 2573: Mr. WEINER and Mr. UNDERWOOD.
H.R. 2640: Mr. BARCIA.
H.R. 2655: Mr. YOUNG of Alaska and Mr. MICA.
H.R. 2660: Mr. PETERSON of Minnesota.
H.R. 2662: Mrs. MALONEY of New York, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. SHAYS, Mr. RANGEL, Mr. THOMPSON of Mississippi, and Mr. LEWIS of Georgia.
H.R. 2687: Mr. SHAYS.
H.R. 2711: Mr. RANGEL.
H.R. 2733: Ms. EDDIE BERNICE JOHNSON of Texas and Mr. LIPINSKI.
H.R. 2735: Mr. MCCRERY.
H.R. 2749: Mr. DOOLITTLE.
H.R. 2759: Mr. DOYLE.
H.R. 2783: Mr. FOSSELLA and Mr. OXLEY.
H.R. 2785: Mr. BLAGOJEVICH.
H.R. 2798: Mr. GALLEGLY, Mr. GREENWOOD, Mr. DIXON, Mrs. CAPPS, and Mr. KUYKENDALL.
H.R. 2801: Mr. WU, Mr. SCOTT, and Ms. SANCHEZ.
H.R. 2807: Mr. OWENS.
H.R. 2814: Mr. MATSUI.
H.R. 2383: Mr. HINCHEY.
H.R. 2870: Mrs. LOWEY.
H.R. 2899: Mr. HINOJOSA and Mr. BERMAN.
H.R. 2907: Mr. DEAL of Georgia, Ms. MCKINNEY, and Mr. GEORGE MILLER of California.
H.R. 2925: Mr. WALSH, Mr. GILMAN, Mr. PICKERING, Mr. THOMPSON of Mississippi, Mr. KING Mr. ENGLISH, and Mr. CANADY of Florida.
H.R. 2934: Mr. KENNEDY of Rhode Island.
H.R. 2939: Mr. ENGLISH, Mr. CAMPBELL, Mr. HINCHEY, and Mr. JACKSON of Illinois.
H.R. 2960: Mr. TANCREDO.
H.R. 2962: Mrs. TAUSCHER, Mr. GEORGE MILLER of California, and Mr. MARTINEZ.
H.R. 2966: Mr. BARCIA, Mr. BILBRAY, Mr. BONIOR, Mr. CUNNINGHAM, Ms. DANNER, Mr. EHRLICH, Mrs. EMERSON, Mr. FILNER, Mr. PETERSON of Minnesota, Mr. PICKERING, Mr. RAHALL, Mr. ROGAN, and Mr. THOMPSON of Mississippi.
H.R. 2991: Mr. POMEROY, Mr. ENGLISH, Mr. OSE, Mr. HAYES, Mr. FOLEY, Mr. MORAN of Kansas, and Mrs. EMERSON.
H.R. 2999: Mr. FROST.
H.J. Res. 48: Mr. MINGE and Mr. LARSON.
H.J. Res. 56: Mr. FOSSELLA.
H.J. Res. 70: Mr. BROWN of Ohio.
H. Con. Res. 51: Mr. MCGOVERN and Mr. WOLF.
H. Con. Res. 89: Mr. HALL of Texas and Mr. HORN.
H. Con. Res. 141: Mr. FARR of California, Mrs. KELLY, Ms. NORTON, Ms. BALDWIN, Mr. KING and Ms. MILLENDER-MCDONALD.
H. Con. Res. 166: Mr. SESSIONS.
H. Con. Res. 186: Mr. CALVERT, Mr. COLLINS, Mr. MICA, Mr. POMBO and Mr. RADANOVICH.
H. Con. Res. 189: Mr. KUYKENDALL.
H. Con. Res. 190: Mr. PACKARD.
H. Res. 82: Mr. THOMPSON of California.
H. Res. 213: Mr. KLECZKA.
H. Res. 298: Mr. HOYER, Ms. ROYBAL-ALLARD, Mr. CONDIT, Mr. ENGEL, Mr. HALL of Ohio, Mr. MOAKLEY, Mr. POMEROY and Mr. SKELTON.
H. Res. 303: Mr. CALVERT, Mr. LARGENT and Mr. GILLMOR.
H. Res. 315: Mr. FARR of California, Mr. WAXMAN, Mr. DIXON, Ms. PELOSI, Mr. GEORGE MILLER of California, Mr. CLAY, Mr. FROST, Mr. PORTMAN and Ms. ROYBAL-ALLARD.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:

H. Con. Res. 189: Mr. UNDERWOOD.

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of America

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PROCEEDINGS AND DEBATES OF THE *106th* CONGRESS, FIRST SESSION

Vol. 145 WASHINGTON, THURSDAY, OCTOBER 7, 1999 *No. 135*

Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore [Mr. THURMOND].

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, Dr. John C. Compton, First Baptist Church of Alexandria, VA. He is the guest of Senator HELMS.

We are delighted to have you with us.

PRAYER

The guest Chaplain, Dr. John C. Compton, offered the following prayer:

Let us pray.

Heavenly Father, we thank You for the privilege of bowing our heads today and acknowledging You as our Creator Lord. We confess that we are dependent upon You completely for everything. Father, we ask for Your leadership on this day. We pray for each man and woman in the Senate, Father, that You would give them wisdom and courage and insight as they are about to deliberate on national and international affairs. Heavenly Father, we thank You for the wisdom of Your word that teaches us that the supreme principle of life is to love the Lord our God with all our heart, mind, and soul and to love our neighbors as ourselves. Father, may this principle of love guide everything the Senate does today. And, Dear Lord, we ask that You bless each Senator with a measure of health and fulfillment as they serve You, for we pray in Jesus' name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable JOHN ASHCROFT, a Senator from the State of Missouri, 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.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The Senator from Pennsylvania is recognized.

Mr. SPECTER. Mr. President, I thank the Chair. I compliment the distinguished leader of the prayer, and I compliment the President pro tempore.

I will be glad to yield to my distinguished colleague from North Carolina.

The PRESIDING OFFICER (Mr. CRAPO). The Senator from North Carolina is recognized.

GUEST CHAPLAIN JOHN C. COMPTON

Mr. HELMS. Mr. President, the inspiring prayer which Senators just heard was delivered by the remarkable Dr. John C. Compton, whose church is the home church for Dot Helms and me when the Senate is in session.

The congregation at First Baptist Alexandria includes many good folks from North Carolina, with relatives in our State. Dr. Compton has been senior pastor at First Baptist Alexandria since June 1997, and what an enormous impact he has had. His powerful sermons are always meaningful and helpful. Young adults are flocking to the various services and other events at his church. Dr. Compton's messages to all who hear him are straight from the Bible. He dares to address with candor the moral and spiritual breakdown so evident in America today. That is because his message, without exception, emphasizes the hope available to all who will follow and embrace the precepts and faith of our Founding Fathers.

John and Teresa Compton have two daughters, Sarah and Rachel. Dr. Compton's father, deceased, and his mother served as missionaries in Brazil for a quarter of a century beginning in 1950.

Numerous staff members from Capitol Hill attend First Baptist Alexandria, including several from my own office. A warm welcome is extended to the Senate's guest Chaplain for today, Dr. John C. Compton. And for my part, Mr. President, I am genuinely grateful for what this remarkable minister has meant to Dot Helms and me and countless others.

I thank the Chair and I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2000

The PRESIDING OFFICER. The Senate will now resume consideration of S. 1650, which the clerk will report.

The legislative assistant read as follows:

A bill (S. 1650) making appropriations for the Departments of Labor, Health and Human Services, and Education, and Related Agencies for the fiscal year ending September 30, 2000, and for other purposes.

Pending:

Abraham (for Coverdell) amendment No. 1828, to prohibit the use of funds for any program for the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, on behalf of the leader, I have been asked to announce that we will proceed now to the consideration of the bill on Labor, Health and Human Services, and Education. The pending amendment is one offered by the distinguished Senator from Michigan, Mr. ABRAHAM.

We are culling the list, and we have it now in reasonable shape so that I do believe that if we are able to have a

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couple of very contentious amendments not acted upon and proceed promptly, we can complete action on this bill today.

The leader has asked me to announce that following completion of the Labor-HHS appropriations bill, it is the intention of the leader to consider the Agriculture appropriations conference report, and the Senate may also consider any other conference reports available for action.

When we move beyond Senator ABRAHAM's amendment, the next amendment to be offered is by Senator BINGAMAN. It is hoped that we could get reasonably short time agreements.

I would ask if we may proceed now, as we had on so many matters yesterday, with a 30-minute time agreement equally divided on this pending amendment.

The PRESIDING OFFICER. Is there objection?

Mr. WELLSTONE. Mr. President, reserving the right to object for just a moment, could we look at it for a second, the second degree?

Mr. ABRAHAM. Here is a copy.

Mr. SPECTER. While the Senator from Minnesota and the Senator from Nevada are taking a look at it, Mr. President, this would be a good time for me to say that we hope that anyone who wishes to offer amendments will come to the floor promptly so that we can inventory the amendments and try to establish time agreements. We are going to have to move very expeditiously without quorum calls if we do have any realistic chance of finishing the bill today.

Mr. WELLSTONE. Mr. President, the time agreement is fine on our side.

Mr. SPECTER. Thirty minutes equally divided, Mr. President.

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

Mr. WELLSTONE. Thirty minutes equally divided on the second degree.

Mr. SPECTER. The same agreement we had yesterday with respect to 30 minutes on second degrees.

The PRESIDING OFFICER. Without objection, the time on the second-degree amendment will be 30 minutes equally divided.

Under the previous order, the Senator from Michigan, Mr. ABRAHAM, is recognized to speak on amendment No. 1828.

Mr. ABRAHAM. Mr. President, before I speak, may I clarify, I believe I am speaking on the second-degree amendment?

The PRESIDING OFFICER. The second-degree amendment has not been offered.

AMENDMENT NO. 2269 TO AMENDMENT NO. 1828

(Purpose: To prohibit the use of funds for any program for the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug)

Mr. ABRAHAM. Mr. President, I call up amendment No. 2269.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative assistant read as follows:

The Senator from Michigan [Mr. ABRAHAM], for himself, Mr. COVERDELL, Mr. GRASSLEY, Mr. ASHCROFT, and Mr. SMITH of New Hampshire, proposes an amendment numbered 2269 to amendment No. 1828.

Mr. ABRAHAM. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

Strike all after the first word and insert the following:

Notwithstanding any other provision of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug. This provision shall become effective one day after the date of enactment.

Mr. ABRAHAM. Mr. President, I rise to join Senator COVERDELL in offering this amendment to the Labor, Health and Human Services appropriations bill. Our amendment would prohibit the expenditure of taxpayer dollars on programs that provide free hypodermic needles to drug addicts.

In the past, President Clinton, through his Secretary of Health and Human Services, Donna Shalala, has tried to lift the ongoing ban on federal funds for needle exchange programs. His reasoning? Such programs could reduce the rate of HIV infection among intravenous (IV) drug users without increasing the use of drugs like heroin.

Unfortunately, the evidence we have to date suggests that each of these suspicions is wrong. We now know beyond a reasonable doubt that needle exchange programs actually increase both the rate of HIV infection and the use of IV drugs.

What is more, they send the wrong message to our children. And they hurt our communities.

This administration has claimed a great deal of credit for the recent drop in some categories of drug use.

I don't want to downplay the progress that has been made over the last year.

But we must keep in mind that the improvements were small, and that this administration has a lot of work to do before it can bring us back to the levels of drug use achieved in 1992, the year before President Clinton took office.

The percentage of 8th, 10th, and 12th graders who had used an illicit drug during the previous 30 days dropped between 1997 and 1998, by 0.8 for 8th graders, 1.5 for 10th graders and 0.6 for 12th graders percentage points.

But levels of drug use remain substantially higher than in 1992—in some instances almost twice as high.

In 1992, 6.8 percent of 8th graders, 11 percent of 10th graders, and 14.4 percent of 12th graders reported having used an illicit drug within the past 30 days.

By 1998, even with recent dips, those figures ranged from 12.1 percent for 8th graders to 21.5 percent for 10th graders to 25.6 percent—more than one in four 12th graders.

Now is not the time, Mr. President, to let our guard down in the war on drugs. As we continue to fight our difficult battle with drug abuse, the last thing we need is for Washington to send the message that drug use is okay.

Let me very quickly review some of the overwhelming evidence that has made it crystal clear that needle exchange programs are inherently ill-considered and doomed to failure.

First, we now know that needle exchange programs encourage drug use: Deaths from drug overdoses have increased over five times since 1988.

In addition, we now have clinical studies, including one conducted in Vancouver and published in the Journal of AIDS. That study showed that deaths from drug overdoses have increased over five times in that city since needle exchanges began in 1988. Vancouver now has the highest death rate from heroin in North America.

Such terrible statistics should not surprise us given the lack of basic, commonsense logic in needle exchange programs.

Mr. President, giving an addict a clean needle is equivalent to giving an alcoholic a clean glass.

And once we lose sight of this logic, we have already lost the war on drugs. We have, in effect, handed our streets over to people who do not believe that we should win that war.

Let me cite just one example of the recklessness with which so many of these programs are run. The New York Times magazine in 1997 reported that one New York City needle exchange program gave out 60 syringes to a single person, little pans to ''cook'' the heroin, instructions on how to inject the drug, and a card exempting the user from arrest for possession of drug paraphernalia.

But needle exchange programs do not have to be run recklessly in order to encourage drug use.

Dr. Janet Lapey with Drug Watch International recently quoted pro-needle activist Donald Grove, who pointed out that ''most needle exchange programs . . . Serve as sites of informal organizing and coming together. A user might be able to do the networking needed to find drugs in the half an hour he spends at the street-based needle exchange site—networking that might otherwise have taken half a day.''

It's just common sense, Mr. President. If you give an addict more needles, he will use them, drug use will increase, and so will the dying.

And that includes deaths from HIV/AIDS. We now know that needle exchange programs actually increase the spread of this dread disease.

For example, a Montreal study was published in the American Journal of Epidemiology. It found that intravenous drug users in a needle exchange program were more than twice as likely to become infected with HIV as addicts not using such a program.

And the figures from the Vancouver study are astounding. When the Vancouver needle exchange program started in 1988, 1 to 2 percent of drug addicts in that city had HIV. Now 23 percent of drug addicts in Vancouver have HIV.

To put it succinctly, Mr. President, we now know that needle exchange programs are bad for drug users. They promote this deadly habit and they promote the spread of HIV.

But we know more, Mr. President. We also know that needle exchange programs send the wrong message to our kids:

Let me quote President Clinton's own drug czar, General Barry McCaffrey, who said ''the problem is not dirty needles, the problem is heroin addiction. . . . The focus should be on bringing help to this suffering population—not giving them more effective means to continue their addiction. One doesn't want to facilitate this dreadful scourge on mankind.''

Mr. President, needle exchange programs undermine our drug fighting efforts, and they undermine the very rule of law we all depend on for our safety and freedom.

I urge my colleagues to support our amendment to prohibit taxpayer dollars from being spent on needle exchange programs.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. SPECTER. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. SPECTER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. SPECTER. Mr. President, in the absence of anyone seeking recognition, I ask unanimous consent that the quorum call be charged equally.

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

The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. SPECTER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded

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

Mr. SPECTER. Mr. President, the Senate bill language, as it currently reads, is as follows: Notwithstanding any other provision of this act, no funds appropriated under this act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the illegal use of drugs.

The amendment, which is now pending, would strike the discretion of the Secretary to make a determination that such a program would be effective in preventing the spread of HIV and would not encourage the use of illegal drugs.

This issue on needle exchange is a highly emotional issue. There is no doubt the reuse of needles by drug addicts does result in the infection of more people with HIV/AIDS. The Secretary of Health and Human Services has never used this waiver language to make a determination that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs. There is dispute on whether clean needles would, in fact, prevent the spread of HIV and whether clean needles would—in fact, could—be used without the encouragement of the use of illegal drugs.

It is the view of the subcommittee and the full committee, which passed this in its present form, that question ought to be left open to the Secretary of Health and Human Services, who has never used this exception and is not likely to use it promiscuously but only if there was a very sound scientific base for doing so. My own preference is to continue the discretion of the Secretary to be able to make this waiver, if the facts and figures show that such a needle exchange would not encourage the use of illegal drugs, that such a legal exchange would prevent the spread of HIV/AIDS.

There is some concern within the community that is interested in having needle exchange that raising this issue again may lead to some broader prohibition, which might even reach private groups. I think that is highly unlikely. But those are concerns that we are trying to resolve in deciding what step to take with response to the Abraham amendment.

The PRESIDING OFFICER. Who yields time?

Mr. WELLSTONE. Mr. President, with the support of this side, I yield myself 5 minutes.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. Mr. President, let me just support the remarks of my colleague from Pennsylvania, Senator SPECTER. I understand all the emotion that surrounds this issue, but I think it would be a profound mistake on our part to now pass an amendment that would take away an important discretion from the Secretary of Health and Human Services as to whether or not the needle exchange program is badly needed and would be effective in some of our local communities. I think to have an across-the-board prohibition without taking a really close look at this question could have tragic consequences.

So I say to my colleagues I think if we no longer enable the Secretary of Health and Human Services to have some discretion and to know when Federal funds would make a huge difference, and to make sure this is all being done in an above-board manner, then I think we are passing a prohibition which, in personal terms, will translate into more of our citizens—many of them inner city, many poor, and too many of them children—becoming HIV infected and dying from AIDS. I rise to support the comments of my colleague from Pennsylvania.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. SPECTER. Mr. President, after consulting with the distinguished ranking member, Senator HARKIN, and listening to the comments of the Senator from Minnesota, it is the judgment of the managers that prudence would warrant accepting the Abraham amendment on a voice vote, if that is acceptable to the distinguished Senator from Michigan.

Mr. ABRAHAM. Mr. President, I appreciate the offer. I think we would be prepared to accept a voice vote. My colleague from Georgia is here and had planned to speak briefly on the amendment. So I defer to him if he wishes to have up to 5 minutes.

Mr. SPECTER. Mr. President, before the Senator from Georgia speaks, I want to propound a unanimous consent request. We have Senator BINGAMAN present now. His amendment will be the next one offered. I ask unanimous consent that there be 40 minutes equally divided on the Bingaman amendment, subject to the same terms and conditions on the other time agreements.

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

The Senator from Georgia is recognized.

Mr. COVERDELL. Mr. President, I will just be a moment and yield to the Senator from Michigan so he might call for a voice vote on his amendment.

I want to just quote the administration's own drug czar, General McCaffrey. He said:

> As public servants, citizens, and parents, we owe our children an unambiguous no use message. And if they should become ensnared in drugs, we must offer them a way out, not a means to continue addictive behavior.
>
> The problem is not dirty needles, the problem is heroin addiction . . . the focus should be on bringing help to this suffering population—not giving them more effective means to continue their addiction. One doesn't want to facilitate this dreadful scourge on mankind.

James Curtis, a professor of psychiatry at Columbia University Medical School and Director of Psychiatry at Harlem Hospital, said:

> [Needle exchange programs] should be recognized as reckless experimentation on human beings, the unproven hypothesis being that it prevents AIDS.
>
> Addicts are actively encouraged to continue to inject themselves with illegal drugs, and are exempted from arrest in areas surrounding the needle exchange program.

I can go on and on with expert people involved in the drug war. This is a good amendment. I am pleased that the other side has decided to adopt it. I

compliment the Senator from Michigan for bringing it to the floor.

I yield the floor.

Mr. ABRAHAM addressed the Chair.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Mr. ABRAHAM. Mr. President, I believe we had a previous acknowledgment of moving to a voice vote.

Before we do, I thank the Senator from Georgia for his leadership on this issue. Again, our goal is to send a clear message to the children of this country that the Federal Government will not be supporting, in any way, programs that would seem to lead to increases in the uses of drugs, as well as HIV, as it appears in studies.

At this point, I am prepared to yield the remainder of our time.

Mr. REID. The minority yields back our time.

Mr. COVERDELL. As does the majority.

The PRESIDING OFFICER. Without objection, the second-degree amendment is agreed to.

The amendment (No. 2269) was agreed to.

The PRESIDING OFFICER. Without objection, the first-degree amendment, as amended, is agreed to.

The amendment (No. 1828), as amended, was agreed to.

Mr. ABRAHAM. Mr. President, I move to reconsider the vote.

Mr. COVERDELL. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, the Senator from New Mexico is recognized.

AMENDMENT NO. 1861

(Purpose: To ensure accountability in programs for disadvantaged students)

Mr. BINGAMAN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN], for himself, Mr. REED, Mr. KERRY, and Mr. KENNEDY, proposes an amendment numbered 1861.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

On page 52, line 8, after ''section 1124A'', insert the following: ''*Provided further,* That $200 million of funds available under section 1124 and 1124A shall be available to carry out the purposes of section 1116(c) of the Elementary and Secondary Education Act of 1965.''

Mr. BINGAMAN. Mr. President, first let me yield myself 6 minutes off of my time at this point.

I am offering this amendment on behalf of myself, Senator JACK REED from Rhode Island and JOHN KERRY from Massachusetts, and I believe they will both be here, I hope, to speak on behalf of the amendment as well.

This amendment is intended to ensure greater accountability in our educational system and in the expenditure of title I funds. Let me make it very clear to my colleagues at the very beginning of this debate, this amendment does not add money to the bill. Instead, it tries to ensure that a small portion of the title I funds that we are going to appropriate in this bill are spent to achieve greater accountability and improvement in the schools that are failing, about which we are all so concerned.

I think we can all agree that greater accountability in our schools is an imperative. It is particularly important to have this accountability where high concentrations of disadvantaged students are in order to ensure that all students have some semblance of equal educational opportunity. Although most States have adopted statewide standards, they have not directed adequate resources to schools that are failing to meet those new standards. Dedicated funds are necessary in order to develop improved strategies in those schools and create rewards and penalties that will hold schools accountable for continuous improvement in their students.

The Federal Government directs over $8 billion, nearly $9 billion, in Federal funding to provide critical support for disadvantaged students under title I. But the accountability provisions in title I have not been adequately implemented due to insufficient resources. Title I authorizes State school support teams to provide support for schoolwide programs and to provide assistance to schools in need of improvement through activities such as professional development or identifying resources for changing the instruction in the school or the organization of the school.

In 1998, however, only eight States reported that school support teams have been able to serve the majority of the schools identified as needing improvement. Less than half of the schools identified as being in need of improvement in the 1997–1998 school year reported that this designation of being a school needing improvement led to additional professional development or assistance.

Schools and school districts need additional support and resources to address weaknesses soon after those weaknesses are identified. They need that support to promote a progressively intensive range of interventions, continuously assess the results of those interventions and implement incentives and strategies for improvement.

The bill before the Senate does not identify specific funds for accountability enforcement efforts. I believe we need to ensure that a significant funding stream is provided to guarantee these accountability provisions are enforced.

This amendment seeks to ensure that 2.5 percent of the funds appropriated to LEAs under title I—that is $200 million in this year's bill—is directed toward this objective. This money is to be used to ensure that States and local school districts have the necessary resources available to implement the corrective action provisions of title I by providing immediate and intensive interventions to turn around low-performing or failing schools.

The type of intervention that the State and the school district could provide using these funds includes a variety of things. Let me mention a few:

One would be purchasing necessary materials such as updated textbooks and curriculum technology.

The second would be to provide intensive, ongoing teacher training. Inadequate training of teachers has been a problem in many of the failing schools.

A third would be providing access to distance learning where they don't have the teachers on site who can provide that instruction.

Fourth, extending the learning time for students through afterschool or Saturday programs or summer school programs so students can catch up to the grade level at which they should be performing.

Next, providing rewards to low-performing schools that show significant improvements, including cash awards or other incentives such as release time for teachers.

Sixth, intensive technical assistance from teams of experts outside the schools to help develop and implement school improvement plans in failing schools. The teams would determine the causes of low performance—for example, low expectations, an outdated curriculum, poorly trained teachers or unsafe conditions—and provide assistance in implementing research-based models for improvement.

One example of the type of research-based school improvement model that needs to be introduced in failing schools and can be introduced in failing schools with the resources we are earmarking in this amendment is the Success for All Program. This program is a proven early grade reading program in place now in over 1,500 schools around the country, some in my own State of New Mexico. At the end of the first grade, Success for All Program schools have average reading scores almost 3 months ahead of those in matching controlled schools. By the end of the fifth grade, students read more than 1 year ahead of their control group peers. This program can reduce the need for special education placements by more than 50 percent and virtually eliminate retention of students in the grade they have just completed.

This Success for All Program incorporates small classes, regular assessments, team learning, and parental involvement into a comprehensive reading program based on phonics and contextual learning techniques. In order to implement this program, however, schools need resources, particularly in the first year. The estimated costs is about $62,000 for 500 students in that first year; that decreases substantially

to about $5,000 per year in the third year the program is in place. They must provide the initial training for the school's principal, the facilitators, the teachers, and 23 days of onsite training and curriculum materials.

This is the kind of program of which we need to see more. It is the kind of program for which the funds we would earmark in this amendment would be made available. In my view, this is the type of thing the American people want to see. Instead of just sending another big check, let's try to attract some attention to the strategies we know will work so the failing schools can move up and the students who attend these schools can get a good education.

I see my colleague, Senator REED. I reserve the remainder of my time and yield 5 minutes to the Senator from Rhode Island, Mr. REED.

Mr. REED. Mr. President, I rise to support the amendment sponsored by my colleague from New Mexico. I commend him for his commitment and dedication.

During the 1994 reauthorization of the Elementary and Secondary Education Act, I was a member of the other body. There I proposed an accountability amendment in committee which strengthened our oversight and accountability for title I and other elementary and secondary school programs. When we came to the conference, it was Senator JEFF BINGAMAN of New Mexico who was leading the fight on the Senate side to ensure accountability was part and parcel of the 1994 reauthorization of the Elementary and Secondary Education Act. I am pleased to work with him today on this very important amendment.

What we propose to do is to provide $200 million so the States can move from talking about accountability and intervening in low-performing schools to actually taking the steps to do just that. There are scarce Federal dollars that we provide for elementary and secondary education programs, the principal program being title I. Although we allocate $8 billion a year for title I, there still appears to be insufficient resources to ensure that accountability reforms and oversight are effectively taking place in our schools.

This amendment provides for those resources. It ensures we get the best value for the money we invest in title I. It allows schools to not only provide piecemeal services to students but to look and seek out ways to reform the way they educate the students in their classrooms.

We will continue as the reauthorization of the Elementary and Secondary Education Act approaches to stress this issue of accountability. But today we have an opportune moment to invest in accountability and school reform. What we find is that the States, either through lack of financial resources, lack of focus, or due to other commitments and priorities, are not intervening in low-performing and failing schools as they should. They are not directing the kind of school improvement teams, for example, that have been authorized under title I. This amendment gives them not only the incentive but the resources to do that. In effect, what we are trying to do is make title I not just a way to distribute money to low-income schools but to stimulate the reform and improvement of these schools.

It should be noted that the amendment targets the lowest performing schools to try to lift up those schools which are consistently failing their students. We all know if the schools are not working, these young people are not going to get the education they need and require to be productive citizens and workers and to contribute to our community and to our country. That is at the heart of all of our efforts on both sides of the aisle in the Senate.

It is vitally important to turn around the lowest performing and failing schools. The 1994 reauthorization focused attention in the States on accountability, improvement, and reform. The States have taken steps to adopt accountability systems. But today we are here to give States and school districts the tools to ensure the job of turning around failing schools can be done effectively and completely. I urge passage of this amendment.

Once again, I commend the Senator from New Mexico for his leadership and look forward to working with him as we undertake the reauthorization of the Elementary and Secondary Education Act in the months ahead.

I yield whatever time I have.

Mr. BINGAMAN. Mr. President, how much time remains on our side?

The PRESIDING OFFICER (Mr. ROBERTS). The Senator has 8 minutes 10 seconds remaining.

Mr. BINGAMAN. I yield 3 minutes to the Senator from Massachusetts, Mr. KENNEDY.

The PRESIDING OFFICER. The distinguished Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I congratulate Senator BINGAMAN, Senator REED, and Senator WELLSTONE for this particular proposal. Effectively, what they are saying is we want to improve low-performing schools and we want to do it now—not wait until next year. It is reasonable to ask whether this kind of effort can be productive and whether it can be useful. I want to raise my voice and say: Absolutely.

I had the opportunity to visit the Harriet Tubman Elementary School in New York City, one of the lowest-performing schools in the city, where 99 percent of the children come from low-income families. After being assigned to the Chancellor's District—a special school district created for the lowest-performing schools—school leaders, parents, and teachers devised a plan for comprehensive change. The school adopted a comprehensive reform program including an intensive reading program.

By 1997–98, it had been removed from the state's list of low-performing schools and reading scores had improved; the percentage of students performing at or above grade level on the citywide assessment had risen from 30 percent in 1996, to 46 percent.

We have instance after instance where that has happened. At Hawthorne Elementary school in Texas, 96 percent of the students qualify for free lunch and 28 percent of the students have limited English language skills.

In 1992–93, Hawthorne implemented a rigorous curriculum to challenge students in the early grades. In 1994 only 24 percent of students in the school passed all portions of the Texas Assessment of Academic Skills. In 1998, almost 63 percent of students passed this test, with the largest gains over the period being made by African American students.

The States themselves have been reluctant to use scarce resources when we have not had adequate funding for the Title I program. The Bingaman amendment sets aside a specific amount of resources that will be out there and available to help those particular schools. This makes a great deal of sense.

I hope our colleagues will support the Bingaman-Reed-Wellstone amendment. These students have spent enough time in low-performing schools, and deserve much better. The time is now to take action to fix these schools. The nation's children deserve no less.

Mr. BINGAMAN. Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Chair will observe if neither side yields time, the time will be taken from both sides and equally charged.

Mr. BINGAMAN. Mr. President, I yield 2 minutes to the Senator from Minnesota.

The PRESIDING OFFICER. The distinguished Senator from Minnesota is recognized.

Mr. WELLSTONE. Mr. President, I probably will not even take 2 minutes.

I rise to support the Bingaman amendment. I appreciate what my colleague from New Mexico said earlier in his remarks, which was that the focus on accountability is terribly important. We also have to make sure we invest the resources that will enable each child to have the same opportunity to succeed. I think that is extremely important as well. The two go together.

But I do believe this is very helpful to States. It is very helpful to low-income children. I think it is terribly important that States devise and put into effect strategies that make sure we have the highest quality title I programs, which are, after all, all about expanding opportunities for low-income children, dealing with the learning gap, enabling a child to do well in school and therefore well in his or her life.

I applaud his emphasis on accountability and rise to indicate my support.

Mr. KERRY. Mr. President, the amendment before us today provides a chance not just to make this spending bill better and stronger, not just to move forward by completing another stage of the budget process the American people are already unsure we can complete, but to take this spending bill and use it as a real vehicle for reform of our public schools. Today we can make the single largest investment in accountability ever at the Federal level—today we can help serve as a catalyst for the innovative and, I think, critical reform efforts taking shape around this country. The amendment would reserve $200 million of title I funds for disadvantaged children to provide assistance and support to low-performing schools. This amendment will compel school districts to take strong corrective actions to improve consistently low-performing schools. Passage of this amendment signals our commitment to the public schools. Our commitment to their success. And our commitment to ensuring failing schools turn around.

For too long in this Nation we have tolerated low standards and low expectations for our poor children. The standards movement has begun to turn the tide on low expectations and we must build on that momentum and demand accountability from schools that fail our children. We have this opportunity at a time when the American people are telling us that—for their families, for their futures—in every poll of public opinion, in every survey of national priorities—one issue matters most—and it's education. Good news for all of us who care about education, who care about our kids. But the bad news is, the American people aren't so sure we know how to meet their needs anymore. They aren't even so sure we know how to listen.

Every morning, more and more parents—rich, middle class, and even the poor—are driving their sons and daughters to parochial and private schools where they believe there will be more discipline, more standards, and more opportunity. Families are enrolling their children in charter schools, paying for private schools when they can afford them, or even resorting to home schooling—the largest growth area in American education.

This amendment comes at an important time for our schools, you might say it comes at an even more important time for this Congress. We have to break out of the ideological bind we've put ourselves in—we can't just talk about education—it's more than an issue for an election—we've got to do something about it. Parents in this country believe that public schools are in crisis and despite a decade of talk about reform, they give them no higher grade than a decade ago. 67 percent are dissatisfied with the way public education is working; 66 percent use the word crisis to describe what's going on in our schools today. But the American people—at times more than we seem to be in the Senate—are firmly committed to fixing our public schools—fixing our schools—not talking about fixing them, not using kids as pawns in a political chess game.

It boils down to one fundamental, overriding concern: Americans want accountability for performance and consequences for failure in the public school system. Americans support a variety of innovative approaches to improving education—it's actually Washington that is more afraid of change than the citizens who sent us here. And it is time for us to be a catalyst for change—to help facilitate more innovation, not less—to improve the state of education in America: to address the problem of reading scores that show that of 2.6 million graduating high school students, one-third are below basic reading level, one-third are at basic, only one-third are proficient and only 100,000 are at a world class reading level.

The time to lay down the marker of accountability for student performance is now. That's why today's discussion is so important—because we have the opportunity today to do it—to stop talking past each other—and to deliver on the most important principle of real education reform—accountability.

When schools begin to fail, when there is social promotion, when kids are being left behind, we need to hold those schools accountable for taking those best practices and turning around low performing schools not 5 years from now, not some time in the future, not after another study, but today—now. And if we can commit ourselves to that kind of accountability then we will have taken an incredible leap forward, not just building public confidence in public education, but in making all our schools better. It is past time that we coalesce around an approach to reform grounded in four simple concepts: high standards; teaching to those standards; giving every student the opportunity to meet those standards; and building strict accountability into the system to make those standards meaningful.

Mr. President, 49 States have embraced or will soon embrace meaningful standards; there should be no partisan divide over this issue—and now is the time for us all to embrace the policies which empower our teachers to teach to standards and give every student the real opportunity to meet high standards. Now is the time for us to embrace the accountability that has worked so well for real leaders like Gov. Tom Carper in Delaware, and Mayor Daley in Chicago—now is the time for us to say not just that we hope schools will meet high standards, but that we'll work with them—holding them accountable—to get them there. It's time for us to say that we're willing—in our title I spending—to hold schools accountable for meeting those high benchmarks—to reach out to low performing schools and give them the intensive help they need to turn things around and help raise student performance. It boils down to real accountability—to acknowledging that though the Federal role in education, in terms of pure spending, has been relatively small, it does provide the leverage—if we are willing to embrace it—to empower schools in need of reform to turn themselves around rapidly—to cut through layers of bureaucracy—to access new resources—to shake up staff—and, if need be, to reconstitute itself—to become a new school in a fundamental sense—or to turn itself into, essentially, a charter school within the public school system. We know that title I itself, with the early accountability reforms already in place have raised accountability—but I would say that in this amendment we could do so much more—and we should.

Consider the impact more accountability would make—the ability we would have to truly adhere to high standards throughout the system: to raise teacher quality; reform certification; provide mentoring and ongoing education; embrace merit pay; higher salaries; and end teacher tenure as we know it.

Consider the ability to hold schools accountable for our childrens' needs—to say that we will not allow schools to be the dumping ground for adult problems—and to acknowledge that we need to fill those hours after school with meaningful study—curriculum—and mentoring.

Consider the ability to hold students accountable for discipline and violence: to allow schools to write discipline codes and create second chance schools: to eliminate the crime that turns too many hallways and classrooms into arenas of violence.

We need to do these things now—to be willing to challenge the status quo—to do more for our schools, to help every student achieve, to guarantee reform when they don't—and—in no small measure—to renew the promise of public education for the 21st century.

This will not happen overnight, but it will happen. I look forward to joining with all of my colleagues in that effort: to pass this amendment, to make accountability the foundation of reform, and to face the challenge of fixing our public schools together.

Mr. BINGAMAN. Mr. President, I ask unanimous consent two letters be printed in the RECORD at this point, one from Michael Davis, who is the superintendent of public instruction from my home State of New Mexico, and the other from Gordon Ambach, who is the head of the Council of Chief State School Officers. The first letter from Mr. Davis is in support of the amendment. The second letter supports providing additional funds to States to implement the accountability provisions of title I. Mr. Ambach had not seen the amendment yet when he wrote that letter.

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

STATE OF NEW MEXICO,
DEPARTMENT OF EDUCATION,
Santa Fe, NM, October 6, 1999.

Hon. JEFF BINGAMAN,
U.S. Senate, Washington, DC.

DEAR SENATOR BINGAMAN: I write to applaud your efforts to secure a dedicated source of funding for States and local school districts to implement the accountability provisions of Title I. As you know, we have been working hard in New Mexico to raise standards and implement a rigorous accountability system. We will be unable to successfully implement high standards and accountability, however, unless we are able to provide local districts with additional resources to help them address weaknesses in their educational programs and to turn around failing schools. I believe that your amendment seeking to direct $200 million for this purpose will go a long way towards ensuring proper enforcement of the accountability provisions under Title I.

Thank you for your efforts. Please let me know if I can be of assistance to you.

Sincerely,

MICHAEL J. DAVIS,
State Superintendent of Public Instruction.

COUNCIL OF CHIEF STATE SCHOOL OFFICERS,
Washington, DC, June 22, 1999.

Member, House Education and the Workforce Committee,
U.S. House of Representatives, Washington, DC.

RE: Provisions for Program Improvement in Reauthorization of ESEA Title I—The need for greater funding

DEAR REPRESENTATIVE: Title I of the Elementary and Secondary Education Act (ESEA) now includes very important provisions for the identification in each state of those schools with lowest levels of student achievement and most in need to program improvement. This provision earmarks funds for the state education agency (SEA) to assist local education authorities and these schools with their strategies to improve achievement. This state role is authorized on the assumption that if the district and school had the capacity internally to improve; improvement would have occurred and be reflected by increased achievement scores. Unfortunately, the analysis of Title I school by school test scores reveals that nearly 7,000 schools have continuing low performance over the years and need ''external'' program improvement help. The problem is that the federal appropriation for program improvement is far too small to serve 7,000 schools effectively.

An increase in the state education agency (SEA) set-aside for program improvement is urgently needed to help the 7,000 lowest performing schools in the nation build capacity, improve student achievement and meet new accountability requirements for student progress. As your Committee develops a bill to reauthorize Title I for introduction and markup, we urge a substantial increase in the funds set-aside for improving programs in schools where students are not making adequate progress toward achieving state standards. The current ½ of 1% of each state's total Title I allocation which may be set-aside for program improvement provides only $40 million of the $8 billion program for SEAs to fulfill the required activities for schools identified as needing improvement. An increase to 2.5% by FY2001 and 3.5% by FY 2004 as proposed by the Administration is critical to provide $200 million to $300 million to serve the 7,000 schools with support teams, mentors, distinguished educators, additional comprehensive school reform efforts, professional development and other forms of technical assistance called for in the bill.

Increased program improvement funding is the right strategy for these reasons:

(1) All program improvement funds are used directly to raise quality in the classrooms of the lowest performing Title I schools. Under the Administration proposal for ESEA reauthorization, 70% of the funds authorized for program improvement must be allocated by the SEA to the LEA to carry out its program improvement activities in failing schools according to its local plan approved by the SEA. The remaining 30% of the program improvement funds will be used by the SEA for direct support and assistance to the classrooms of such schools. This state service assures that both the state and local districts are partners in bringing external resources to help teachers and leaders in those schools. All of the uses of funds for program improvement are defined as the ''Dollars to the Classroom'' bill of the same title. All of these funds support improvement in the classrooms which most need the help.

(2) The current $40 million which is available under the .5% set-aside is woefully inadequate for SEAs and districts to serve and improve low-performing schools. This amount is grossly insufficient to fulfill the requirements and needs of the almost 7,000 schools already identified as needing improvement. The average amount available now per school is only $5,715 per year. New provisions expected in the reauthorization for school support teams, distinguished educators and mentors, technical assistance to adopt and implement research-based models for improved instruction, and professional development for teachers and school leaders in methods which assure student success require more resources per school. The need will increase substantially for schools identified as needing improvement as states and districts continue to implement challenging standards and assessments for all students. Proposed accountability requirements to assure all students are continually learning the skills necessary to achieve on grade level and comparability of teacher quality in each school will add to the challenges for schools in need of improvement and must be met with increased external support.

(3) Although Title I is the single largest federal elementary and secondary program, Title I has the smallest proportion of funds devoted to administration, support and assistance, and quality control monitoring of any of the major federal programs. The Individuals with Disabilities Education Act (IDEA) has 25%, and the Perkins Vocational-Technical Education Act has 15% with an additional 10% directed by the state to rural and urban areas through competitive grants. Only 1% of the Title I total is authorized for states to operate and support all eligible schools in a program which expends $8 billion in federal taxpayers' funds to serve 11 million students in 45,000 schools in 90% of the nation's school districts. The amount of funds devoted to state and locally assisted program improvement in the lowest-performing schools is an additional 0.5%. State capacity for helping title I districts and schools is significantly underfunded and therefore underused. Congress should rely on state level assistance for Title I, as it does for IDEA, Perkins Vocational-Technical Education, Technology Challenge Grants, and other federal programs. Leveraging substantial, sustained gains in student achievement in these schools requires a far stronger investment in state assistance than in the current law.

We hope these comments are helpful as you develop this critical piece of legislation. We urge you to act on them. Please feel free to call us at (202) 336–7009 if you have any questions or find we can be of further assistance.

Respectfully Submitted,

GORDON M. AMBACH,
Executive Director.

Mr. BINGAMAN. Mr. President, let me read a few sentences from the letter from Michael Davis. He is a very capable, respected, State school superintendent from my State. He writes:

DEAR SENATOR BINGAMAN: I write to applaud your efforts to secure a dedicated source of funding for States and local school districts to implement the accountability provisions of Title I. As you know, we have been working hard in New Mexico to raise standards and implement a rigorous accountability system. We will be unable to successfully implement high standards and accountability, however, unless we are able to provide local districts with additional resources to help them address weaknesses in their educational programs and to turn around failing schools. I believe that your amendment seeking to direct $200 million for this purpose will go a long way towards ensuring proper enforcement of the accountability provisions under Title I.

Then, in the letter from the executive director, Mr. Ambach, of the Council of Chief State School Officers, the point that is made strongly is that the current $40 million that is available under the 0.5-percent set-aside for States is woefully inadequate for local school districts to serve and improve low-performing schools. I think those two letters speak very strongly in favor of what we are trying to do.

I very much appreciate the support of Senator KENNEDY, Senator WELLSTONE, Senator REED, and Senator KERREY.

Let me say a few other things before my time is up. How much time remains on my side?

The PRESIDING OFFICER. The Senator has 1 minute 50 seconds.

Mr. BINGAMAN. Mr. President, this amendment, as I have said before, should not be a partisan issue. I know many of the amendments that have been brought to the Senate floor in recent days and weeks and even months have been voted along partisan lines. This amendment should not be. The need for accountability is not a partisan issue.

Just yesterday, Governor Bush from Texas talked about his plan for improving accountability in title I schools. Under his plan, school districts and schools would have to show improvement in test performance. If schools improved, they would be rewarded with additional funds. If schools did not improve in 5 years, those funds would be taken and given to parents or students in vouchers of $1,500 each.

The problem with this proposal is it provides the stick, a very big stick with dire consequences for schools that do not perform, but it does not provide resources to help those schools avoid that failure. This proposal says if you can figure out how to turn your school around with the meager resources you have, fine; if you cannot, then we will let the clock run out and then take the money away, so your odds against succeeding become insurmountable.

What this amendment will do is provide that assistance to those schools immediately when the failing nature of that school is recognized. I think this is an extremely important amendment. It is something we ought to do. I hope this is considered by each Senator as a good-faith effort to better use the funds we are spending in this bill.

Once again, I remind all my colleagues, this amendment does not add money to the bill. This is not a question of whether we are going to spend more or less on education. It is a question of how effectively we can spend the funds we are going to spend.

Mr. President, I gather my time is up. I yield the floor at this time and wait for the response, if there is any opposition to the amendment, which I certainly hope there is not.

The PRESIDING OFFICER. Who yields time in opposition?

Without objection, the Chair, acting in my capacity as an individual Senator from Kansas, notes the absence of a quorum, and the clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. COVERDELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. COVERDELL. Mr. President, the Bingaman amendment will provide $200 million from the funds the committee provided for basic and concentration grants to support State and local accountability efforts to identify school failure and provide progressively more interventions to turn around the performance of the local school. Under the current law, States may now reserve 0.5 percent for such activity. This amendment would set aside $200 million, or 2.5 percent, specifically for State and local accountability efforts. States would not, therefore, be given the choice of whether or not to spend funds for accountability purposes which resemble very much a mandate. This amendment would take education funds away from States to educate low-income students. Most States already have adopted statewide accountability systems that include State assessments to measure whether students are meeting State standards, report cards that summarize performance of individual schools, and rating systems that determine whether a school's performance is adequate.

The authorizing committees have not had the opportunity to carefully examine the issue of whether to increase the amount set aside for accountability. Hearings should be held where States can express their views, and this issue should be addressed during the reauthorization of the Elementary and Secondary Education Act.

Mr. President. how much time remains on our side?

The PRESIDING OFFICER. The Senator from Georgia has 12 minutes 42 seconds.

Mr. BINGAMAN. Mr. President, may I ask if the Senator will yield for a question?

Mr. COVERDELL. I would be glad to yield for a question.

Mr. BINGAMAN. Mr. President, I was informed that the Governors Association supports this amendment, and that the States would want the initial ability to use these funds. Does the Senator have information to the contrary? I know he raised a concern about requiring States to do something different. My information is that this is the authority they would want.

Mr. COVERDELL. I am advised by the committee staff that we don't have the same information the Senator has just expressed, so I cannot comment one way or the other.

Mr. BINGAMAN. Mr. President, I might just respond that we will try to get that information to the Senator from Georgia before the vote occurs at 11:30.

Mr. COVERDELL. Very good. I appreciate the comment of the Senator.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. WELLSTONE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. WELLSTONE. Would it be in order for me to call up my amendment in order to move on? I ask unanimous consent to set aside the pending amendment and call up amendment numbered 1842.

The PRESIDING OFFICER. Is there an objection to setting aside the amendment?

Mr. COVERDELL. Mr. President, reserving the right to object——

Mr. WELLSTONE. Just to be clear to colleagues, I thought we were finished and were trying to move along. I am willing to wait, if Senator BINGAMAN wishes to continue.

Mr. COVERDELL. We may wish to continue.

Mr. WELLSTONE. Very well.

Mr. COVERDELL. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. WELLSTONE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. WELLSTONE. I wonder whether I could ask unanimous consent for 3 minutes as in morning business to make a statement while we are in deliberations. I ask unanimous consent to be able to do that.

The PRESIDING OFFICER. Is there objection?

Mr. COVERDELL. Mr. President, I do not object to yielding 3 minutes of time as in morning business, and that following that we go back to this.

Mr. WELLSTONE. Absolutely. I am trying to make the best use of our time, Mr. President.

The PRESIDING OFFICER. The Senator is recognized for 3 minutes.

MERGERS IN THE MEDIA AND COMMUNICATIONS INDUSTRIES

Mr. WELLSTONE. Mr. President, we are in the midst of an unprecedented wave of mergers and concentration in the media and the communications industries. We are talking about the flow of information in democracy and whether a few are going to control this. But instead of doing anything about it, to protect American consumers or to safeguard the flow of information that our democracy depends upon, I am troubled by efforts underway to undermine protections that are already on the books.

I cite that the CBS-Viacom merger announced last month would be the biggest media deal ever. Today, the FCC announced its approval of a merger between SBC and Ameritech. On Tuesday, Clear Channel Communications announced that it is buying AMFM to create a huge radio conglomerate with 830 stations that will dominate American radio.

I am amazed so few people are concerned about these developments. The reason I rise to speak about this is that when FCC Chairman Bill Kennard is so bold as to point out that the MCI-Sprint deal would undermine competition, he is simply doing his job. I want to say on the floor of the Senate, he should not be punished for doing his job.

Last year, when the FCC approved the merger of Worldcom and MCI, Chairman Kennard said the industry was one merger away from undue concentration. Now this merger would be the one that pushes us over the top.

So when Antitrust Division Chief Joel Klein of the Justice Department brings some very difficult cases to enforce our country's antitrust laws, he is simply doing his job. When FCC Chairman Bill Kennard raises these kinds of questions, he is simply doing his job.

We cannot expect these agencies to enforce our laws, to do their job, if we take away their budgets or their statutory authority every time they do it. We need to strengthen our review of these mergers. We need to strength our antitrust laws, on which I think we have to do much better. And we need to give the Justice Department, the FTC, and the FCC the resources they need to enforce the law.

So more than anything else, I rise to support Bill Kennard's concerns, to tell him he is doing his job, and urge my colleagues to understand that he has an important responsibility to protect the consumers. The flow of information in our democracy is the most important thing we have. He certainly

should not be punished for doing his job and doing his job well.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2000—Continued

Mr. BINGAMAN. Mr. President, is there time remaining on the amendment I have offered?

The PRESIDING OFFICER. There is not. All time has expired.

Mr. BINGAMAN. I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Georgia.

Mr. COVERDELL. Mr. President, I ask unanimous consent that the vote occur in relation to the Bingaman amendment at 11:15, with 2 minutes equally divided prior to the vote.

The PRESIDING OFFICER. Is there objection?

Mr. BINGAMAN. Mr. President, may we have 4 minutes equally divided?

Mr. COVERDELL. I change the unanimous consent to ask that we have 4 minutes equally divided.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Minnesota.

AMENDMENT NO. 1842

(Purpose: To express the sense of the Senate regarding the importance of determining the economic status of former recipients of temporary assistance to needy families)

Mr. WELLSTONE. I ask unanimous consent to set aside the pending amendment, and I call up amendment No. 1842.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from Minnesota [Mr. WELLSTONE] proposes an amendment numbered 1842.

The amendment is as follows:

At the appropriate place add the following:

SEC. . It is the sense of the Senate that it is important that Congress determine the economic status of former recipients of assistance under the temporary assistance to needy families program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

Mr. WELLSTONE. Mr. President, let me first explain this amendment to colleagues and then marshal my evidence for it.

I believe we will have a good, strong vote on the floor of the Senate for this amendment. I have introduced a similar amendment in the past, which lost by one vote, but I have now changed the amendment which I think will make it more acceptable to colleagues.

In the 1996 welfare law we passed, we set aside $1 billion for high-performance bonuses to go to States, and currently this money goes to States. The way it works is, it uses a formula that takes into account the State's effectiveness in enabling TANF recipients to find jobs, which is terribly important. The whole goal of the welfare bill was to move families from welfare dependency to becoming economically independent.

This amendment would add three more criteria. We have had, in the last year or two, a dramatic decline in food stamp participation, about a 25-percent decline. This should be of concern to all of us because the Food Stamp Program has been the most important safety net program for poor children in our country. Indeed, it was President Nixon, a Republican President, who, in 1972, federalized this program and said: One thing we are going to do as a national community is make sure children aren't going hungry in our country. We are going to make sure we have a program with national standards and that those families who are eligible to participate are, indeed, able to obtain this assistance.

In addition, what we want to find out is the proportion of families leaving TANF who were covered by Medicaid or health insurance. Families USA, which is an organization that has tremendous credibility with all of us, issued a disturbing report a few months ago. To summarize it, because of the welfare bill, there are about 670,000 Americans who no longer have any health care coverage.

Maybe that is worth repeating. Because of the welfare bill, there are about 670,000 Americans who no longer have any coverage. Since about two-thirds of welfare recipients have always been children—this was, after all, mainly for mothers and children—we want to make sure these children and these families still have health care coverage.

We want to also make sure we get some information about the number of children in these working families who receive some form of affordable child care. In other words, again, what we want to find out is, as families move from welfare to work, which is the goal—and I think work with dignity is terribly important—we also want to make sure the children are OK.

Again, I will use but one of many examples. It will take me some time to develop my argument, but one very gripping example, I say to the Chair, is when I was in east LA, I was meeting with a group of Head Start mothers. As we were discussing the Head Start Program and their children, one of the mothers was telling me she had been a welfare mother and was emphasizing that she was working. Indeed, she was quite proud of working. In the middle of our discussion, all of a sudden she became upset and started to cry.

I asked her: If I am poking my nose into your business, pay no attention to me, but can you tell me why you are so upset? She said: The one problem with my working is when my second grader goes home—she lived in a housing project; later I visited that housing project—it is a pretty dangerous area. It used to be I could walk my second grader to school, and then I could walk her home, make sure she was OK. I was there with her. Now I am always frightened, especially after school. I tell her to go home, and I tell her to lock the door. I tell her not to take any phone calls because no one is there.

It makes us wonder how many children are in apartments where they have locked the door and can't take any phone calls and can't go outside to play, even when it is a beautiful day. I think we do need to know how the children are faring and what is going on. Again, this is a matter of doing some good policy evaluation.

Finally, for those States that have adopted the family violence option, which we were able to do with the help of my wife Sheila and Senator PATTY MURRAY, we want to know how well they are doing in providing the services for victims of domestic violence. This is important. The family violence option essentially said we are not saying these mothers should be exempt. What we are saying is there should be an opportunity for States to be able to say to the Federal Government—it would be up to States, and they would not be penalized for that—look, this woman has been battered and beaten over and over again and we are not going to get her to work as quickly as we are other mothers; there are additional support services she needs. When she goes to work, this guy is there threatening her. Because of these kinds of circumstances, please give us more flexibility.

We want to find out how these States are dealing with that. Otherwise, what happens is if you don't have that kind of flexibility, then a mother finds herself sanctioned if she doesn't take the job; but she can't really take the job and, therefore, the only thing she ends up doing is going back into a very dangerous home. She has left, she has tried to get away, and she is trying to be safe. If you cut off her assistance, then she has no other choice but to go back into a very dangerous home.

That should not happen in America. By the way, colleagues, I know it is an incredible statistic, but October is the month we focus on violence in homes. I wish it didn't happen. About the most conservative statistic is that every 13 seconds a woman is battered in her home in our country. I can't even grasp the meaning of that. A home should be a safe place.

As I have said before—and I hope my colleagues, Senator HOLLINGS and Senator JUDD GREGG, will help me keep this in conference committee—about 5 million children see this violence. So we talk about the fact children should not see the violence in movies and on television. A lot of them see the violence right in their homes. It has a devastating impact on their own lives. We need to make sure these kids don't fall between the cracks and that we provide some services.

I am going to start out in a moment with some examples. I am talking about nothing more than good policy evaluation. Let me wear my teacher hat. All I am saying—and we can disagree or agree about the bill, on should we have passed it or not, and some things are working well but some have questions; I have questions—let's at least do some good thorough policy evaluation. We are saying that the States just merge their tapes —they have the data—and present it to Health and Human Services. We have a report. We know what is going on in these areas.

This is a sense-of-the-Senate amendment because, otherwise, I would have been subject to a rule XVI point of order. I hoped I would not have had to do a sense of the Senate because, under normal circumstances, we would have had the House bill over here. If the House bill had been over here, then I could have introduced this amendment, and I would not have been subject to any rule XVI challenge. Since that has not happened, what I am doing is bringing this amendment out, getting, I hope, a good, strong vote, and if the House does, in fact, move forward with some work and gets the Labor-Health and Human Services Appropriation bill passed, then I will bring this amendment back as a regular amendment. I say to colleagues, all the time I spend today will have been well spent, and we can have 5 minutes of debate and then vote on it. In a way, I am trying to move us forward in an expeditious manner.

When we are talking about families that are worried about whether they can put food on the table or worried about whether they can pay the rent at the end of the month, I don't think they much care whether or not my amendment is subject to rule XVI; I don't think they much care whether or not this is an amendment on an appropriations bill; I don't think they much care about why the House hasn't sent an appropriations bill over to the Senate. What they care about are more pressing issues.

What I am concerned about is that there is, indeed, a segment of our population who are very poor, the majority of whom are children, who are, indeed, falling between the cracks. Let me also say at the very beginning that I think this is the question: Since the welfare bill passed, we have reduced the rolls by about 4.5 million people, the majority of them children. That has been about a 50-percent reduction in the welfare population. The question is whether or not the reduction of the welfare rolls has led to a reduction of poverty because the goal of the legislation was to move these families to some kind of economic self-sufficiency and certainly not to put them in a more precarious situation.

I think we ought to have the data. I think we ought to do the policy evaluation. I have said it before on the floor of the Senate, and I think it is worth saying again: One of my favorite sociologists, Gunnar Myrdal, a Swedish sociologist, once said, ''Ignorance is never random; sometimes we don't know what we don't want to know.'' I think we ought not to be ignorant about this. We ought to have the data.

My appeal is to do the policy evaluation. This amendment will not cost additional money. It can be absorbed into the existing amount of money, according to CBO. There is no reason why we should not want to know—especially since, in many States, the drop-dead date certain is approaching where everyone will have used up the number of years they can receive an AFDC benefit and will be cut off assistance. Before we do that with the rest of the population, let's at least have some kind of policy evaluation. Let's understand what is happening to these families.

By the way, I think among those families that are still on welfare, we are talking about a fair number of children who had children and who need, therefore, to get a high school diploma or are in need of job training. We are talking about single parents with severely disabled children. We are talking about a fair number of single parents who are women who struggle with substance abuse. I am being blunt about it. This is an issue I know well from work I have done all of my adult life in local communities. We are talking about women who have been victims of domestic violence. We need to be careful about what we are doing. Sometimes we forget it, but this is about the lives of people in the country and, in particular, poor women and children. I think we ought to have an honest policy evaluation.

I want to put this in a very personal context now. Before I do this, I wish to start out with some art work that will speak to this part of my presentation. We had a group of high school students from Minneapolis here—it was incredible—who were working with the Harriet Tubman Center, which is a very special shelter. These high school kids—I think 300 or 400 of them submitted their art, and these 11 or 12 students were the ones who had the best art, but all of it was exceptional—came to Washington, DC, 2 days ago. This display is now in the Russell Building Rotunda for a week. Every year, for the last 6 or 7 years, Sheila and I have brought different works from around the country—sometimes from Minnesota and sometimes from other States—to the Nation's Capitol. I want to show a little bit of these students' work.

So often the focus on students is so negative. These are inner-city high school students. It was a wonderful diversity, with all sorts of nationalities, cultures, histories, different colors, a great group of students. I was so pleased they came to Washington. This work I think speaks for itself. I will read from the top:

Is a corner in your home the only place your child felt safe today? Why is it always my fault? Stop it. Speak up. Seeing or hearing violence among family members hurts children in many ways. They do not have to be hit to feel the pain of violence.

I am going to hold this up for a moment so it can be seen by people who are watching this presentation. My colleagues can see this in the Russell Rotunda.

Next picture. I will hold it up. It says:

In the time it takes you to tie your shoe, a woman is beaten. . ..Go ahead, now tie your other one! Speak up! Domestic violence causes almost 100,000 days of hospitalization, 30,000 emergency room visits, and 40,000 trips to the doctor every single year.

I will just hold this up for a moment so it can be seen. This is pretty marvelous work. This is art from the heart. This is art from the heart of high school students. I say that to the pages; they are high school students.

The next work:

If we hear the violence and see the violence, why is it so hard to speak of the violence?

Is being a passer-by keeping a secret? ''Speak up.''

Ninety-two percent of women who are physically abused by their partners do not discuss these incidents with a physician. Fifty-seven percent do not discuss the incidents with anyone.

Finally, this is really powerful. I will show it this way, too.

So . . . how do your kids behave on a date? Love isn't supposed to hurt.

Two high school kids.

On average, 100 out of 300 school students are or have been in an abusive dating relationship. Only 4 out of 10 of these relationships end when the violence and abuse begin. One out of three high school students is or has been in an abusive dating relationship.

I say to my colleague from Nevada this is marvelous artwork done by high school students in inner-city Minneapolis. Twelve of them came to Washington, DC. I thank my colleague, Senator REID from Nevada, for having the courtesy and graciousness to acknowledge this work.

I want to tell you about a conversation I had. Maureen, who works with Interchange Food Pantry in Milwaukee, WI, told me about a phone call she received on Monday of this week—Monday this week. On Monday, Maureen received a phone call. It was a woman who was well known at the food pantry, a woman who has a file about an inch and a half thick documenting the domestic violence she has endured at the hands of an abusive husband.

Yesterday, this woman—we are talking about this week, right now. I want everyone to understand that this debate is about people's lives.

Yesterday, this woman ran out of her home with her 3-year-old child in her arms, fleeing her abusive husband. She went to school, and she picked up her three other young children. She went to a laundromat. She called Maureen. She was looking for help, and she didn't know where else to turn.

The people at the food pantry tried to place this woman in a domestic violence shelter. But homelessness right now seems to have reached epidemic proportions in Milwaukee. So many women are becoming homeless that all of the battered women's shelters are full to overflowing, and desperate women are presenting themselves as victims of domestic violence so they can be placed in shelters. The shelters don't have any room because there are so many homeless women and children. Some of these women are basically pretending as if they are victims. Plenty of them are. Because they are so battered, they try to find shelter. What this means is there is no place left to go for homeless women and women who are victims of domestic violence.

She couldn't find a shelter at this food pantry. They could find no shelter to place this woman. On the phone, they couldn't find anything for her.

This is 1999 in America. The economy is booming. We don't have this kind of discussion on the floor of the Senate enough.

All that food pantry was able to do was to give her some food vouchers and a bus ticket so they could go spend the night with her mother. But her mother lives in senior housing. She is not supposed to have overnight guests, and she could actually end up losing her house if they get caught.

So this woman, who has a 15-year history of abuse, is going to have to return to her home. That is where she is going. She will have to go back to this abusive, violent, dangerous situation for herself and for her children because she lacks the economic independence to do anything else.

No one should be forced to risk their life or the lives of their children because they are poor. This woman's story is a welfare nightmare. She is doing all she can. Her children are clean, and they are well cared for. But she is not making it economically. Her husband isn't willing to work. Therefore, the family has been sanctioned by the welfare department on and off. She has been forced to rely on the food pantry for help.

So she sells her plasma as often as possible—about three times a week. She doesn't have a high school degree. But the welfare agency, instead of making sure she gets her GED and the training she needs to get some kind of a living-wage job, has put her into a training program so she can become a housekeeper in a hotel. Their idea of getting this woman to a life of economic independence is to place her as a housekeeper in a hotel.

She has been in an abusive, dangerous situation for 15 years. Her caseworker is aware of her situation. But there is no help. There is no effort to make her economically independent so she can leave the marriage, and she is now being forced back into this home. She does not have the economic wherewithal to leave her home.

This woman has tried. She went to the welfare office. She asked to be placed in a job. They put her to work in a light manufacturing job, a job for which she had no training whatsoever. Making the situation even worse, they placed her in a job that was way out in the suburbs with a 45-minute commute each way on a bus.

Listen to this. This is why I think we need to know what is going on in the country. She had to get up at 4:30 in the morning, drop her kid off at child care—child care is hard to find at 4:30 in the morning—travel to her job, put in a full day's work, and ride all the way home, pick up her kids, and go back home to face her abusive husband. When she went to the welfare worker and explained the situation, she was told that if she quit this job, she would be sanctioned and she would lose her benefits.

This woman's life and the lives of her children are not going to get better until she can get out of her situation. But under the current welfare program—at least the way it is working in one State, in one community—this isn't going to happen.

Let me give a few examples from some of the studies that have been done. Then let me go into the overall debate.

Applying for cash assistance has become difficult in many places. In one Alabama county, a professor found that intake workers gave public assistance applications to only 6 out of 27 undergraduate students who requested them despite State policy that says anyone who asks for an application should get one.

This was from a Children's Defense Fund study. The study cited was by the professor who was doing fieldwork research on the application process in two Alabama counties.

Before I actually give the examples, let me go to the debate. There are those who argue that we don't need to do any policy evaluation because we have cut the rolls in half. But the goal was never cutting the rolls in half. The goal was to reduce poverty.

Let me cite some disturbing evidence: The reduction in the roles is not bringing a reduction in poverty. We want to know, what kind of jobs do the mothers have? What kind of wages? Are the families still receiving medical coverage? Is there affordable child care? Are children still participating in the Food Stamp Program? This is what we need to know.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. ALLARD). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. COVERDELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. COVERDELL. Mr. President, I ask consent that following the vote which is to occur momentarily, Senator WELLSTONE be recognized for an additional 45 minutes, and following the use of or yielding back of time, Senator COVERDELL be recognized to move to table amendment No. 1842, no second-degree amendment be in order prior to the vote, and the vote would occur at 1:50.

Mr. WELLSTONE. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I agree with the request and I am pleased to work within this framework. I have a judge I have to meet; he is going to be appearing before an important committee. I do not get done with that until a little bit after 2 o'clock. Could we say 2:15 instead of 1:50?

Mr. COVERDELL. I wonder if it could be 1:45? What I am dealing with is a total sequence of time. There are other amendments. I wonder if we voted at 1:45, would it give the Senator time to get to his introduction? It would be very helpful if we could do that.

Mr. WELLSTONE. Mr. President, I will figure out how to do it.

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

AMENDMENT NO. 1861

Who yields time on the Bingaman amendment?

Mr. BINGAMAN. Mr. President, how much time is there at this point?

The PRESIDING OFFICER. There are 4 minutes equally divided.

Mr. BINGAMAN. Mr. President, let me sum up what the amendment does. It is an amendment to set aside $200 million of title I funds to be targeted at helping schools that are failing. We give a lot of speeches about how we need to help failing schools. This is a chance to vote to help failing schools. The amendment does not add money to the bill. The amendment says we are serious about accountability. We are giving the States some funds, earmarking some funds so they also can be serious about accountability in the expenditure of title I funds.

I have a letter from the National Governors' Association. I ask unanimous consent it be printed in the RECORD.

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

NATIONAL GOVERNORS' ASSOCIATION,
Washington, DC, October 7, 1999.

Hon. Senator JEFF BINGAMAN,
703 Hart Senate Office Building,
U.S. Senate, Washington, DC.

DEAR SENATOR BINGAMAN: On behalf of the nation's Governors, I write to express our

strong support for your amendment to provide states with additional funds to help turn around schools that are failing to provide a quality education for Title I students.

As you know, under current law, states are permitted to reserve one-half of one percent of their Title I monies to administer the Title I program and provide schools with additional assistance. However, this small set-aside does not provide the states with sufficient funds to improve the quality of Title I schools. A recent study by the U.S. Department of Education noted that the ''capacity of state school support teams to assist schools in need of improvement of Title I is a major concern.'' The programs authorized to fund such improvement efforts have not been funded. As a result, states have been unable to provide such services. According to ''Promising Results, Continuing Challenges: The Final Report of the National Assessment of Title I,'' in 1998, only eight states reported that school support teams had been able to serve the majority of schools identified as needing improvement. In twenty-four states, Title I directors reported more schools in need of school support teams than Title I could assist.

Earlier this year, the National Governors' Association (NGA) adopted an education policy that recognizes the important role of the states in providing technical assistance to local school districts to help them implement federal education programs. In addition, the policy calls for full implementation of the current Title I accountability provisions, including the requirements that states intervene in low performing schools. However, the policy calls on the federal government to provide states with sufficient funds to enable states to provide school districts with the tools to meet federal program requirements. Your amendment would provide such funding. Therefore, NGA supports your amendment and will urge other Senators to support the adoption of it.

We look forward to working with you towards the enactment of this and other provisions that will help states improve the quality of services provided to Title I students.

Sincerely,

RAYMOND C. SCHEPPACH.

Mr. BINGAMAN. Let me read a few sentences from it. This is addressed to me, Senator BINGAMAN.

On behalf of the nation's Governors, I write to express our strong support for your amendment to provide states with additional funds to help turn around schools that are failing to provide a quality education for Title I students.

It goes on to say:

Earlier this year, the National Governors' Association (NGA) adopted an education policy that recognizes the important role of the states in providing technical assistance to local school districts to help them implement federal education programs.

It goes on to say:

. . . the policy calls on the federal government to provide states with sufficient funds to enable states to provide school districts with the tools to meet federal program requirements. Your amendment would provide such funding. Therefore, NGA supports your amendment and will urge other Senators to support the adoption of it.

This is a good amendment. The States support it. It will help dramatically in improving our schools. We should not postpone this. We should not kick this down the road and say we will deal with it sometime in the future. We should do it today.

I urge my colleagues to adopt the amendment.

The PRESIDING OFFICER. The time of the Senator has expired. The Senator from Georgia.

Mr. COVERDELL. Mr. President, the amendment would take money that currently goes directly to school districts and give it to States for accountability purposes. The authorizing committee, chaired by Senator JEFFORDS of Vermont, wants to have an opportunity to take a careful look at this issue during reauthorization of the Elementary and Secondary Education Act. While the letter from the National Governors' Association states that the association supports the amendment, the fact remains that funds would still be taken from local school districts. While this may be a decision the authorizing committee may ultimately make, it needs to be decided at the authorizing committee level. This is a significant decision, to take money directly from classrooms, and should be carefully reviewed.

I yield the remainder of the majority's time, if any remains, and I move to table the Bingaman amendment.

Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to table amendment No. 1861.

The yeas and nays have been ordered.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from Arizona (Mr. MCCAIN) is necessarily absent.

Mr. REID. I announce that the Senator from Connecticut (Mr. DODD) is absent because of family illness.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 53, nays 45, as follows:

[Rollcall Vote No. 317 Leg.]

YEAS—53

Abraham	Fitzgerald	Murkowski
Allard	Frist	Nickles
Ashcroft	Gorton	Roberts
Bennett	Gramm	Roth
Bond	Grams	Santorum
Brownback	Grassley	Sessions
Bunning	Gregg	Shelby
Burns	Hagel	Smith (NH)
Campbell	Hatch	Smith (OR)
Chafee	Helms	Snowe
Cochran	Hutchinson	Specter
Collins	Hutchison	Stevens
Coverdell	Inhofe	Thomas
Craig	Jeffords	Thompson
Crapo	Kyl	Thurmond
DeWine	Lott	Voinovich
Domenici	Mack	Warner
Enzi	McConnell	

NAYS—45

Akaka	Byrd	Feinstein
Baucus	Cleland	Graham
Bayh	Conrad	Harkin
Biden	Daschle	Hollings
Bingaman	Dorgan	Inouye
Boxer	Durbin	Johnson
Breaux	Edwards	Kennedy
Bryan	Feingold	Kerrey
Kerry	Lincoln	Robb
Kohl	Lugar	Rockefeller
Landrieu	Mikulski	Sarbanes
Lautenberg	Moynihan	Schumer
Leahy	Murray	Torricelli
Levin	Reed	Wellstone
Lieberman	Reid	Wyden

NOT VOTING—2

Dodd	McCain

The motion was agreed to.

AMENDMENT NO. 1842

Mr. COVERDELL. Mr. President, it is my understanding of the previous unanimous consent that we now are ready to hear Senator WELLSTONE from Minnesota for up to 45 minutes.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. I thank my colleague from Georgia.

Mr. President, since I had a chance to speak on this amendment, I can be brief and probably will not need to take anywhere near the full amount of time.

Let me remind Senators what the vote on this amendment will be: To express the sense of the Senate regarding the importance of determining the economic status of former recipients of temporary assistance to needy families. I am hoping not one Senator votes against this.

Again, the purpose of this amendment is to express the sense of the Senate that we want to know, what is the economic status of welfare mothers no longer on welfare? What is happening with this legislation? It is called policy evaluation.

It is a sense of the Senate because otherwise I would be subject to rule XVI. If the House had done their work and had sent over the Labor, Health and Human Services appropriations bill, I could do this amendment and I wouldn't have to do a sense-of-the-Senate amendment. I certainly hope there is not a motion to table this. I can't imagine why it would be controversial.

The Senate goes on record that we need to determine the economic status of these former recipients. We need to know how this legislation is working. We need to know whether or not these mothers, who have been sanctioned, actually have jobs. We need to know whether the jobs pay a living wage. We need to know whether these families have been cut off medical assistance when they are still eligible. We need to know whether or not families have been cut from food stamp assistance even when they are eligible, and we need to know what the child care situation is. We need to know the status of 2-year-olds and 3-year-olds.

This sense-of-the-Senate amendment has the support of some 120 different organizations: from Catholic Charities USA; Center for Community Change; Food Research and Action Center; National Center on Poverty Law; National Coalition Against Domestic Violence; NETWORK, a National Catholic Social Justice Lobby; YWCA of America—the list goes on and on—Children's Defense Fund; Women for Reform Judaism. There is a long list of organizations to which I think all of us give

some credibility as important justice organizations.

Again, I had a chance to speak about this amendment earlier. I will just summarize. Yes, the welfare rolls have been reduced by about half. There are 4.5 million fewer Americans receiving any assistance. But the goal wasn't to basically reduce the welfare rolls; the goal was to reduce poverty. There are still some 34-, 35 million poor Americans. Unfortunately, some 6.5 million children live in households with incomes less than half of the official poverty level. Among one subgroup of our population, the poorest of poor people, poverty has gone up.

Today, about 20 percent of all the children in our country and about a third of the children of color under the age of 6 are growing up poor. Still today the largest poverty-stricken group of Americans are children. Still today we have a set of social arrangements that allow children to be the most poverty-stricken group in our country. I cite as evidence, again, some disturbing studies. Families USA says we have about 670,000 fewer people who no longer receive medical coverage because of the welfare bill; 670,000 citizens no longer receiving any medical assistance because of the welfare bill. We have the U.S. Department of Agriculture telling us there has been about a 20- to 25-percent drop in food stamp participation, which has been the most important safety net program for children.

In addition, we have any number of different studies—NETWORK, Catholic Justice Organization being but one—which point out that most of the jobs these mothers are getting pay about $7 an hour. But if they don't have any health care coverage, they are worse off. There are too many examples I can give. Again, I want to make sure we have the data about children, 2 and 3 years old, who are not receiving adequate child care.

The question I am asking is embodied in the wording of this amendment: To express the sense of the Senate regarding the importance of determining the economic status of these former recipients.

What has happened to these women and children? How are they doing? Is this welfare bill working? We should do some honest policy evaluation. Today, at about quarter to 2, we will have a vote on an amendment every Senator should support. How can a Senator argue that it isn't important to know the economic status of these women and children? I don't see the case against it. I hope we get a strong vote, and then that will give us some momentum for finally moving forward with some legislation that eventually will have some teeth that will, in fact, call for this kind of policy evaluation.

I say to colleagues I could give many State-by-State examples of ways in which I don't think this is working quite the way we want it to. I won't. I could say to Democrats and Republicans that, in some cases, in some communities, there is success; in other cases, in other communities, what is going on it is rather brutal.

I can certainly say to all of my colleagues, in very good faith, we need to understand the drop in food stamp participation; they are so important to meeting the nutritional needs of children. We need to understand why so many people have been dropped from medical assistance. We need to know whether there is decent child care for these children, and we need to know whether or not these families are moving toward economic independence.

It is extremely important that we do this policy evaluation. That is all this amendment calls for. It is a sense-of-the-Senate amendment. It is to get Senators on record with a good, strong vote that we ''express the sense of the Senate regarding the importance of determining the economic status of former recipients of temporary assistance in needy families.''

Mr. President, I don't know that more needs to be said about this amendment. I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. GRAMS). The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. REID. Mr. President, we will allow the majority to go to another amendment and we will reserve the time of the Senator from Minnesota.

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

Mr. BOND addressed the Chair.

The PRESIDING OFFICER. A vote is set for 1:50 on the Wellstone amendment.

The Senator from Missouri is recognized.

Mr. BOND. Mr. President, I ask unanimous consent that the pending amendment be set aside.

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

AMENDMENT NO. 1825

(Purpose: To prohibit the use of funds for the promulgation or issuing of any standard relating to ergonomic protection)

Mr. BOND. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative assistant clerk read as follows:

The Senator from Missouri [Mr. BOND] proposes an amendment numbered 1825.

Mr. BOND. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

At the appropriate place, insert the following:

SEC. ___. (a) FINDINGS.—Congress makes the following findings:

(1) The Department of Labor, through the Occupational Safety and Health Administration (referred to in this section as ''OSHA'') plans to propose regulations during 1999 to regulate ergonomics in the workplace. A draft of OSHA's ergonomics regulation became available on February 19, 1999.

(2) A July 1997 report by the National Institute for Occupational Safety and Health that reviewed epidemiological studies that have been conducted of ''work related musculoskeletal disorders of the neck, upper extremity, and low back'' showed that there is insufficient evidence to assess the level of risk to workers from repetitive motions. Such evidence would be necessary to write an efficient and effective regulation.

(3) An August 1998 workshop on ''work related musculoskeletal injuries'' held by the National Academy of Sciences reviewed existing research on musculoskeletal disorders. The workshop showed that there is insufficient evidence to assess the level of risk to workers from repetitive motions.

(4) In October 1998, Congress and the President agreed that the National Academy of Sciences should conduct a comprehensive study of the medical and scientific evidence regarding musculoskeletal disorders. The study is intended to evaluate the basic questions about diagnosis and causes of such disorders.

(5) To complete that study, Public Law 105-277 appropriated $890,000 for the National Academy of Sciences to complete a peer-reviewed scientific study of the available evidence examining a cause and effect relationship between repetitive tasks in the workplace and musculoskeletal disorders or repetitive stress injuries.

(6) The National Academy of Sciences currently estimates that this study will be completed late in 2000 or early in 2001.

(7) Given the uncertainty and dispute about these basic questions, and Congress' intention that they be addressed in a comprehensive study by the National Academy of Sciences, it is premature for OSHA to propose a regulation on ergonomics as being necessary or appropriate to improve workers' health and safety until such study is completed.

(b) PROHIBITION.—None of the funds made available in this Act may be used by the Secretary of Labor or the Occupational Safety and Health Administration to promulgate or issue, or to continue the rulemaking process of promulgating or issuing, any standard or regulation regarding ergonomics prior to September 29, 2000.

AMENDMENT NO. 2270 TO AMENDMENT NO. 1825

(Purpose: To prohibit the use of funds for the promulgation or issuing of any standard, regulation, or guideline relating to ergonomic protection)

Mr. BOND. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative assistant clerk read as follows:

The Senator from Missouri [Mr. BOND] proposes an amendment numbered 2270 to amendment No. 1825.

Mr. BOND. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

On page 1 of the amendment, strike all after the first word and insert the following:

___. (a) FINDINGS.—Congress makes the following findings:

(1) The Department of Labor, through the Occupational Safety and Health Administration (referred to in this section as ''OSHA'') plans to propose regulations during 1999 to regulate ergonomics in the workplace. A draft of OSHA's ergonomics regulation became available on February 19, 1999.

(2) A July 1997 report by the National Institute for Occupational Safety and Health that reviewed epidemiological studies that have been conducted of ''work related musculoskeletal disorders of the neck, upper extremity, and low back'' showed that there is insufficient evidence to assess the level of risk to workers from repetitive motions. Such evidence would be necessary for OSHA and the Administration to write an efficient and effective regulation.

(3) An August 1998 workshop on ''work related musculoskeletal injuries'' held by the National Academy of Sciences reviewed existing research on musculoskeletal disorders. The workshop showed that there is insufficient evidence to assess the level of risk to workers from repetitive motions.

(4) In October 1998, Congress and the President agreed that the National Academy of Sciences should conduct a comprehensive study of the medical and scientific evidence regarding musculoskeletal disorders. The study is intended to evaluate the basic questions about diagnosis and causes of such disorders.

(5) To complete that study, Public Law 105-277 appropriated $890,000 for the National Academy of Sciences to complete a peer-reviewed scientific study of the available evidence examining a cause and effect relationship between repetitive tasks in the workplace and musculoskeletal disorders or repetitive stress injuries.

(6) The National Academy of Sciences currently estimates that this study will be completed late in 2000 or early in 2001.

(7) Given the uncertainty and dispute about these basic questions, and Congress' intention that they be addressed in a comprehensive study by the National Academy of Sciences, it is premature for OSHA to propose a regulation on ergonomics as being necessary or appropriate to improve workers' health and safety until such study is completed.

(b) PROHIBITION.—None of the funds made available in this Act may be used by the Secretary of Labor or the Occupational Safety and Health Administration to promulgate or issue, or to continue the rulemaking process of promulgating or issuing, any standard, regulation, or guideline regarding ergonomics prior to September 30, 2000.

Mr. BOND. Mr. President, the perfecting amendment corrects an error in the date in the language we provided in the original amendment.

This is an amendment with respect to ergonomics. The issue of protecting employees against workplace injuries is critically important. We all can and must agree to that. However, we are concerned about the proposed actions of OSHA. Small businesses and concerned employers know that ensuring safe workplaces is critical to their employees and to their businesses. It is in their best interest to protect employees from workplace injury, but they can only accomplish that goal without regulations that are unduly harsh. They need to proceed on a basis that is carefully thought out, makes sense, and is based on sound science.

Since the 1990s, OSHA has been trying to develop a rule that would tell employers what they are supposed to do to protect employees from ergonomic injuries. But the agency still has no answers to fundamental questions that need to be answered before a regulation can be issued or will be effective. These questions are basic: How much lifting is too much? How many repetitions are too many? How can an employer determine what part of an injury is due to workplace factors? And, perhaps most important: What can an employer do to prevent injuries or to cure an injury that has happened?

After all the effort and time OSHA has spent on developing their proposal, there is not a single threshold or recommendation contained in it. Instead, it basically says to employers. ''We know there's a problem, and we can't figure it out. So we expect you to figure it out for us, and we will inspire you with fines and penalties if you don't.''

That doesn't make much sense.

As I said before, employers—particularly small businesses—know how much they can lose in lost time and lost employees through ergonomic injuries. They want help and good guidance. They don't want to say: Take your best guess and we will fine you if you are wrong. That is no way to do business.

The amendment I propose today delays the Occupational Safety and Health Administration's (OSHA) proposed standard on ergonomic protection until the essential scientific research to support this standard has been completed. Sound science to support a sound safety standard.

Some opponents have tried to deflect attention from the flaws and lack of scientific basic for OSHA's proposal by mischaracterizing this amendment as ''anti-women.'' Nothing could be further from the truth. To use the words of several women construction business owners representing the Associated General Contractors of America (AGC): ''Safety has no gender.''

We all want to promote safe and healthy workplaces. To date, voluntary efforts by the business community have led to a 17 percent decline in repetitive stress injuries over the past 3 years, according to the Bureau of Labor Statistics. This includes a 29 percent decline in carpal tunnel syndrome cases and a 28 percent decline in tendinitis cases—two of the most commonly cited ergonomic injuries. Such injuries make up just 4 percent of all workplace injuries and illnesses.

There are too many. We need to do better. But we need to do so based on sound science so employers, and particularly small businesses, will know what reasonable standards they should meet so they can protect their employees, which they, I believe, not only want to do but which is in their economic self-interest to do.

Despite this decline in ergonomic injuries, OSHA is on a rampage to impose new mandates with no clear thresholds or guidance to address the causes of these injuries. This irresponsible behavior helps no employee—woman or man.

Some proponents of OSHA's ergonomics standard have argued that because many large companies have been able to spend significant resources of time and money to solve ergonomic problems in their workplaces, all employers should now be required to do this. The problem with using these examples as the basis of a regulation is that each one of these companies approached the problem differently, and was able to address the problem in a way that made sense for them in their workplace and in their business with their employees. It does not follow from these examples that OSHA should seek to impose on all employers a regulation that will have to fit a wide variety of companies. There is a vast difference between Ford Motor Company being able to implement an ergonomics program and a small business being able to hire the necessary consultants, purchase the necessary equipment, and possibly redesign its processes to address ergonomic questions.

OSHA'a ergonomics rule is different from all other OSHA regulations that establish a threshold for exposure to a specific hazard and then tell the employer that if an employee exceeds that threshold, certain measures must be taken, or exposure must be reduced.

Because of this vagueness of OSHA's proposed standard, and the impact it would have on small businesses which would be forced to comply with it, I introduced the Sensible Ergonomics Needs Scientific Evidence Act—the SENSE Act—S. 1070 on May 18 of this year.

The amendment I offer today is fundamentally the same as that bill. It is simple and direct—it tells OSHA that it may not proceed with publishing a proposed rule on ergonomics until after fiscal year 2000. Why?

Because by that time National Academy of Sciences is expected to have completed a study that Congress and the President agreed upon last year. This study is intended to determine whether there is sufficient evidence to answer those questions I just laid out and to support a regulation on ergonomics.

We agreed to pay $890,000 for a study. As I said, Congress agreed, and the President signed it. If we are to disregard that, we waste the money, and we don't get the benefit of the investigation that has been going on during this period of time and is expected to make a sound basis for proceeding in a scientific manner to do something about workplace ergonomic injuries. But if OSHA publishes its proposal first, that is a classic example of what I have described as the bureaucracy's desire for, ready, fire, and aim. You need to figure out what you need to accomplish, and how you can do it before you start out and do it.

My amendment would not preclude OSHA from continuing its study of this issue, and I urgently call on the agency

to redouble its efforts, especially in light of the report of the SBA Chief Counsel for Advocacy, which I received last week.

That report is very critical of OSHA's estimates outlined in the agency's Preliminary Regulatory Flexibility Analysis of the proposed ergonomics standard. In fact, the report concludes that ''OSHA's estimates of the benefits of the proposed standard may be significantly overstated.'' In other words, this standard may not help employees—women and men—as much as OSHA would have us believe.

Equally troubling is the report's conclusion that the cost of the ergonomics standard to all businesses could be as much as 15 times more than what OSHA estimates. Moreover, the report emphasizes that the cost of the ergonomics standard could be as much as 10 times higher for small businesses than for large companies.

So for what a large company would have to do for employees, if it had to pay $1,000 per employee, a small business might have to pay $10,000 per employee. Those are some pretty significant margins of error. If this rule goes forward, small business, once again, is left holding the bag.

The report also points out that ''a small business is not simply a large business with fewer employees. Many factors affect how a standard may impact a small business much differently than a large business.'' It goes on to discuss the fact that small businesses often have higher employee turnover rates meaning that any training requirement will have a more significant impact on the small firm than the large one.

For women business owners, the cost issue is particularly worrisome. As AGC's women construction business owners put it: ''Women-owned companies are the fastest growing sector of our economy. Unfortunately, burdensome regulations are a barrier to women starting their own businesses. Often, these regulations discourage women from starting a new business or expanding an existing one.''

Mr. President, one thing is very clear—this is an extremely complicated issue. And we must have more reliable cost and benefit estimates—not to mention sound science and thorough medical evidence—before we push the Nation's small businesses into another maze of redtape.

If there are regulations which are burdensome but which are necessary on the basis of sound science to protect against ergonomic injuries, then let OSHA set them out. Let everybody abide by those standards. But when we don't even know what best medical and scientific evidence provides, why are we going forward down a blind alley with nothing but a huge cost at the other end?

Employees have a right to expect regulations will achieve realistic benefits to them—not exaggerated lofty goals that miss the mark and help no one.

Let me be clear about something. When you talk to workers who are in businesses or in jobs where they do lifting and work, they are very much concerned about their medical care.

They are very much concerned about their pension. They are also concerned about their job.

We are talking about something that could be a job killer. If we are telling this employee—because we have issued a standard without scientific basis—the cost may be so great that your employer can't afford to continue to hire you, what favor have we done that employee? If she is put out of work because the unknown requirements of a very expensive regulation are too much for the employer to bear, that woman could lose her job and lose the means of livelihood in the name of lessening ergonomic injuries, without any proof that they do so.

Let me stress again, we all agree in protecting employees from workplace injuries, it is extremely important. That is something we must do, we must assure. Employers want employees to be safe. If your mother, father, sister, or brother is working in a job with lifting or repetitive motions, the employers want them to be safe. However, small firms cannot accomplish the goal of worker protection through ill-conceived and poorly supported proposals such as OSHA's ergonomic standard which has such potential burden for small business. If the burdens are too high, the business may not survive.

As I indicated earlier, this has been a concern that women-owned businesses have shared. If a business folds, there are no employees to protect. Where is the sense in that? OSHA is doing everything in its power to get its proposal published soon. The House passed legislation on this issue, the Workplace Preservation Act, H.R. 987, by a vote of 217–209. I think it is time for the Senate to add its voice to the call for OSHA to act responsibly, to act dispassionately, but to act in good science.

To summarize: We don't have the science; we don't have the medical evidence; we don't have accurate cost figures; we don't know the benefits to employees; and we don't know what works in preventing injuries. Moreover, OSHA doesn't know those either. All we have is a potentially burdensome standard that small businesses, whether owned by a woman or a man, can ill afford.

I urge my colleagues to support this amendment to make certain that OSHA's ergonomic standard is based on sound science and ensure that we are protecting men and women in the workplace. I hope we can get a reasonable time agreement so views on both sides can be expressed and we can proceed to a vote on this very important amendment.

Mr. SPECTER. Mr. President, I seek to propound a unanimous-consent request for a time limit. I have already had some informal indications that Members on the other side of the aisle intend to speak at some length. I will propound a request for consent when the manager returns to the floor.

Mr. DURBIN. Will the Senator yield?

Mr. SPECTER. For a question.

Mr. DURBIN. I am happy to propound a question. Does the Senator from Pennsylvania not understand, the complexity of this issue virtually prohibits a time agreement? We will continue the debate until it is fully explored.

I think the Senator from Pennsylvania and Senator from Missouri are forewarned: Bringing an issue of this complexity to the floor invites a lengthy debate regarding worker safety, and we will object to a time limit.

Mr. SPECTER. This Senator does not understand how this matter—for that matter, any matter—is so complicated as not to be subject to a time agreement. We are all here under time limitations. I only have 5 years 3 months left on my term, for example. We all have some time limitations.

I think it is possible to have a time agreement. However, if the other side intends to talk at length—I do not want to inject the word ''filibuster'' into the discussion, but if the other side wishes to talk at length and is unwilling to enter into a time agreement, I do understand that; I do not understand that any matter is so complicated as to preclude a time agreement.

The PRESIDING OFFICER. The Senator from Pennsylvania has the floor.

Mr. SPECTER. I will speak since I have the floor and I am manager of the bill.

Mr. President, this issue has been the subject of very contentious debate for years. Last year in the conference committee in the House and Senate, we debated at great length; the year before, we debated at great length. There is no doubt about emotions running high.

The subject of ergonomics is an effort to have some way to stop repetitious motions which cause physical injury to workers. Many of the big companies have adopted procedures which will protect their employees because it is cost effective to do so in the long run. Small businesses face a little different situation, which I understand. The distinguished chairman of the Small Business Committee has offered this amendment. I understand the point he is making.

I point out that there have been many studies on the issue. In 1998, a peer review of the National Academy of Sciences involving 85 of the world's leading ergonomic experts found ''research clearly demonstrates'' that specific interventions can reduce or prevent musculoskeletal disorders. The 6-month study answered the same seven questions the National Academy of Sciences is now reviewing.

A 1997 review by NIOSH of 600 studies produced the same result and found that ergonomic solutions were being successfully applied in many work settings. During last year's negotiations,

Congress and the administration agreed, by funding the study, they did not intend to delay OSHA's ruling. House Appropriations Chairman Livingston and ranking member OBEY—I think, on the record—made it clear that the Director of the Office of Management and Budget, Jack Lew, also concurred. We have had a letter from the Secretary of Labor with a veto threat. That is not unusual.

However, I believe there is a balance which can be obtained to protect workers and not to unduly burden businesses, including small businesses. That is why, as chairman of the subcommittee involved in the conference for several years, I have tried to work this out so we can find a way not to overburden small business and at the same time to protect workers from these musculoskeletal problems.

Right now, the Office of Management and Budget has the regulation and we do not know what form it will finally take. But someday we have to come to grips with the issue and stop studying it. Studies are very important to find out what the facts are, and then we must act on the facts. When studies are used to interminably delay, it doesn't become a study; it is a filibuster by study on one side, as it is filibuster by an assertion that it is too complicated, too intricate, to be able to come to grips with it and decide.

We are sent here to try to decide the issues. It is my hope we can debate the facts, try to understand what the underlying issues are, and then try to find a consensus on public policy. At some date, we will have to go ahead and act one way or another on the protection of the workers.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I appreciate the comments made by the manager of the bill, and I also understand the Senate lingo that means if we offer this amendment, you will filibuster. That disappoints me greatly.

I ask unanimous consent to be a cosponsor of the Bond amendment.

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

Mr. NICKLES. I thank and compliment the Senator from Missouri for offering this amendment. It is needed. This amendment is needed because the administration is getting ready to promulgate some regulations in the near future that will cost hundreds of millions, if not billions, of dollars for American industry. When I say American industry, I am talking about small business, as well as, big business. I am talking about an unbelievably complex set of regulations and there is no telling how much it will cost to implement these regulations.

These regulations consist of how many motions you should make. That if you do more than a certain amount, then maybe that is not safe; or if you lift something, it cannot be lifted more than this number of times, or it will be too heavy or too stressful. OSHA and the Department of Labor try to make these very regulations and at the same time they say they honestly do not know what they are doing, so in many cases they will wait until laborers complain and then they will try to come up with regulations to alleviate their pain. These methods are not successful.

We have in fact already addressed this issue. The Senate houses the Congressional Research Service, a nonpartisan group, to research complex issues. There is a CRS study that was updated August 31, 1999. I will read from a copy of this report that addresses further ergonomic regulation:

> Due to the wide variety of circumstances, however, any comprehensive standard would probably have to be complex and costly, while scientific understanding of the problem is not complete.
>
> It would be costly, it would be complex, and, frankly, it would not be understandable. It would not be workable.
>
> The state of scientific knowledge about ergonomics—and especially the role of nonwork and psychological factors in producing observed syndromes—has become a key issue in the debate over how OSHA should proceed.
>
> Even if the problem were fully understood, the wide variety of circumstances will bedevil efforts to frame simple cost-effective rules. What are called ''ergonomic'' injuries are actually a range of distinct problems, much as ''cancer'' is not one but a family of diseases.

Throughout the summary of this report, the point is that, due to a lot of circumstances, any comprehensive rules would have to be complex and costly while scientific understanding of the problem is not complete.

What about a scientific study? Why don't we ask the scientists? If Congress' research arm says this is going to be costly, we do not have the scientific basis to do it, why don't we have scientific basis? Why don't we ask the experts to take a look at it and see if there is something they can come up with that would be workable?

Well, we did do that. Last year, Congress passed and almost every Member of this body, or the majority of the Members of both Houses of Congress, passed a bill that funded $900,000 for the National Academy of Sciences to complete a study and review the scientific literature as mandated by Congress and the President on ergonomics. They have not completed that study. They should complete the study in about a year, January 2001; in 13 or 14 months.

We are spending almost a million dollars on the study to ask the scientists to do an in-depth review. Yet many people say they want OSHA to go forth and come up with these complex rules in spite of the unfinished study. They are saying that they trust OSHA to come up with rules and regulations without this study, without the basis for making such rules? You talk about repetitive motions—OSHA often tells companies that they may possibly be doing something wrong and a company could ask OSHA whether or not they are in violation of certain standards and OSHA would reply: ''We don't know.''

These standards are almost impossible to define. What is repetitive motion? Standing at a machine on the job for 8 hours a day—that is ergonomic—is that too much? I grew up in a machine shop. I grew up in Nickles Machine Corporation. We lifted and moved a lot of heavy equipment. There is no way in the world some Federal bureaucrat knows what is the proper amount of weight that individuals should be moving around. There is no way to create a uniform standard that applies to each individual.

Are they going to come in and supervise and say: You should not be standing there for that period of time? Maybe you should not be working at your computer for this amount of time. Maybe you should not be engaged in moving heavy objects.

We are going to have the heavy hand of the Federal Government, Federal bureaucrats running all across the country trying to make those kinds of determinations, saying: If you do not comply with our infinite wisdom, we are going to fine you. We are going to close you down. Amazing. It is amazing that we would do such a thing.

The proposed regulations by OSHA are not workable. They are unbelievably complex. Anybody who has looked at them from a standpoint of real-life experience in the workforce agrees that this is not workable. So what have we done if we succeed with this amendment? We have passed restrictions keeping this administration from going forward on this enormously complex, expensive, regulatory scheme.

Last year, we said let's have this study, let's let this study go forward; let's look at real scientific facts before we implement a standard that could cost billions of dollars, and no telling how many jobs would be lost as a result. Let's let that happen. I regret that this was not already included in the committee bill.

I think most people will acknowledge we have a majority vote on this. We have the votes to do this. We have Democrats and Republicans who will support this amendment. We have a majority; we have a majority vote in the House as well. Now we have this implied senatorial discussion: If you have this amendment, due to its complexity, we will discuss it for a long time; i.e. we will filibuster this amendment. We will not let this bill pass. We don't care if we bring down the largest appropriations bill, that deals with Education, Labor, Health and a multitude of Governmental agencies—we don't care if we bring down the whole thing.

Why? Because organized labor wants this rule to go forward. I guess if the leadership of AFL/CIO wants this rule to go forward, we should absolutely let it go forward. That is what a few people are saying, although masked with niceties, in senatorial discussion: If

you insist on a vote on this amendment, we are going to talk for a long time and not let this bill pass.

As I said, we passed related legislation in 1998. We authorized the study I previously mentioned, to look deeper into the problems employees and industry face. Let's let the study work. Let's find out what the scientists have to say. Let's listen to the experts.

We had a couple of congressional hearings regarding this very issue. The following was concluded from a hearing in 1997:

> Any attempt to construct an ergonomic standard as a remedy for regional musculoskeletal injuries in the workplace is not just premature, it is likely to be counterproductive in its application and enforcement.

It is likely to be counterproductive. Does this give unions a chance to file complaints for harassment purposes? Has anybody thought of that? Of course they have. Does this increase people's leverage? ''If you work with us, maybe, a little bit, we will not be quite as vigorous in our complaints.'' Is this what we really want?

Another statement was made by Dr. Stephen Atcheson and others with the American Medical Association:

> The debate concerning whether certain occupations actually cause repetitive motion disorders is now well over a century old and far from settled.

This is complex business. You are talking about movements and actions in the workforce, and there are an unlimited number of movements and actions. Now we are going to have that regulated by the Federal Government? We are going to turn loose the Department of Labor, OSHA, to come up with regulations that have the force and the power to fine and assess and have bureaucrats telling people how to operate their businesses? As if people running those businesses could care less about their employees?

The whole premise of this regulation is Government knows best; employers certainly don't care about their employees—which I do not believe. I have been an employer. You show me an employer who doesn't care about his employees, and I will show you somebody who is going out of business in a very short period of time and probably deservedly so. It is this presumption—the Government knows best; we need Government as the caretaker for business operations—that I think is absurd. And we trust some bureaucrat in OSHA, who probably knows nothing about a particular operation, to come in and say: Here is how you should run your business. We know better than the people that have been managing that plant, working in that plant for years. There is no telling how much it will cost. No telling how many jobs will be lost, the costs that could be imposed, the costs that could result from unfair, unworkable regulations.

I compliment my colleague from Missouri, and I urge my colleagues to support the Bond amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I am going to be brief because other colleagues are going to speak, and then I will come back later as we go forward in this debate.

I say to my colleagues on the other side, what Senator DURBIN from Illinois said is right on the mark. As ranking minority member on the Labor Committee, now called HELP, which has jurisdiction over OSHA and occupational health and safety issues which are very important to working people, I have a lot to say about this amendment. What I will say, as this debate goes forward, will be substantive, and it will be important in determining how all of us vote. This is an incredibly important issue.

I will start out for a few brief minutes right now and then turn it over to other colleagues. I will come back later as this debate develops.

This Bond amendment will basically stop OSHA from doing its job, which is the mission of the mandate of keeping American workers from getting injured at work. It basically stops OSHA from doing its job, and OSHA's job is to prevent workers from being injured at work.

This amendment will shut down the normal rulemaking process and stop OSHA from doing anything at all about ergonomic job hazards that are seriously injuring over 600,000 workers every year. That is a statistic my colleagues do not like to talk about. I have heard the arguments about bureaucrats and big government and all of the rest, but we ought not be too generous with the suffering of others. We are talking about 600,000 workers who are seriously injured every year. That is what this debate is all about.

Ergonomic injuries are serious injuries from repetitive motions, overexertion, and physical stress. They include carpal tunnel syndrome, back injuries, and tendonitis. The amendment before us will stop OSHA from issuing a standard to prevent these injuries until the National Academy of Sciences completes a new study which will take somewhere between 18 to 24 months. This amendment will stop OSHA from issuing not only a regulation, but even voluntary guidelines or standards. This amendment is an extreme amendment, extremely harsh in its impact on working people.

Last week, Secretary of Labor Herman wrote that she would recommend a veto of S. 1650 if this amendment is adopted. By the way, I also say to my colleagues, the reason Senator DURBIN was right in what he said earlier—that this debate will take some time—is because it is important to put a focus on the people and their lives and who is going to be affected by this.

With all due respect, quite often—and this particular case is a perfect example—when we talk about OSHA or NIOSH, when we talk about occupational health and safety, we are talking about a group of Americans who are rarely in the Senate or the House. These are not in the main, our sons or daughters. These are not in the main, our brothers or sisters or our parents. In fact, I think if they were, this amendment would not even be before the Senate. I do not want to lose sight of about whom we are talking.

There are four points I want to make as this debate develops. I will not develop any of these points right now, but I will mention them.

First, I want to spend some time later on talking about the people, real people who are affected by this debate. As we speak, there are workers who are injured needlessly because of the continuing efforts by this Congress, as represented by the Bond amendment, to keep OSHA from doing its job. These are real people with real health problems who are hurt at the workplace with disabling injuries. I want to spend a lot of time talking about who these people are. I want to present stories. I want to talk about these people in the most personal terms possible so we know what is at stake.

Second, I want to make the case that something can be done to stop people from being injured in this way, from stopping these physically disabling injuries, from stopping the pain. There is no need to wait another 2 years for another study. We do not need another study to show that ergonomic hazards cause injuries and these injuries can be prevented. We already know it. There are already reams of scientific evidence to prove it, and one more review of the scientific literature is not going to change anything. Later on in this debate, I will talk about the studies that have already taken place and what their conclusions are, all of which say we need to go forward right now.

Third, I want to dispel the mistaken impression among some Senators that a deal was worked out last year whereby OSHA would delay this rulemaking until the National Academy of Sciences completes its second study. Actually, that appears to be just the opposite of what happened.

According to the parties involved in those negotiations, there was an understanding that this new NAS study would not prevent OSHA from going forward. There was a clear understanding that this new NAS study would not prevent OSHA from going forward.

Finally, I want to make it clear that the issue is not the substance of OSHA's proposal. There is already a process in place for addressing any criticisms or any modifications that Senators and others may have. It is the same rulemaking process that is used for any other regulation: Interested parties are encouraged to comment and suggest changes. Criticisms or quibbles with OSHA's current proposal should not be used as an excuse to stop OSHA from doing anything whatsoever, and that is exactly what is happening. This

ergonomic standard has been delayed for far too long.

It was first proposed in 1990 by then-Secretary of Labor Elizabeth Dole. I will go back through that history as well, but I will conclude right now by saying that this amendment just shuts down the normal rulemaking process. It stops OSHA from doing its job. It does not speak to the 600,000 workers right now who are being injured and who are struggling because, in fact, we do not have ergonomic job standards. These injuries are serious injuries. They are disabling injuries. Surely, we can take action right now.

This is all about working people. It is all about making sure there is some safety at the workplace. It is all about our responsibility to move forward with a standard that will provide some protection. It is all about making sure OSHA is not gutted. It is all about making sure this amendment, which I view as a direct threat to many hard-working people, does not go forward.

Yes, we are here to debate this. My colleague, Senator DURBIN, is ready to speak. Senator HARKIN is going to speak. Senator KENNEDY will be here. And later on in the debate, I will come back and lay out story after story of families that will be affected by this amendment. I will talk about what this means in personal terms. I will talk about all the studies that have already taken place and what the science clearly suggests to us. We will have a major debate on this. I have no doubt the vast majority of people in this country expect the Senate to be on the side of providing some decent protection for hard-working Americans. I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I rise in support of the Bond amendment, and I ask unanimous consent to be added as a cosponsor of the amendment.

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

Mr. HUTCHINSON. Mr. President, it is my understanding there are a number of colleagues on both sides of the aisle who want to speak on the amendment. I ask unanimous consent that we limit the debate to 1 hour on this amendment.

Mr. DURBIN. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. HUTCHINSON. Mr. President, I will speak for a moment about why I think this amendment is so important.

When I travel through Arkansas and with the opportunities I have had to be in other parts of the country where we have had hearings on workforce protections, one of the complaints I hear so frequently from my constituents is that regulatory agencies in general exceed the authority that has been delegated by the Congress. One of the frustrations I hear expressed from so many small businesspeople and others is: If you in the Senate and the House are the ones elected by us to represent us, why do these regulatory agencies seem to go off on their own, contrary to what you have expressed in legislation?

It is a question that is always difficult to answer. Frankly, too often we have allowed, whether it be OSHA or the IRS, regulatory agencies to exceed their statutory authority, and we have done an insufficient job in reining in what they are doing.

In this particular case, I think we see exactly that. OSHA is an agency to which we have delegated power. It seems to be determined to extend its regulatory power in a negative way through the imminent implementation of this ergonomic standard, regardless of that standard's effectiveness in protecting workers or its cost to American industry.

So, yes, there is an issue of safety; yes, there is an issue of cost; and, yes, there is an issue of what is the scientific basis for what OSHA is propounding to do.

So often what we find regulatory agencies doing ends up having unintended consequences which the Congress must go back and try to rectify at some later date or which results in a reversal of the rulemaking process in these various agencies.

We have already heard, in evidence presented on the floor of the Senate today, that there is concern that a premature ergonomic standard could have counterproductive consequences.

I say to my colleagues, if you are concerned about the health and welfare of the American workplace, if you are concerned about the safety of the American worker, then let's be sure that when OSHA implements a rule, they do so with a sound scientific basis for what they are doing.

Now, I don't know. If we can't count on the nonpartisan, highly respected Congressional Research Service, then who do we look to? That is why we pay them. That is why we have established them. They are well-respected. This is what they said. Senator NICKLES earlier quoted part of the CRS report. Let me quote an additional part of what they said. They said:

> . . . because of the wide variety of tasks, equipment, stresses and injuries involved, any comprehensive standard would probably have to be complex and costly.

They continue:

> . . . ergonomics is a difficult issue because, while there is substantial evidence of a problem, it is very complex and only partially understood.

I think it is not prudent to move forward with a rule when the CRS has concluded the issue is complex and we do not understand it. It is only partially understood. How can you implement a rule that is in the best interest of the American worker, much less the American economy, if we do not understand what the problem is and we can only acknowledge it is partially understood and it is complex?

As an example, the CRS cites that while a whole ''host of new products and services have become popular—such as back braces and newly designed keyboards—there is little in the way of scientific evidence about whether they do any good.''

What the opponents of this amendment are suggesting is that though we do not understand the issue, though it is acknowledged to be complex, though the CRS says we have a host of new products and services out there but there is no scientific evidence as to whether they do any good or not, we should nonetheless give the green light for OSHA to move ahead in a rulemaking process without substantial scientific basis for that rule.

Proponents of the ergonomics standard claim this issue has been adequately studied, if not overstudied—and that is what my friend and colleague from Minnesota was just saying—but it is simply not the case.

The National Institute for Occupational Safety and Health, NIOSH, after conducting an extensive review of the literature, stated that there are ''huge, fundamental gaps in our understanding'' which ''make it clear how little we really know about ergonomics.''

So those who would say, well, we have studied it—we have studied it and studied it—we have studied it enough, so let's go ahead with the rule, they are ignoring the basic conclusion, the overwhelming conclusion of the evidence and the literature on this issue, which concludes we simply do not understand ergonomics.

There are ''huge, fundamental gaps in our understanding.''

To my colleagues, I say it is for that reason that the Congress wisely, I believe, last year, in the omnibus appropriations bill, appropriated $890,000 so that we could fill those huge, fundamental gaps in our understanding concerning the issue of ergonomics—$890,000 for a more thorough review of literature by the National Academy of Sciences, a thorough study by the NAS, which, if there is a more respected group than the CRS, certainly in the area of science, it would be the NAS.

We want a rule, but we want a rule to be based upon good science, not something that is moved forward without adequate study and without adequate scientific basis, that could have negative impacts upon workers, and certainly will have negative impacts upon the workplace and the economics of the workplace.

Nonetheless, in spite of the fact that we authorized, we spent, we appropriated $890,000, OSHA has refused to wait for the results of that study. They already released a discussion draft of the ergonomic standard in February of this year.

I simply find it inexplicable why OSHA cannot wait for this definitive study to be completed. To me, it does not seem prudent to rush to judgment. To me, it does not seem prudent to rush to implement a rule without knowing exactly what the consequence

of that rule would be, how much it would help workers, or how much it might hurt workers, or exactly how much of a burden it would be to businesses. We do not know the answers to those questions. We need to know the answers before we allow OSHA to move forward with the rule.

Finally, I do not know that I can justify to my constituents in Arkansas, and to the average Arkansas worker who makes a median income of $27,000, how the Federal Government effectively wasted $890,000 of their hard-earned tax dollars by not even waiting for the completion of this study.

Therefore, I urge my colleagues to adopt the Bond amendment and make OSHA await the outcome of the NAS study so they can devise an ergonomics standard that will be effective in protecting American workers without unnecessarily burdening American businesses.

I thank the Chair and yield the floor.

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. I rise in opposition to the amendment of my friend from Missouri and the Chairman of the Small Business Committee. I heard not all but most of the opening comments by the offerer of the amendment, Senator BOND. What I heard mostly was the concerns expressed by Senator BOND regarding its impact on small businesses.

While I happen to serve on the Small Business Committee, Senator BOND is the chairman of that committee. It goes without saying that Senator BOND has had a long and intense interest in the impact of rules and regulations on small businesses. I think I can say without fear of contradiction that Senator BOND has done a very good job in protecting and defending the rights of small businesses. Quite frankly, I believe I have, too, and others on the committee. I can understand Senator BOND's concern, legitimate concern about what would happen with the small businesses.

In that regard, I support his thrust in terms of making sure that we do not impact unduly on small businesses and that we fulfill our obligation to ensure that small businesses get the support whatever it might be, to help change and redesign a workplace that would be injurious to workers suffering from ergonomic types of illnesses.

To say that it would have an impact on small businesses does not mean we can't do anything about it because I think we have an obligation to protect the health and the safety and the welfare of the workers of this country. Whether they work for IBM or General Motors or whether they work for a small concern that employs five people, I believe we have an obligation to be concerned about their health and their safety.

Obviously, we also have an obligation to be concerned about the small businesses in this country. That is why I say, to the extent we can, we better be prepared to help small businesses to cut down on the illnesses and injuries to workers from musculoskeletal disorders and the results of ergonomic illnesses.

So again, I hope this is not just the reason someone might vote against this, because of the impact on small businesses; think about the impact on the workers, what is happening to workers out there.

I would also like to point out that if a small business has no workers with work-related musculoskeletal disorders (MSDs), is not in manufacturing and does not have workers with significant handling duties, that small business doesn't have to do a thing. Millions of small businesses (drycleaners, banks, advertising agencies, shoe repair) will have no obligation to comply unless a worker gets hurt. Then let us have a meeting of the minds to do both. Let's protect our workers, and then meet our obligation to help small businesses. It seems to me this is the way to go.

I know the Senator from Illinois has been waiting to speak, but let me also comment upon the fact that Senator BOND had said something about women-owned businesses, that women-owned businesses will be at risk. Quite frankly, women are at risk.

Here is a study done on ergonomics, called A Women's Issue, from the Department of Labor. The title says: Who is at Risk? Women experienced 33 percent of all serious workplace injuries—those who required time off of work—in 1997, but they suffered 63 percent of repetitive motion injuries, including 91 percent of injuries resulting from repetitive typing or keying and 61 percent from repetitive placing. Women experienced 62 percent of work-related cases of tendonitis and 70 percent of carpal tunnel syndrome cases. So this is a women's issue. It is women who are suffering more from repetitive injury diseases and illnesses than men are. We should keep that in mind.

Secondly, we hear about doing a study and that we shouldn't promulgate or have these rules prior to the study being done. Well, first of all, for the record, there is no new study being done. The study being done by the National Academy of Sciences, which is referred to often, is just a study or a review of existing literature. They are not conducting any new research. All of the literature being reviewed by the National Academy of Sciences is already available to OSHA. The study the NAS is doing is a review of all the existing studies. We have studied this issue to death. There have been more than 2,000 ergonomic studies, and there have been 600 epidemiological studies done on ergonomics. We have more than enough information to move ahead in protecting workers. The study we keep hearing about is simply a study of all the studies. Let us keep that in mind.

We have been a long time in this rulemaking process. We have had over 8 years of study. I think it is well to note, too, the first Secretary of Labor who committed the agency to issuing an ergonomic standard. It was then-Labor Secretary Elizabeth Dole, who committed the agency to issuing an ergonomic standard. We have been studying it ever since.

Also, keep in mind, no rule has been issued, not even a proposed rule. Again, that is all we are talking about, letting OSHA go ahead with a proposed rule. That is not the end of it. Once the proposal is issued, the public, people on all sides of the debate will have ample opportunity to comment on the proposal.

Lastly, this really does kind of break the agreement we had last year. Our word is our bond around this place. If we don't keep our word, this place disintegrates. Last year, we had an agreement made with the House Members, Congressman Livingston, who at that time was chairman of the Appropriations Committee, and DAVID OBEY, who was the ranking member. They signed a letter dated October 19, 1998. What they said was: We understand that OSHA intends to issue a proposed rule on ergonomics late in the summer of 1999. We are writing to make clear that by funding the NAS study, it is in no way our intent to block or delay issuance by OSHA of a proposed rule on ergonomics. It was signed by Chairman Livingston and ranking member OBEY.

I happen to be a member of the Appropriations Committee. Obviously, we are on an appropriations bill. I was involved in the discussions on that last year. The agreement was made to go ahead and let the National Academy of Sciences do a review—that is all it is; it is not a new study—of the studies that have already been done.

Let's keep that in mind; this is not a new study. During that time, OSHA was not prevented from going ahead and issuing a proposed rule—not a final rule, a proposed rule, which I have pointed out, then, allows everyone to have their input and allows us in Congress to see it. Again, people talked about this study, and we had this agreement. We should live up to the agreement.

They talk about the cost. Here is a whole packet—I will have them here if anybody wants to read them—of ergonomic changes made by companies, both large and small, to help reduce the significance and the number of injuries. These are what companies on their own did.

One caught my eye. This is from Sun Microsystems. They make computer equipment and systems in California. Problem: In 1993, the average work-related musculoskeletal disorder disability claim was $45,000 to $55,000. The solution: Sun Microsystems purchased ergonomic chairs and provided education and work station assessments to all who requested them. The company also encouraged workers to adopt proper posture while working with computers. The impact: The average repetitive-strain-injury-related claim dropped from $45,000 to $55,000 in 1993 to $3,500 in 1997.

Does it work? Yes, it does. It works well. We ought to get on with it. Let OSHA issue their proposed rule. These delays hurt workers. More than 600,000 workers lose work each year because of ergonomic-related injuries. These are our cashiers, nurses, cleaning staff, assembly workers in manufacturing and processing plants, computer users, clerical staff, truck drivers, and meat cutters.

This amendment should be defeated because the workers of this country deserve to have their health and their safety protected.

I yield the floor.

The PRESIDING OFFICER (Mr. BUNNING). The Senator from Illinois.

Mr. DURBIN. Mr. President, I rise in opposition to the amendment offered by the Senator from Missouri, Mr. BOND.

During the course of this debate, we will hear many terms, which sound technical in nature, about the issue at hand. It has been described as ergonomics, musculoskeletal disorders. I think we ought to try to get this down to the real-world level of what this debate concerns.

I have before me a study from the Centers for Disease Control and the U.S. Department of Health and Human Services relative to this particular problem. They state, early in the study, the term ''musculoskeletal disorders'' refers to conditions that involve the nerves, tendons, muscles, and supporting structures of the body.

Another definition says: Ergonomic injuries have many names. They are called musculoskeletal disorders, repetitive stress injuries, cumulative trauma disorders, or just simply strains and sprains. These injuries occur when there is a mismatch between the physical requirements of a job and the physical capacity of a worker.

I wanted to make sure we said that at the outset, so those who are following this debate will understand that what is at issue is not a highly technical, scientific issue but something that every one of us who do manual chores at home or at the workplace understands. If you sit there and have to peel a bag of potatoes, when it is all over your hand is a little sore. What if you had to peel a bag of potatoes every half hour, 8 hours a day, 40 hours a week, 12 months a year? How would your hands react to it? That is what we are talking about—ergonomics; musculoskeletal disorders.

I note that the Republican majority wants to limit this debate. They have asked on two occasions that we agree to a limitation. I hope they will reflect on the fact that we are talking about injuries that occur to 600,000 workers a year. It is only fair to those workers, when we consider this amendment by Senator BOND of Missouri, that this debate reflect the gravity of the issue. I will not make a unanimous consent request at this time, but I think it is reasonable that we allot in this debate perhaps 1 minute for every 250 workers who were injured each year by one of these conditions.

That is 1 minute of debate for every 250 workers. By my calculation, that comes out to about 24,000 minutes, and it turns out to be a 40-hour work week. Wouldn't it be interesting if the Members of the Senate had to stand in their workplaces 4 and 5 hours at a time debating this amendment and then talk about the aches and pains they suffer. Imagine the worker who puts up with that every single day.

Each of us in the Senate brings our own personal experiences to this job. I am sure there are many colleagues in support of this amendment who have been engaged in manual labor. I oppose this amendment. I have had the experience, in my youth, of some pretty tough jobs. My folks were pretty adamant that I take on tough jobs so I would want to go back to school and finish my college and law school education.

Well, it worked. I grew up in East St. Louis, IL, and spent several summers working in the stockyards, sometimes working the graveyard shift, from midnight until 8 in the morning, and other times during the day. I did all sorts of manual labor, such as moving livestock, cleaning up in areas that needed to be cleaned up. It was a lot of hard, tough work. At the end of each summer, I was darn glad to go back to school.

But there were two jobs I had that educated me more than others about the workplace, and dangers, and why this debate is not about some dry concept but about real people who get up every single morning, pull themselves out of bed, brush their teeth, and head off to work to earn a paycheck to pay for their families' needs and maybe to realize the American dream.

One job I had was on a railroad. It was considered a clerical job. It involved a lot of moving back and forth, sometimes in the middle of the night, in Brooklyn, IL, between trains that stopped. I was a bill clerk walking up and down with a lantern, trying to keep track of these trains. One night, in the middle of the night, I climbed a ladder on the side of one of these gondolas to see if it was empty or full. As I started to jump down from that ladder, my college graduation ring caught on a burr on the ladder, causing a pretty serious injury and a scar I still carry. That was a minor injury. I was back at work in a few days. Some workers aren't so lucky.

But the job I had really educated me about this issue, so I understand it personally. I hope my colleagues can come to understand it. It is a fact that I worked four straight summers in a slaughterhouse, the Hunter Packing Company of East St. Louis, processing hogs and pork products. We were unionized, the Amalgamated Meat Cutters and Butcher Workers of Greater North America, and we had a contract. Thanks to that contract, I think I received $3.50 an hour, which, in the early 1960s, was a great wage for a college student. I could finish that summer and take $1,500 back to school and do my best to pay my bills. My kids, and a lot of college students today, laugh when they consider that amount of money, but that was a large amount of money in my youth. When you came to the slaughterhouse as a college student, you expected the worst jobs, and you took them if you wanted to make the salary you needed. So I worked all over this slaughterhouse.

The union had entered into an agreement with the company, Hunter Packing Company, which said: You will work an 8-hour day, but we define an 8-hour day in terms of the number of hogs that are processed. If I recall correctly, our contract said we would process 240 hogs an hour, which meant slaughtering or processing on 2 different floors, 2 different responsibilities.

Some people who worked there said: Wait a minute, if 240 hogs equals an hour, and we are supposed to work 8-hour days, and at the end of the day we are supposed to have processed or slaughtered 1,920 hogs, if we can speed up the line that carries these hogs, or speed up the conveyor belt that carries the meat products, we might be able to get out in 7 hours.

So it was a race every day to get to 1,920 hogs. Hundreds of men and women who were standing on these processing lines were receiving that piece of the animal or piece of meat to process it, knowing another one was right behind it, just as fast as they could move—repetitive action, day in and day out.

I saw injuries in that workplace because of the repetition and the speed. I can remember working on what we called the ''kill floor,'' where the first processing of a hog took place. I worked next to an elderly African American gentleman, a nice guy. He joked with me all the time because I was this green college student doing everything wrong. One day, I looked over as he slumped and fell to the floor; he passed out.

I can recall another day when I was working on a line where they were putting hams on a table to be boned and then stuck into a can so we could enjoy them at home. These men were—it was all men at that time—paid by the ham. The faster they could bone the hams, the more money they made. The knives they used were the sharpest they could possibly get their hands on. They covered the other hand with a metal mesh glove, and they would set out to bone the ham as quickly as they could. There were hams flying in every direction and hands flying in every direction. The next thing you know, there were injuries and cuts.

Of course, if your hand is cut and you work as a piece worker, you really don't make much money until it heals. You can't go back too soon into an environment with a lot of meat juices and water because it won't heal. I

would see these men with bandaged hands standing over to the side waiting for another chance to make a living for their family.

These images are as graphic in my mind today, in 1999, standing on the floor of the Senate, as they were in my experience as a kid in that packing house. As I looked around at the men and women who got up every single day and went to work—hard work, dirty work, but respectable work—and brought home a good paycheck for a hard day's work, I saw time and time again these injuries on the job.

The amendment offered by the Senator from Missouri, Mr. BOND, says to the Federal Government—in this case, it says to the Secretary of Labor—not to study and not to come up with regulations that would protect workers in the workplace from repetitive injuries.

It is a common question in legislatures and on Capitol Hill: Who wants this amendment? Who is pushing for this amendment? Who would want to leave millions of American workers vulnerable in the workplace from repetitive stress injuries when we know that over 600,000 workers a year are injured? Who is it who wants to stop or slow down this process?

Well, I am virtually certain it is some business interest. I don't know which one, because the curious thing is that every business that comes to talk to this Senator, or others, is quick to say: We care about our workers. We put things in place to protect our workers. We don't need the Federal Government to come in because safety in the workplace is No. 1 at our plant.

I hear that over and over again. I don't dispute it. When I talk to you a little later on about some of the companies that have responded to this particular challenge, you are going to find big names, Fortune 500 names, such as Caterpillar Tractor Company of Illinois, a big employer in my State. I am proud of what this company makes and exports around the world. You will hear about what they have done to deal with the problem. Chrysler Motor Company in Belvidere, IL. I have been there. We will talk about what they did.

Finally, you are going to say, if the Fortune 500 companies and the ones that talk to you are the good guys, the companies that are really trying to protect workers and understand how expensive and serious it is to have injuries in the workplace, who in the world is pushing for this amendment that would eliminate holding every business in America responsible for safety in the workplace?

My conclusion is that some bad actors out there in the business community who are not living up to the same standard as these companies are the ones behind this amendment. And the sad reality is, the larger companies, through the organizations that represent them in Washington, have joined ranks with the bad actors.

They are playing down the lowest common denominator. They are trying in a way to protect their competitors that aren't living up to the same good standards for their workers. I think that is shameful. I think it is disgraceful.

This Bond amendment—make no mistake—I want to read to you what it does—says after a lot of preparatory language:

> None of the funds made available in this act may be used by the Secretary of Labor, or the Occupational Safety and Health Administration, to promulgate, or to issue, or to continue the rulemaking process of promulgating or issuing any standard regulation or guideline regarding ergonomics prior to September 30, 2000.

In other words, turn out the lights downtown on establishing standards that you send down to businesses to protect workers.

Mr. SCHUMER. Mr. President, will the Senator from Illinois yield for a question?

Mr. DURBIN. I am happy to yield to the Senator from New York for a question.

Mr. SCHUMER. I thank the Senator for yielding.

As I go around my State of New York, I meet all kinds of people who are unable to use their hands anymore because of the kinds of jobs they have had. We have had, for instance, in New York City, workers from a variety of jobs come together to talk about the need for some kind of standard. Many have been disabled by workplace injuries and have had to limit the amount of hours they work. One woman, for instance, an editor for a local TV station, says she can't use her hands for cooking, for opening doors, or for carrying anything.

I ask my colleague from Illinois, how would this amendment affect people in that position?

Mr. DURBIN. The Bond amendment, offered by the Senator from Missouri, would basically say to those workers: Your Government can't establish a standard to protect you in the workplace. It stops the Government from establishing a standard for workers.

Mr. SCHUMER. Mr. President, if the Senator might yield for another question, I guess there is some talk about whether we need to study further; that they are not yet ready to have standards. Yet it is my understanding that scientific and medical journals have had over 2,000 articles about the need for some kinds of standard, about what the problems are, and that it is pretty clear cut that in many new kinds of industries the problems that have developed at the workplace are so real that we have far more than enough information to develop standards.

Would the Senator care to comment on whether or not the argument that we are not ready to have standards in ergonomics washes?

Mr. DURBIN. I say to the Senator from New York, he is correct. Over 2,000 studies have established a causal relationship between certain work patterns and certain injuries.

I also say to the Senator from New York that this large volume I referred to earlier from the Centers for Disease Control, which is not a political organization—it is an organization dedicated to public health in America—concluded after one of their more recent studies as follows:

> A substantial body of credible epidemiological research provides strong evidence of an association between musculoskeletal disorders and certain work-related physical factors when there are high levels of exposure, and especially in combination with exposure to more than one physical factor; that is to say, repetitive lifting of heavy objects in extreme or awkward postures.

So the Senator from New York is correct. The evidence is in. There is need for standard of protection.

Mr. SCHUMER. Mr. President, will the Senator yield for a further question?

Mr. DURBIN. I would be happy to yield.

Mr. SCHUMER. Mr. President, I thank the Senator. I respect his expertise on this issue. I know he has been involved in it for a long time.

It is my understanding that in 1990 the Secretary of Labor, Elizabeth Dole—not a member of our party, now a candidate for President—said that OSHA must take all the needed steps to develop an ergonomics standard. That was virtually 10 years ago. There has been lots of planning since. Am I correct in assuming that even at the beginning of the decade it was pretty clear we needed some kind of standard, and that we have delayed and delayed to the harm of thousands, tens of hundreds, and hundreds of thousands of workers?

Mr. DURBIN. The Senator from New York is accurate. At the conclusion of my remarks, I will ask unanimous consent to enter into the RECORD a news release from the U.S. Department of Labor that is dated Thursday, August 30, 1990, a release from then-Secretary of Labor, Elizabeth Dole, that says as follows in the opening paragraphs:

> Secretary of Labor, Elizabeth Dole——

The same person who is now a Republican candidate for President, I might add——

> * * * today launched a major initiative to reduce repetitive motion trauma, one of the Nation's most debilitating across-the-board worker safety and health illnesses of the 1990s.

She goes on with a quote that says:

> These painful and sometimes crippling illnesses now make up 48 percent of all recordable industrial workplace illnesses. We must do our utmost to protect workers from these hazards, not only in the red meat industry, but all U.S. industries.

That was Secretary Elizabeth Dole, Republican administration, 1990.

Mr. President, I ask unanimous consent to have printed in the RECORD this news release in its entirety from the Department of Labor.

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

SECRETARY DOLE ANNOUNCES ERGONOMICS GUIDELINES TO PROTECT WORKERS FROM REPETITIVE MOTION ILLNESSES/CARPAL TUNNEL SYNDROME

Secretary of Labor Elizabeth Dole today launched a major initiative to reduce repetitive motion trauma, once of the nation's most debilitating across-the-board worker safety and health illnesses of the 1990's.

''These painful and sometime crippling illnesses now make up 48 percent of all recordable industrial workplace illnesses. We must do our utmost to protect workers from these hazards, not only in the red meat industry but all U.S. industries,'' Secretary Dole said.

''We are publishing these guidelines now because we want to eliminate as many illnesses as possible, as quickly as possible.

''The Department is committed to taking the most effective steps necessary to address the problem of ergonomic hazards on an industry-wide basis. Thus, I intend to begin the rulemaking process by asking the public for information about ergonomic hazards across all industry. This could be accomplished through a Request for Information or an Advanced Notice of Proposed Rulemaking consistent with the Administration's Regulatory Program.

''We are emphasizing the need for employers to fit the job to the employee rather than the employee to the job,'' Secretary Dole said. ''This involves such measures as designing flexible work stations which can be adjusted to suit individuals and relying on tools developed to minimize physical stress and eliminate crippling injuries. It begins with organizing work processes with the physical needs of the workers in mind.''

Repetitive motion trauma, also referred to as cumulative trauma disorders (CTD's), are disorders of the musculoskeletal and nervous systems resulting from the repeated exertion, or awkward positioning, of the hand, arm, back, leg or other muscles over extended periods daily.

They include lower back injuries, carpal tunnel syndrome, (a nerve disorder of the hand and wrist), and various tendon disorders, among others.

''We are initially focussing on the red meat industry because its problems are well-documented and very severe,'' Secretary dole said.

The guidelines for the red meat industry, being issued in the form of a booklet by the Labor Department's Occupational Safety and Health Administration (OSHA), were developed to assist employers in the industry in developing ergonomic hazard abatement programs.

''The message in the guidelines is simple: repetitive motion illnesses can be minimized through proper workplace engineering and job design and by effective employee training and education,'' Secretary Dole said. ''The guidelines list the keys for success: commitment by top management, a written ergonomics program, employee involvement and regular program review and evaluation.

''We will be closely monitoring and assessing the success of the Red Meat Guidelines in addressing ergonomic hazards to give us more information on which to proceed as we deal with these issues on an industry-wide basis.

''We owe a debt of thanks to the United Food and Commercial Workers, AFL–CIO; the American Meat Institute, and the National Institute for Occupational Safety and Health for their expert assistance in developing these guidelines. Their willingness to join with us in finding and implementing solutions to ergonomic problems has been most encouraging.''

Assistant Secretary of Labor Gerard F. Scannel, who heads OSHA, said his agency would begin an inspection program early next year in the red meat industry as another phase of the special emphasis program initiated by the issuance of the guidelines.

He said the special emphasis program for the meat industry has been designed to ensure that the well-recognized ergonomic hazards in the industry are being adequately addressed and that ergonomic programs are in place in all major meatpacking plants.

Each red meat plant in the U.S. will be sent a copy of the meatpacking guidelines. As part of the special emphasis program, employers will be offered the opportunity to enter into agreements with OSHA to abate their ergonomic hazards.

Though those who sign such an agreement will be subject to monitoring visits and OSHA inspections in response to complaints, they will not be cited or penalized on ergonomic issues if the monitoring visits show a comprehensive effort and satisfactory progress in abating such hazards.

Scannell said that while the guidelines are advisory, ''compliance with them could demonstrate to an OSHA inspection team that an employer is committed to addressing ergonomic hazards.''

Scannell said the guidelines include a list of questions and answers about common problems to provide more specific assistance to small businesses.

''Ergonomics Program Management Guidelines for Meatpacking Plants,'' the official title of the booklet, builds on the cooperative approach of OSHA's safety and health program management guidelines issued in January 1989. Although strict adherence to today's guidelines is not mandatory, OSHA believes following them can produce significant reductions in repetitive motion illnesses.

The recommended program begins with analysis of the worksite to identify potential ergonomic problems. Ergonomic solutions may include: engineering controls such as proper work stations, work methods and tool designs, work practice controls such as proper cutting techniques, new employee training, monitoring adjustments and modifications, personal protective equipment such as assuring proper fit of gloves and appropriate protection against cold and administrative controls such as reducing the duration, frequency and severity of motions; slowing production rates; limiting overtime; providing adequate rest pauses; increasing the number of workers assigned to a particular task; rotating workers among jobs with different stressors; ensuring availability of relief workers; and maintaining equipment and tools in top condition.

Further, meatpackers need to develop an effective training program to explain to employees the importance of working in ways that limit stress and strain, and the need to report symptoms of CTDs early so that preventive treatment can forestall permanent damage.

Employers must also instruct employees in the proper techniques for their individual jobs. Annual retraining is necessary to assure that employees continue to do their jobs correctly.

An effective ergonomics program also includes medical management with trained health care providers to work with those implementing the ergonomics program and to treat employees. The guidelines describe helpful steps including periodic workplace walkthroughs, symptoms surveys and lists of light-duty jobs for employees recovering from repetitive motion injuries.

They stress the importance of a good health surveillance program; the need to encourage early reporting of symptoms; appropriate protocols for health care providers; and evaluation, treatment and follow-up for repetitive motion illnesses.

Finally, the booklet offers suggestions for recordkeeping and monitoring injury and illness trends.

The guidelines also include a glossary of terms and a list of references. Employers may contact OSHA regional offices with questions about ergonomics, recordkeeping or other safety and health issues by consulting the directory at the end of the booklet.

Single copies of ''Ergonomics Program Management Guidelines for Meatpacking Plants'' are available free from OSHA Publications, Room N3101, Frances Perkins Building, 200 Constitution Ave., NW, Washington, D.C. 20210 by sending a self-addressed mailing label.

Mr. SCHUMER. Mr. President, I rise today to state my opposition to this amendment.

When people say government is not responsive to people's problems or that it gets nothing done—they are talking about this amendment which bars OSHA from issuing a standard on ergonomics.

We know the facts. Ergonomics is no longer the mystery it once was. Over 2,000 articles related to this appear in scientific and medical journals.

We do not need new studies. How many studies do we need before everyone recognizes the obvious—ergonomic injury is real?

The 600,000 workers who experience severe back pain or hand and wrist pain have been studied ad nauseam.

So let's move forward and develop a standard. It will ultimately save businesses money and it will protect workers, because a standard will keep people in the workplace.

The Department of Labor has worked on formulating a standard since former-Secretary Elizabeth Dole said in 1990 that OSHA must take all the needed steps to develop an ergonomics standard. That's 10 years of planning. We don't need another year of delay.

This shouldn't be a partisan issue. We need not pit business versus labor. All sides will benefit.

If not now, I predict eventually we will develop an ergonomics standard. Because as this economy becomes more dependent on the computer, and more top level managers spend much of their day in front of a screen—they will develop the same injuries that are reserved now only for secretaries.

And that will be impetus to develop a standard for them and for those in construction and factories that develop repetitive motion stress.

Last April in New York City, workers from a variety of jobs came together to talk about the need for an ergonomics standard. Some have been permanently disabled by workplace injuries. Some have had to limit the hours they work.

One woman, an editor at a local television station, said can't use her hands ''not for cooking, opening doors, carrying anything.''

Passing this amendment means we believe these people are faking it. No wonder people are so frustrated by government.

Let's defeat this amendment.

Mr. President, will the Senator also answer another question?

Mr. DURBIN. Certainly.

Mr. SCHUMER. This is one other problem that I have heard from my constituents in New York. Workers who have labored long and hard who show up at the job day in, day out develop certain types of problems, and because there are no standards, all too often when they go to their supervisor, when they go to their boss, when they go to somebody of some authority in the company in which they work—it could be a large company, it could be a small company—and complain of these problems, they are told they are faking because these injuries are different. Many of them are the kinds of injuries we are used to where, God forbid, you see blood or bone or some bruise. These are injuries that hurt and affect their ability to work just as much, but they can't be seen in the same way.

Has the Senator from Illinois come across the same type of problem, and wouldn't the promulgation and maintenance of standards help these people prove they have a real problem?

Mr. DURBIN. I think the Senator from New York identifies the real problem here in defining the issue because in many cases we are talking about what is characterized as a ''soft tissue injury.'' In other words, examination by an x ray or an MRI may not disclose any problem and yet there is a very serious and real problem.

I used to find in my life experience people suffering neck and back injuries. You couldn't point to objective evidence of why this person was crippling up or why this person had a problem. In fact, the problem was very real.

What we are trying to do is establish a standard so the worker is not accused of malingering and the worker is not accused of faking it, but the worker has a recourse when there is a very real and serious injury to at least get time off and at least go for some medical attention.

The Senator from Missouri, Mr. BOND, with this amendment wants to stop this process, wants to say that this Government will not establish that standard of protection for American workers. The net result of it, of course, is that 600,000 victims of these injuries each year will not have the protection to which the Senator from New York has alluded.

Mr. SCHUMER. I thank the Senator.

Mr. DURBIN. Mr. President, let me go on to say that the objective of continuing to study this matter is one of the oldest strategies on Capitol Hill. It is the way many people who object to a certain thing occurring delay the inevitable and prolong the process of review.

I have been involved for years in the battle against the tobacco companies. I can't think of a product in America that has been studied more than tobacco. It shouldn't be. It is the No. 1 preventable cause of death in America today.

When the tobacco companies ruled the roost on Capitol Hill, they would postpone health standards and warning labels, and banning smoking on airplanes, for example, by saying: We just need another study. If we can get another study, then maybe we will arrive at the truth about what to deal with, what to do in dealing with tobacco products.

This is another good illustration. I listened to the Senator from Missouri. He said in his conclusion supporting this amendment, which I rise in opposition to: ''It is time for OSHA to act compassionately.''

I understand the virtue of compassion, and I hope I have some in my life. But there is no compassion for millions of American workers if we do not set out to establish a standard of protection when it comes to these types of injuries.

To postpone this for another year—which is what this amendment would do—is to put their health and safety at risk. For what? So that bad companies that care less about their worker injuries don't have to improve the workplace? That is what it is all about. That is the bottom line on this debate.

As I said earlier, major companies already recognize the problem and respond to it. Go into many of your discount stores and one sees workers wearing back brace belts. I have seen them at Wal-Mart and other stores. Their employers understand reaching over and pulling groceries hour after hour can cause some back strain, so they have done something about it. Voluntarily, on their own, they have done something. They don't want the workers to be off work and an expense to the company. They want them to continue on the job with good morale and they provide them some protection.

When I went to the Belvidere Chrysler plant where they make the Neon automobile in my State of Illinois, I was pleasantly surprised to see all the changes that had taken place on the assembly line. In the old days, a worker would turn around and pick up a piece of an automobile, move around, and put it on the automobile to fix it in place. That has changed. There are all sorts of cranes and devices so parts can be moved without strain or stress to the employee. That was done not just to protect the employee but to protect the bottom line of the company.

Frankly, worker injuries cost the companies in terms of time lost and in terms of productivity as the experienced workers leave the line and someone new takes their place. That is being done by conscientious companies. OSHA needs to develop a standard for those that are not conscientious. The Bond amendment is not compassionate. The Bond amendment stops the Department of Labor from establishing that standard of protection.

As I mentioned earlier, over 6 million workers have been injured in the course of keeping records on this particular type of injury, 600,000 each year. Over 2,000 studies on these hazards have detailed how the hazards in the workplace harm people and put them out of work, and the devastating impact they have had on the American workforce.

Yet the Bond amendment delays, stops it, says to the workers who go to work every single day, put your life and your earning capacity at risk in the workplace. And we in Congress, each year, for the sake of a handful of companies that refuse to act responsibly in dealing with their workers, will stop you from any standard of protection.

The following disorders in 1997 accounted for more than 600,000 workplace injuries. One is fairly common. In fact, some people who work in my office have dealt with this problem because of the nature of working on a keyboard. This type of musculoskeletal disorder is called carpal tunnel syndrome. It accounts for $20 billion annually in workers' compensation costs. As I am speaking now, there is a court reporter standing in front of me working away at her machine; she does that every single day. If she is not careful, she can develop problems, as people in ordinary clerical situations do on a regular basis.

I don't think these people are malingerers. I don't think these people are faking. Ever seen the scars from the surgery? That strikes me as a great length to go to to fake an injury. I think these people are in real pain and seeking real relief.

One of the things I have noticed, some of the keyboards have been changed now so there is less stress on the hands of workers who use them. Companies have decided in redesigning the keyboard that they will address that problem directly. It could be that the development of a standard by the Department of Labor will move our country in that direction and reduce the $20 billion paid out every year by American businesses for workers' compensation cases involving those with carpal tunnel syndrome.

Who is affected the most by the Bond amendment? Which workers will be hurt the most by the Bond amendment? Women across America. Women workers suffer a much higher rate of carpal tunnel syndrome. According to the Bureau of Labor Statistics, 86 percent of repetitive motion injury increases were suffered by women; 78 percent of tendinitis increases were suffered by women. Yet women make up 46 percent of the workforce.

What kind of jobs are these women in? We have talked about clerical jobs, obviously. But there are nurses, nurse's aides, cashiers, assemblers, maids, laborers, custodians, and, yes, many of these jobs employ minority workers. It is estimated between 25 and 50 percent of the workforce are Hispanic and African American workers in those particular jobs.

A 6-month study by the National Academy of Sciences in 1998 stated,

''The positive relationship between the occurrence of musculoskeletal disorders and the conduct of work is clear.''

We heard the Senator from Arkansas, we heard the Senator from Missouri—I am sure we hear others—stand up and defy this scientific conclusion. Despite 2,000 studies and this clear language, some would lead Members to believe that it is still a mystery how 600,000 workers could complain of this type of injury in America every single year. We know better. We know better from our life experience. That is why this amendment is so bad, why this amendment, in delaying protection for those workers, ignores the obvious, the injuries and the scientific conclusion that leads us to at least a standard of care to protect those same workers.

A few minutes ago, I made reference to the press release from the Department of Labor, 1990, at a time when the Secretary was Elizabeth Dole. Elizabeth Dole is a person I came to know and respect when she was Secretary of Transportation and appeared before my subcommittee in the House of Representatives. There was a time when we spoke of worker protection issues as bipartisan issues. Sadly, with a very few exceptions, that is not the case anymore.

If we are talking about increasing the minimum wage, which historically was a bipartisan issue—both Democrats and Republicans understanding that people who went to work every day deserve a living wage—that has changed. It has changed for the worse.

This amendment, if it comes to a vote, will evidence that this has become a very partisan matter. Those offering the amendment on the Republican side of the aisle will generally, if not exclusively, vote in support of the amendment; those on the Democratic side of the aisle will generally vote against it. We have broken down on partisan lines.

The sad reality is the workers we are talking about and the workers who were injured do not break down on partisan lines. The workers who come off that job with neck and back injuries and carpal tunnel syndromes are Republicans, Democrats, Independents, and nonvoters. They deserve better than to let this issue break down to the partisan battle which it has.

Secretary of Labor Elizabeth Dole said in August of 1990:

We must do our utmost to protect workers from these hazards in all U.S. industries.

She said at that time, 9 years ago:

We are publishing these guidelines now because we want to eliminate as many illnesses as possible as quickly as possible.

She goes on to say:

The Department [of Labor] is committed to taking the most effective steps necessary to address the problem of ergonomic hazards on an industry-wide basis.

That was 9 years ago. Here we are today, without those standards of protection, and an effort underway by Senator BOND of Missouri to, once again, delay the establishment of these standards.

Secretary Elizabeth Dole said in 1990:

We are emphasizing the need for employers to fit the job to the employee, rather than the employee to the job. This involves such measures as designing flexible workstations which can be adjusted to suit individuals and relying on tools developed to minimize physical distress and eliminate crippling injuries. It begins by organizing work processes with the physical needs of the workers in mind.

That is basically what I have seen applied to businesses in my home State of Illinois, by companies that care. This entire news release has now been agreed to be part of the RECORD. Those who review this debate will see that Secretary Dole was on the right track—a Republican Secretary of Labor.

Why, today, the Republican Party, through the amendment of Senator BOND of Missouri, wants to take a different venue, a different tack, and to eliminate this responsibility, I cannot explain.

This press release is from a different Labor Secretary, not our current Secretary of Labor, Alexis Herman, who said if the Bond amendment is adopted, she will veto this entire important bill; it is from Secretary Elizabeth Dole. But it is from Secretary Elizabeth Dole. Secretaries Dole, Reich, and Herman have support this issue, but they are not alone. Other endorsements establishing the standard of protection for American workers come from the American Nurses Association, the American Academy of Orthopedic Surgeons, the National Academy of Sciences, the American Public Health Association, and the National Advisory Committee on Occupational Safety and Health.

I received a letter from the American Public Health Association, which I would like to make part of this record as well.

I ask unanimous consent this letter be printed in the RECORD.

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

AMERICAN PUBLIC HEALTH ASSOCIATION,
Washington, DC, September 27, 1999.

U.S. Senate,
Washington, DC.

DEAR SENATOR: We are deeply concerned about S. 1070, legislation that would not only block OSHA from issuing an ergonomics standard, but even from issuing voluntary guidelines to protect working men and women from ergonomic hazards, the biggest safety and health problem facing workers today.

We strongly support OSHA's efforts to promulgate a standard to protect workers from ergonomic injuries and illnesses. These disorders are real, they are serious and they account for nearly a third of all serious job related injuries (more than 600,000 workers a year); moreover, they are preventable. One type, carpal tunnel syndrome, alone results in workers losing more time from their jobs than any other type of injury, including amputations. The workers' compensation costs of ergonomic injuries are estimated at $20 billion annually, the overall costs at $60 billion.

For women workers, OSHA's efforts are particularly important, because nearly half of all injuries and illnesses among women workers result from ergonomic hazards. Though these hazards are present in a variety of jobs, many of the occupations predominantly occupied by women are among the hardest hit by ergonomic injuries.

Workplace musculoskeletal disorders can be prevented. There is a clear and adequate foundation of scientific and practical evidence, including a 1998 congressionally requested National Academy of Sciences study demonstrating that these disorders are work-related and that ergonomic solutions in the workplace can prevent injuries. These workplace solutions can protect workers, decrease workers' compensation costs, and produce gains in productivity and workplace innovation.

We recognize that there is another National Academy of Sciences study pending, and that this is the reason for the legislation. We also recognize that useful information will come out of that study that can be applied to improve protections for workers. However, sufficient data already exists to protect workers. Failure to act on adequate data in this regard is irresponsible.

After almost a decade of work, OSHA is finally moving forward with a proposed ergonomics standard to prevent work-related musculoskeletal disorders. Upon official publication, this proposal will allow a public debate on ergonomics before a final rule is issued. We are aware of the differing views surrounding this proposal. However, such debate is not unique to ergonomics. Such differences in views have existed in almost all of OSHA's major rulemaking, including other serious workplace hazards such as asbestos, benzene and lead.

The rulemaking process—the proper forum for debate over regulatory proposals—will provide the opportunity for all parties to present their views, opinions and evidence.

We urge you to resist efforts to block OSHA from working on the development and adoption of an ergonomics standard by voting ''no'' on S. 1070 or any other effort to prevent OSHA from protecting workers from ergonomic hazards. Blocking these necessary safeguards will needlessly risk the health of millions more working people.

Sincerely,

ORGANIZATIONS

9–5, National Association of Working Women.
Alaska Health Project.
American Association of Occupational Health Nurses, Inc.
American Nurses Association.
American Public Health Association.
Central New York Occupational Health Clinical Center.
Chicago Area Committee on Occupational Safety and Health.
Connecticut Council on Occupational Safety and Health.
Johns Hopkins Education and Research Center.
Montana Tech of the University of Montana, Safety, Health and Industrial Hygiene Department.
National Organization for Women.
National Partnership for Women and Families.
National Women's Law Center.
New Hampshire Coalition for Occupational Safety and Health.
New York Committee for Occupational Safety and Health.
North Carolina Occupational Safety and Health Project.
Northwest Center for Occupational Health and Safety (University of Washington).
Rhode Island Committee on Occupational Safety and Health.

Rochester Council on Occupational Safety and Health.
San Diego State University, Graduate School of Public Health.
South Central Wisconsin Committee on Occupational Safety and Health.
Southeast Michigan Coalition on Occupational Safety and Health.
University of Puerto Rico School of Public Health.
Western New York Council on Occupational Safety and Health.
Wider Opportunities for Women.
Wisconsin Committee on Occupational Safety and Health.
Women Work! The National Network for Women's Employment.

Mr. DURBIN. Mr. President, this letter is dated September 27, 1999. It comes from a long list of organizations that comprise the American Public Health Association.

Reading the introductory paragraphs will make it clear where they stand, in opposition to the Bond amendment:

We are deeply concerned about S. 1070, legislation that would not only block OSHA from issuing an ergonomics standard, but even from issuing voluntary guidelines to protect working men and women from ergonomic hazards, the biggest safety and health problem facing workers today.

We strongly support OSHA's efforts to promulgate a standard to protect workers from ergonomic injuries and illnesses. These disorders are real, they are serious and they account for nearly a third of all serious job related injuries (more than 600,000 workers a year); moreover, they are preventable. One type, carpal tunnel syndrome, alone results in workers losing more time from their jobs than any other type of injury, including amputations. The worker's compensation costs of ergonomic injuries are estimated at $20 billion annually, the overall costs at $60 billion.

For women workers, OSHA's efforts are particularly important, because nearly half of all injuries and illnesses among women workers result from ergonomic hazards. Though these hazards are present in a variety of jobs, many of the occupations predominantly occupied by women are among the hardest hit by ergonomic injuries.

Why is it when it comes to this floor and the battle is worth fighting, if the well-heeled special interest groups with the strongest lobbies can come in, whether it is an oil company trying to avoid paying its fair share of royalties to drill for oil on public lands or other large companies, we take the time and end up giving the special favors, but when it comes to women in the workplace, minorities in the workplace, time and time again this Senate, this Congress, will cut a corner and say, ultimately: Perhaps we ought to give the benefit of the doubt to the employer, perhaps we ought to ignore the 600,000 who are injured?

As one who spent a small part of my life in the workplace, that standard is upside down. If the Senate in Washington, DC, is not here to protect those who are voiceless, then we have lost our bearings completely. This issue goes to the heart of that debate.

The General Accounting Office has found employers can reduce costs and injuries associated with musculoskeletal disorders and improve not only employee health but productivity and product quality.

When workers know their employer cares enough about them to make the workplace safer for them, it is a clear and strong message to them that increases employee morale. The time has come for the other side of the aisle to make good on its promise to the American people. The leader in the candidacy for the Presidency on the Republican side, Gov. George W. Bush of Texas, claims he is a compassionate conservative. During the course of this campaign, we will try to figure out what that means.

Today, we can ask ourselves if we are seeing an exhibition of compassionate conservatism from the Republican side of the aisle. I think not. With this amendment, I think we see an effort to turn our backs on people who need compassion, understanding, and protection.

Last year, the chairman of the House Appropriations Committee, Robert Livingston of Louisiana, and his ranking Democratic member, DAVID OBEY of Wisconsin, made it clear in a letter to the Secretary of Labor:

. . . by funding the National Academy of Sciences study [on this issue], it is no way our intent to block or delay issuance by OSHA of a proposed rule on ergonomics.

The reason I raise that is so those who are following the debate understand that this attempt at delay is nothing new. I have the letter. The letter makes it clear that both the Democratic and Republican leaders on the House Appropriations Committee last year made it clear they wanted to go forward with the rule or a standard of protection on these types of injuries.

I ask unanimous consent the letter be printed in the RECORD.

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

HOUSE OF REPRESENTATIVES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC, October 19, 1998.

Hon. Alexis Herman,
Secretary of Labor,
Washington, DC.

DEAR MADAM SECRETARY: Congress has chosen not to include language in the Fiscal Year 1999 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act that would prohibit OSHA from using funds to issue or promulgate a proposed or final rule on ergonomics. As you are well aware, the Fiscal Year 1998 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act did contain such a prohibition, though OSHA was free to continue the work required to develop such a rule.

Congress has also chosen to provide $890,000 for the Secretary of Health and Human Services to fund a review by the National Academy of Sciences (NAS) of the scientific literature regarding work-related musculoskeletal disorders. We understand that OSHA intends to issue a proposed rule on ergonomics late in the summer of 1999. We are writing to make clear that by funding the NAS study, it is in no way our intent to block or delay issuance by OSHA of a proposed rule on ergonomics.

Sincerely,

BOB LIVINGSTON,
Chairman.
DAVID OBEY,
Ranking Member.

Mr. DURBIN. Here we have the Bond amendment which says the deal is off. For the sake of some companies which do not protect their workers in the workplace and do not care to spend the money to do it, we are basically going to say we will establish no standards for workplaces across America. Senator GREGG, my colleague, proposed the new National Academy of Sciences study last September in committee. Then he stated, ''. . . the study does not in any way limit OSHA'' in moving forward with the ergonomic standard.

By the way, this study asks exactly the same seven questions the previous study asked. Even Chairman STEVENS of Alaska stated, ''There is no moratorium under this agreement.''

So we are told the Department is supposed to go forward in establishing these standards. Along comes the Bond amendment. I remind my colleagues, the Bond amendment stops the Department of Labor in its tracks. It prohibits that department, OSHA, from promulgating or continuing the rulemaking process, issuing any standard, regulation, or guidelines regarding ergonomics for a year.

So the deal has been changed. The losers in this bargain are the workers across America who expect us to care and expect us to respond. I think it is time to bring an end to this charade. We have a real problem. We need real solutions. Workers across this country need real protection. The Bond amendment removes the possibility of establishing this standard of protection.

A few weeks ago I was visited by Madeleine Sherod. Madeleine is a victim of these injuries, a mother of five children who are now all grown. She has worked for an Illinois paint company for 20 years.

When she started, she literally lifted and moved work stations from one area of the plant to another. This job consisted of lifting several different sizes and weights of boxes. After several months of this type of work she transferred to the shipping department where she performed the duties of a warehouse worker. Her job consisted of driving a material handling truck and lifting cartons of paint that were packaged in various sizes and weights (5 gallon pails weighing approximately 20 lbs–90 lbs). She performed this job for at least 13 years. She later transferred to a job where she now operates several different pieces of machinery. She must keep the equipment operating efficiently—if the machinery breaks down then manual labor must be performed.

Her first injury occurred about 15 years ago. She was diagnosed with carpal tunnel syndrome and had surgery to relieve the pain. As a mother of 5 children her ability to perform the normal tasks as a parent was an everyday struggle. She was unable to comb her three daughters hair, wash dishes, sweep floors, or many other day-to-day tasks that working moms must perform.

Her second injury occurred about 7 years ago. Madeleine was diagnosed with tendinitis and this time had tenon release surgery. Even today she has to wear a wrist brace to help strengthen her wrist. Being extra cautious has become part of her everyday life when it comes to the use of her wrist.

She recently found a lump on her left wrist, and is preparing herself for yet another surgery.

The company has not been able to make any adjustments for her at this time. They say that there really is nothing they can do to change the work that is preformed in the shipping department to curtail repetitive use of the hands, knees and back.

And here's the clincher: the majority of the women who have worked for this company for more than 10 year have had similar surgeries for their injuries.

The PRESIDING OFFICER. If the Senator will suspend, we have an order to vote on the Wellstone amendment at 1:50.

Mr. DURBIN. I will suspend.

VOTE ON AMENDMENT NO. 1842

Mr. COVERDELL. Mr. President, I ask for the yeas and nays on the Wellstone amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1842. The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Connecticut (Mr. DODD) is absent because of family illness.

The result was announced—yeas 98, nays 1, as follows:

[Rollcall Vote No. 318 Leg.]

YEAS—98

Abraham	Feinstein	Mack
Akaka	Fitzgerald	McCain
Allard	Frist	McConnell
Ashcroft	Gorton	Mikulski
Baucus	Graham	Moynihan
Bayh	Gramm	Murkowski
Bennett	Grams	Murray
Biden	Grassley	Nickles
Bingaman	Gregg	Reed
Bond	Hagel	Reid
Boxer	Harkin	Robb
Breaux	Hatch	Roberts
Brownback	Helms	Rockefeller
Bryan	Hollings	Roth
Bunning	Hutchinson	Santorum
Burns	Hutchison	Sarbanes
Byrd	Inhofe	Schumer
Campbell	Inouye	Sessions
Chafee	Jeffords	Shelby
Cleland	Johnson	Smith (NH)
Cochran	Kennedy	Smith (OR)
Collins	Kerrey	Snowe
Conrad	Kerry	Specter
Coverdell	Kohl	Stevens
Craig	Kyl	Thomas
Crapo	Landrieu	Thompson
Daschle	Lautenberg	Thurmond
DeWine	Leahy	Torricelli
Domenici	Levin	Voinovich
Dorgan	Lieberman	Warner
Durbin	Lincoln	Wellstone
Edwards	Lott	Wyden
Feingold	Lugar	

NAYS—1

Enzi

NOT VOTING—1

Dodd

The amendment (No. 1842) was agreed to.

AMENDMENT NO. 1825

Mr. NICKLES. Mr. President, parliamentary inquiry: What is the pending business before the Senate?

The PRESIDING OFFICER (Mr. VOINOVICH). Amendment No. 2270, in the second degree, offered by Senator BOND.

Mr. BURNS. Mr. President, I am pleased to support an amendment that I feel to be extremely important to the small business owners of Montana. That amendment is the Sensible Ergonomics Needs Scientific Evidence Act, the SENSE Act. This amendment makes the Occupational Safety and Health Administration, OSHA, to do the sensible thing—wait for a scientific report before OSHA can impose any new ergonomics regulations on small business.

According to the Bureau of Labor Statistics, BLS, the overall injury and illness rate is currently at its lowest level. Date shows that musculoskeletal disorders have declined by 17 percent over the past 3 years. But OSHA continues to aggressively move forward with an ergonomics regulation and ignoring the intent of Congress.

I have been hearing from small business owners of across the State of Montana. Businesses that range from construction companies to florists that fall under OSHA's mandated ergonomics regulations are telling me something has to be done. They are being forced to comply with ridiculous rules and regulations that OSHA cannot prove to be harmful to employees.

Before OSHA can move forward with any new regulations a few things need to be proven. First, OSHA needs to objectively define the medical conditions that should be addressed, not a broad category of all soft tissue and bone pains and injuries that might have resulted. Second, they need to identify the particular exposures in magnitude and nature which cause the defined medical conditions. Last they need to prescribe the changes necessary to prevent their recurrence. Right now OSHA cannot prove any of these things.

We need to make sure that OSHA is not running free and loose. They cannot have free rein to enact new rules and regulations without having significant scientific evidence to back up their new mandate. This amendment, to put it simply, will delay moving forward with any ergonomics rule or guideline until completion of an independent study of the medical and scientific evidence linking on-the-job activities and repetitive stress injuries.

This is a very complicated issue, and we need to make sure that there is sound science and through medical evidence to protect our small business and employees from misguided rules and regulations. The SENSE Act does not prohibit OSHA from continuing to research ergonomics or from exercising its enforcement authority, it just puts the small business owner on a level playing field. I yield the floor.

Mrs. MURRAY. Mr. President, I strongly oppose this amendment. It is our responsibility as the Nation's leader to reduce the hazards that America's workers face—not putting roadblocks in the way of increased workers safety. Ergonomic injuries are the single largest occupational health crisis faced by men and women in our workforce today. We should let the OSHA issue an ergonomics standard.

Ergonomic injuries hurt America's workers. Each year, more than 600,000 private sector workers in America are forced to miss time from work because of musculoskeletal disorders, MSDs. These injuries hurt our America's companies because these disorders can cause workers to miss three full weeks of work or more. Employers pay over $20 billion annually in worker's compensation benefits due to MSDs and up to $60 billion in lost productivity, disability benefits, and other associated costs.

The impact of MSDs on women workers is especially serious. While women make up 46 percent of the total workforce and only make up 33 percent of total injured workers, they receive 63 percent of all lost work time ergonomic injuries and 69 percent of lost work time carpal tunnel syndrome.

In addition, women in the health care, retail and textile industries are particularly hard hit by MSDs and carpal tunnel syndrome. In fact women suffer over 90 percent of the MSDs among nurses, nurse aides, health care aides, and sewing machine operators. Women also account for 91 percent of the carpal tunnel cases that occur among cashiers.

Despite all the overwhelming financial and physical impacts of MSDs and the disproportionate impact they have on our Nation's women, there have been several efforts over the years to prevent the Occupational Safety and Health Administration, OSHA from issuing an ergonomics standard.

Let's be clear, this amendment is intended to delay OSHA's ergonomic standard until yet another scientific study is performed on ergonomic injuries. We have examined the merits of this rule over and over again. Contrary to what those on the other side of this issue say, the science supports an ergonomics standard. We also had a bipartisan agreement that the current National Academy of Sciences, NAS, study would—in no way—impede implementation by OSHA.

NAS has already studied this issue. The new study would address the exact same issues that were dealt with in the previous study. They are also using the same science. No new science. It is mind boggling.

The National Institute for Occupational Safety and Health, NIOSH, studied ergonomics and conclude that there is ''clear and compelling evidence''

that MSDs are caused by work and can be reduced and prevented through workplace interventions. The American College of Occupational and Environmental Medicine, the world's largest occupational medical society, agreed with NIOSH and saw no reason to delay implementation. The studies and science are conclusive in the Senator's mind.

Further—and possibly most persuasive—last year, the administration and leaders in Congress on this side of the aisle only agreed to a new study because those on the other side said that this new study would not delay the issuance by OSHA of a rule on ergonomics. Now they are not standing by their word.

We cannot afford to delay an important standard which will greatly improve workplace safety.

I urge my colleagues to oppose this amendment. We should allow OSHA to issue an ergonomics standard. It will be an important first step in protecting our Nation's workers from crippling injuries.

Mr. KERRY. Mr. President, I want to spend some time this afternoon speaking to my colleagues to vote against the amendment before us today, the amendment that would prohibit the Department of Labor or the Occupational Safety and Health Administration from issuing any standard or regulation addressing ergonomic concerns in the workplace for one year.

Mr. President, this prohibition would come just as OSHA prepares, in the next few weeks, to publish its proposed rule on ergonomics for public comment. This would be a blow to American workers and a real step backwards for the kind of cooperative approach to business and the workplace that we need in this country.

Mr. President, let's be clear about the issue before us, the question of ergonomics and which workplace injuries will continue to occur if this amendment becomes law.

Ergonomics is the science of fitting workplace conditions and job demands to the capabilities of the working population. The study of ergonomics is large in scope, but generally, the term refers to the assessment of those work-related factors that may pose a risk of musculoskeletal disorders. It is well-settled that effective and successful ergonomics programs assure high productivity, avoidance of illness and injury risks, and increased satisfaction among the workforce.

Many businesses and trade associations have already implemented safety and health programs in the workplace and have seen productivity rise as fewer hours on the job are lost. According to Assistant Secretary of Labor Charles N. Jeffress in his testimony before the House Committee on Small Business, programs implemented by individual employers reduce total job-related injuries and illnesses by an average of 45 percent and lost work time injuries and illnesses by an average of 75 percent.

Ergonomic disorders include sprains and strains, which affect the muscles, nerves, tendons, ligaments, joints, cartilage, or spinal discs; repetitive stress injuries, that are typically not the result of any instantaneous or acute event but are usually chronic in nature, and brought on as a result of a poorly designed work environment (these injuries are common causes of muscoskeletal problems such as chronic and disabling lower-back pain); and carpal tunnel syndrome.

And let's be clear that this, Mr. President, is a real problem for American businesses and workers. Industry experts have estimated that injuries and illnesses caused by ergonomic hazards are the biggest job safety problem in the workplace today, as each year more than 600 thousand workers suffer from back injuries, tendinitis, and other ergonomic disorders. In fact, OSHA, estimates that injuries related to carpal tunnel syndrome alone result in more workers losing their jobs than any other injury. The worker compensation cost of all ergonomics injuries is estimated at over 20 billion dollars annually.

What is most troubling, Mr. President, is that these types of injuries are preventable. There is something that can be done to protect the American worker. It should be noted that in drafting its proposed rule—a rule Mr. President, that is scheduled to be issued in just a few weeks—OSHA worked extensively with a number of stakeholders, including representatives from industry, labor, safety and health organizations, State governments, trade associations, and insurance companies. OSHA has drafted an interactive, flexible rule that allows managers and labor to work in unison to create a safer workplace environment. OSHA even placed on its Website a preliminary version of the draft proposed rule, in order to facilitate comments from the public. Mr. President, this is not a ''command and control'' regulatory action.

As noted by Assistant Secretary Jeffress: ''An employer [should] work credibly with employees to find workplace hazards and fix them . . . the rule creates no new obligations for employers to control hazards that they have not already been required to control under the General Duty Clause under Section 5 of the Occupational Safety Act or existing OSHA standards.''

In other words, Mr. President, this rule is simply an interactive approach between employee and manager to protect the assets of the company in ways that are either already being done, or should be done under existing rules. This new rule is a guide and a tool, not an inflexible mandate.

According to the Department of Labor, thirty-two states have some form of safety and health program. Four States (Alaska, California, Hawaii, and Washington) have mandated comprehensive programs that have core elements similar to those in OSHA's draft proposal. In these four states, injury and illness rates fell by nearly 18 percent over the five years after implementation, in comparison with national rates over the same period.

I'd like to share with my colleagues two examples from my home state of Massachusetts that show how business and labor can benefit from successful ergonomics programs. Crane & Company, a paper company located in Dalton, Massachusetts signed an agreement with OSHA to establish comprehensive ergonomics programs at each of their plants. According to the company's own report, within three years of starting this program, the company's musculoskeletal injury rate was almost cut in half.

Lunt Silversmiths, a flatware manufacturer in Greenfield, was troubled by high worker's compensation costs. One OSHA log revealed that back injuries were the number one problem in three departments. By implementing basic ergonomic controls, lost workdays dropped from more that 300 in 1992 to 72 in 1997, and total worker's compensation costs for the company dropped from $192,500 in 1992 to $27,000 in 1997.

That's the difference this common sense approach can make. And, Mr. President, in spite of the arguments for the Bond amendment, there bulk of the science and the research proves that an ergonomic standard is needed in the American workplace.

The National Academy of Sciences, the same group directed in this amendment to complete a study on this issue, already has compiled a report entitled Work-Related Musculoskeletal Disorders. And the report tells us that workers exposed to ergonomic hazards have a higher level of pain, injury and disability, that there is a biological basis for these injuries, and that there exist today interventions to prevent these injuries.

In 1997, the National Institute for Occupational Safety and Health completed a critical review of epidemiologic evidence for work-related musculoskeletal disorders of the neck, upper extremity, and lower back. This critical review of 600 studies culled from a bibliographic database of more than 2,000 found that there is substantial evidence for a causal relationship between physical work factors and musculoskeletal disorders.

Furthermore, Mr. President, we are not talking about a new phenomenon, or the latest fad. In 1990, Secretary of Labor Elizabeth Dole, in response to evidence showing that repetitive stress disorders (such as carpal tunnel syndrome) were the fastest growing category of occupational illnesses, committed the agency to begin working on an ergonomics standard. This rulemaking has been almost ten years in the making. Now is the time to put something in place for the American worker.

This rule has been delayed for far too long. In 1996, the Senate and the House

agreed to language in an appropriations conference report that would prevent OSHA from developing an ergonomics standard in FY 1997. In 1997, Congress prevented OSHA from spending any of its FY 1998 budget on promulgating an ergonomics standard. Last year, money in the FY 1999 budget was set aside for the new NAS study cited in this amendment, and the then-Chairman and Ranking Members of the House Appropriations Committee sent a letter to Secretary of Labor Alexis Herman, stating that this study ''was not intended to block or delay OSHA from moving forward with its ergonomics standard.''

Mr. President, we should wait no longer for this standard to be proposed, and workers should not have to wait until a new study is completed to be directed from preventable injuries. The time to protect the American workplace is now.

People on the other side of this issue may argue that this is an expensive rule, or that the science is inadequate. This is simply not true. The changes envisioned by the rule will increase productivity and save costs. The studies have been numerous. Preventing OSHA from even working on an ergonomic standard, much less issuing one, at the eleventh hour is not the right approach for American workers.

This standard is a win-win for workers and management: the better that workers are protected, the more time they spend on the job. The more time they spend on the job, the more productive the workplace. And it is obvious, but it bears restating, the more productive the workplace, the more productive this country. Workers want to be at work, and their bosses want them at work.

We ought to be capable—as a Senate—to put that common sense approach and this simple ergonomics standard into place and we all be able to vote against the Bond amendment and help out workers and our businesses move forward together.

Mrs. FEINSTEIN. Mr. President, I rise in opposition to the amendment offered by the Senator from Missouri. This amendment would needlessly delay OSHA from implementing regulations to prevent one of the leading causes of work place injuries, musculoskeletal disorders (MSDs).

Each year, more than 600,000 American workers suffer work related MSDs and it is costing businesses $15 to $20 billion in workers' compensation costs alone. It is estimated that one out of every three dollars spent on worker's compensation is related to repetitive motion injuries.

Many of the jobs that are disproportionately subject to ergonomic injuries are held by women. In fact, while women experience 33 percent of all serious workplace injuries, they suffer 61 percent of repetitive motion injuries. This includes:

91 percent of all injuries related to repetitive typing;

61 percent of repetitive placing injuries;

62 percent of work related cases of tendinitis; and

70 percent of carpal tunnel syndrome cases.

The supporters of this amendment argue that OSHA should delay ergonomic protection until the National Academy of Sciences completes a second review of existing studies. This comes despite the fact that there is already substantial scientific evidence linking MSDs to the workplace.

The first study completed by the National Academy of Sciences found that ''research clearly demonstrates that specific interventions can reduce the reported rates of musculoskeletal disorders for workers who perform high-risk tasks.'' That peer reviewed study was conducted just last year.

The National Institute for Occupational Safety and Health reviewed more than 2,000 studies of work-related musculoskeletal disorders. They concluded that ''compelling scientific evidence shows a consistent relationship between musculoskeletal disorders and certain work related factors.''

In a letter to the Department of Labor, William Grieves, president of the American College of Occupational and Environmental Medicine, notes that ''there is an adequate scientific foundation for OSHA to proceed with a proposal and, therefore, no reason for OSHA to delay the rulemaking process while the National Academy of Science panel conducts its review.''

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

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

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE,

February 15, 1999.

CHARLES N. JEFFRESS,
Assistant Secretary of Labor, Occupational Safety and Health, U.S. Department of Labor, Washington, DC.

DEAR MR. JEFFRESS: The American College of Occupational and Environmental Medicine (ACOEM) urges you to move forward with a proposed Ergonomics Program Standard.

The College represents over 7,000 physicians and is the world's largest occupational medical society concerned with the health of the workforce. Although the College and its members may not agree with all aspects of the draft proposal, we support the Occupational Safety and Health Administrations's (OSHA) efforts to promulgate a standard. An ergonomics program standard that ensures worker protection and provides certainty to employers is preferable to the uncertainties of the general duty clause. As physicians, the College's members will vigorously participate during rulemaking to ensure that a final standard is protective of workers, represents the best medical practices and is supported by the science of musculoskeletal diseases.

It is incumbent on OSHA to carefully consider the science and to give all due consideration to the results that will come from the National Academy of Science panel's review of the scientific literature regarding musculoskeletal disorders. However, there is an adequate scientific foundation for OSHA to proceed with a proposal and, therefore, no reason for OSHA to delay the rulemaking process while the National Academy of Science panel conducts its review.

The College looks forward to its active participation in this rulemaking. In the interim, please do not hesitate to contact me or Dr. Eugene Handley, Executive Director.

Sincerely,

WILLIAM GREAVES,
President.

Mrs. FEINSTEIN. All of these studies have found links between repetitive motion injuries and workplace factors and suggest that OSHA must be permitted to go forward with sensible regulations to insure a safe workplace.

Ergonomic programs have proven to be effective in reducing repetitive motion injuries in the workplace. Many businesses which have voluntarily instituted an ergonomic program have found the long term benefits to far outweigh the short term costs.

Red Wing Shoes in Minnesota found that their workers' compensation costs dropped 75 percent in the 4 years after they began an ergonomic program.

Fieldcrest-Cannon in Columbus, Georgia, saw the number of workers' suffering from repetitive motion injuries drop from 121 in 1993 to 21 in 1996.

By redesigning its workstations, Osh-Kosh B'Gosh reduced workers' compensation costs by one-third.

Mr. President, I certainly agree that decisions on government regulations should be based on sound science. In this case, there is already a substantial body of scientific evidence which concludes that there is a relationship between MSDs and the workplace and that ergonomic programs can significantly reduce these injuries.

During this decade, more than 6.1 million workers have suffered from serious workplace injuries as a result of ergonomic hazards. As we move into the next century, American workers must be given adequate protection from these preventable injuries. Congress must allow OSHA to move forward with sensible ergonomic regulations. I urge my colleagues to vote to defeat this amendment.

Ms. MIKULSKI. Mr. President, I rise in opposition to the Bond Amendment. It's bad for American workers and bad for our economy.

OSHA must move forward with an ergonomics standard. Each year, more than 600,000 individuals in our private sector work force miss time due to ergonomic injuries, or musculoskeletal disorders (MSDs). These injuries cost our economy over $80 billion annually, including approximately $60 billion on lost productivity costs. Nearly $1 out of every $3 in worker's compensation payments result from MSDs.

More importantly, these injuries cause terrible pain and suffering—as well as increased health care costs. OSHA's ergonomics standard is supported by overwhelming scientific evidence. The National Academy of Sciences (NAS) study concluded that workplace interventions can reduce the incidence of MSDs. When this study

was funded in 1998, the Appropriations Committee and the Administration agreed that funding this study was not a mechanism for delaying the OSHA standard. We must honor our agreement and let OSHA do it's work on behalf of working men and women in our country.

Mr. President, ergonomics is also a women's issue. Women account for nearly 75% of lost work time due to carpal tunnel syndrome and 62% of lost time due to tendinitis. Many of the women affected by MSDs are in the health care industry, including nurses, nurse aides and health care aides. Women in the retail industry are also disproportionately affected by ergonomic injuries.

I strongly urge my colleagues to help improve workplace safety by joining me in opposing this amendment. As a great nation, it is our duty to protect our most valuable resource—our working men and women.

Mr. NICKLES. Mr. President, for the information of my colleagues, we have been debating for the last hour or so—although we did have a discussion on the Wellstone amendment—the issue of the Bond amendment dealing with ergonomics. We have been debating it for a significant period of time. I personally am ready to vote on the amendment. I know there has been some discussion on both sides, but I ask unanimous consent that we have 30 additional minutes equally divided on the Bond amendment.

Mr. REID. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. NICKLES. Mr. President, again, I think most things have been said on this amendment that need to be said. I don't know if Members want more debate. I will make an additional request, and that is that we have 2 hours of debate on the Bond amendment equally divided.

Mr. REID. Reserving the right to object, Mr. President, I say to my friend from Oklahoma, this deserves some attention. We have 600,000 people a year who are injured as a result of these accidents. We had over 2,000 studies. The time is here to go forward with some rules and regulations to protect American workers. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. NICKLES. Mr. President, I will make one additional try. I ask unanimous consent that we have 4 hours equally divided on this bill.

Mr. REID. Reserving the right to object, I have been on the floor—this is the fifth or sixth day—trying to work with the majority to move this bill along. We have worked with the Members on the minority. We have moved a significant number of amendments, probably 65 or 70. We are to a point now where this bill could be completed but for this one contentious issue. From the very beginning, we have said this is an issue that deserves a lot of attention. We say, again, we are willing to work with the majority on this bill, but if this matter is here, we are going to have to discuss it. The American people, 600,000 a year, are injured with these accidents. It deserves more than 2 hours or 4 hours. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Pennsylvania.

Mr. SPECTER. Senator KENNEDY.

Mr. KENNEDY. Mr. President, I ask unanimous consent that a minimum wage amendment be in order and that we have 1 hour of debate on that.

Mr. NICKLES. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, in light of the fact that we are not going to get a time agreement on ergonomics, on the Bond amendment, in a moment I will move to table, as manager. First, I would like to move ahead on sequencing after the vote.

I ask unanimous consent that the Senator from West Virginia, Mr. BYRD, be recognized at the conclusion of the vote and then, following Senator BYRD's statement, we move to the amendment to be offered by the Senator from New Hampshire, Mr. SMITH, so we will be on notice that that will be the next order of business.

The PRESIDING OFFICER. Is there objection? Is there objection to the request?

Mr. KENNEDY. Mr. President, reserving the right to object, is it the intention to withdraw the amendment, then, if it is not tabled?

Mr. NICKLES. Let's have the vote.

Mr. KENNEDY. Is it the intention to withdraw the amendment if it is not tabled?

Mr. SPECTER. If I may respond to the Senator from Massachusetts, it is not my amendment, but it is my hope, as manager of the bill, that that would happen. But that is up to the offeror of the amendment.

Mr. KENNEDY. Well, unless such is clear, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. SPECTER. Mr. President, I move to table the Bond amendment No. 1825 and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

Mr. BYRD. Mr. President, was the unanimous consent request agreed to?

The PRESIDING OFFICER. The request was objected to.

Mr. BYRD. Mr. President, I ask unanimous consent that at the conclusion of the vote, I be recognized for not to exceed 30 minutes to speak on another matter.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered. The Senator will have 30 minutes following the vote.

The PRESIDING OFFICER. The question is on the motion to table.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Connecticut (Mr. DODD) is absent because of family illness.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 2, nays 97, as follows:

[Rollcall Vote No. 319 Leg.]

YEAS—2

Jeffords	Specter

NAYS—97

Abraham	Feingold	Mack
Akaka	Feinstein	McCain
Allard	Fitzgerald	McConnell
Ashcroft	Frist	Mikulski
Baucus	Gorton	Moynihan
Bayh	Graham	Murkowski
Bennett	Gramm	Murray
Biden	Grams	Nickles
Bingaman	Grassley	Reed
Bond	Gregg	Reid
Boxer	Hagel	Robb
Breaux	Harkin	Roberts
Brownback	Hatch	Rockefeller
Bryan	Helms	Roth
Bunning	Hollings	Santorum
Burns	Hutchinson	Sarbanes
Byrd	Hutchison	Schumer
Campbell	Inhofe	Sessions
Chafee	Inouye	Shelby
Cleland	Johnson	Smith (NH)
Cochran	Kennedy	Smith (OR)
Collins	Kerrey	Snowe
Conrad	Kerry	Stevens
Coverdell	Kohl	Thomas
Craig	Kyl	Thompson
Crapo	Landrieu	Thurmond
Daschle	Lautenberg	Torricelli
DeWine	Leahy	Voinovich
Domenici	Levin	Warner
Dorgan	Lieberman	Wellstone
Durbin	Lincoln	Wyden
Edwards	Lott	
Enzi	Lugar	

NOT VOTING—1

Dodd

The motion to table was rejected.

Mr. LOTT. Mr. President, in view of the time that has been spent discussing this very important issue, and also the fact there have been several attempts to find ways to limit the debate, and now in view of the vote on the motion to table which was unanimous against tabling it, putting the Senate back to exactly the position we were in before, I think the thing to do at this time is to withdraw this amendment and move forward.

I think that is a mistake. I want to say to one and all, this issue will be joined further, and we will find a way for the content of this amendment to be in some legislation and passed through the Congress this year.

Mr. BOND. Mr. President, it has become clear to me that my amendment, which would force OSHA to do their job correctly instead of hastily, is a bigger concern to those on the other side than the wide range of benefits that the underlying Labor/HHS appropriations bill provides. This disappoints me tremendously.

However, because the Labor/HHS appropriations bill will provide funding for so many programs that will help causes I support, I will not allow my amendment to prevent passage of this bill.

By allowing OSHA to go forward at this moment, we are saying that it is

acceptable for an agency charged with protecting employees to promulgate a regulation that has insufficient scientific and medical support. We are saying that it is acceptable for OSHA to tell employers that we don't have the answers, but we expect you to come up with them, and we will fine you if you don't. We are saying that it is acceptable for an agency that should be focusing on helping employers protect their employees from hazards, instead to tell them that they have no idea how to help them do this, but it would be OK for them to be cited just the same.

The heart of this issue is that although there have indeed been many studies conducted, they have not managed to answer the critical questions that employers need to know to be able to protect their employees: ''How much lifting is too much?'', How many repetitions are too many?'', and ''What interventions can an employer implement to protect his or her employees?'' This is what we mean by saying that there is not sufficient sound science to support this regulation.

This regulation, whenever it comes out and takes effect, will be the most far reaching regulation ever issued by OSHA. It will be one of the most far reaching regulations from any agency and will ultimately effect every business in this country. To say that we will allow OSHA to proceed with a regulation of this nature, that we know is horribly flawed and without adequate scientific and medical support, borders on a dereliction of our duty.

Many speakers opposed to my amendment have focused on the number of workers who are believed to be suffering from ergonomics injuries. One of the great uncertainties about this issue is that we don't even know what it means to be in that group. That number includes many people who suffer from common problems like back pain which may or may not have any connection to the workplace. What constitutes a musculoskeletal disorder is one of those questions around which there is still no consensus within the medical and scientific communities.

Under the Occupational Safety and Health Act, OSHA has jurisdiction only over workplace safety questions. If the condition which represents a hazard is not part of the workplace, OSHA has no authority to compel an employer to address the problem. With ergonomics, there is no way for an employer to be able to tell when a condition has arisen because of exposures at the workplace or because of activities or conditions that have nothing to do with the workplace. Many factors such as age, physical condition, diet, weight, and even family history can influence whether someone is vulnerable to an ergonomic injury. We still don't know why two workers doing the same work for the same amount of time will have different experiences with injuries. It is simply beyond an employer's role and ability to ask them to determine how much of an injury may have been caused by factors outside their control. I do not believe that we should be telling employers that they should intrude into their employee's private lives to the degree that would be necessary to eliminate all possibility of suffering an ergonomic injury.

I will continue to seek opportunities to come back to this issue because I believe so strongly that without sound science on this issue, OSHA's regulation on ergonomics will force many small businesses to choose between complying and staying in business. Under this decision everyone loses. However, in the interest of moving the Labor/HHS appropriations bill, I will allow my amendment to be withdrawn.

AMENDMENT NO. 1825 WITHDRAWN

Mr. LOTT. I ask unanimous consent that amendment 1825 be withdrawn.

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

The amendment (No. 1825) was withdrawn.

The PRESIDING OFFICER. The Senator from West Virginia.

THE COMPREHENSIVE TEST BAN TREATY

Mr. BYRD. Mr. President, the Senate tomorrow is scheduled to begin debate on one of the most important and solemn matters that can come before this body—a resolution of ratification of a Treaty of the United States. The Treaty scheduled to come before us on Friday is the Comprehensive Nuclear Test Ban Treaty, commonly referred to as the CTBT.

Consideration of a Treaty of this stature is not—and it should never be—business as usual. A Treaty is the supreme law of this land along with the Constitution and the Laws that are made by Congress pursuant to that Constitution. Article VI of the Constitution so states: ''This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution of Laws of any State to the Contrary notwithstanding.''

Mr. President, consideration of a Treaty is not business as usual.

And yet, Mr. President, I regret to say that the Senate is prepared to begin consideration of the Comprehensive Test Ban Treaty under a common, garden-variety, unanimous consent agreement, the type of agreement that the Senate has come to rely upon to churn through the nuts-and-bolts legislation with which we must routinely deal, as well as to thread a course through the more contentious political minefields with which we are frequently confronted.

In fact, unanimous consent agreements have become so ubiquitous that silence from a Senator's office is often automatically assumed to be acquiescence. So it was the case when this unanimous consent request came to my office. I was not in the office at the time. We are very busy doing other things, working on appropriations bills, and so on. And so at the point when this unanimous consent agreement proposal reached my office, I was out of the office. When I came back to the office a little while later, the request was brought to my attention. But by the time it was brought to my attention, it was too late. I notified the Democratic Cloakroom that I would object to the unanimous consent agreement, but I was informed that the agreement had already been entered into.

I make this point not to criticize the well-intentioned objective of this unanimous consent agreement, which was to seek consensus on the handling of a controversial matter. I do not criticize the two leaders who devised the agreement. I criticize no one. I do, however, point out the unfortunate repercussions of the agreement as it affects the Senate's ability to consider the ratification of a treaty.

In short, unanimous consent is a useful tool, and it is a practical tool of the Senate. I suppose I may have, during the times I was majority leader of the Senate, constructed as many or more unanimous consent agreements than perhaps anybody else; I certainly have had my share of them, but it is not an all-purpose tool.

The unanimous consent agreement under which the Comprehensive Test Ban Treaty is to be considered reads as follows, and I now read from the Executive Calendar of the Senate dated Thursday, October 7, 1999.

Ordered, That on Friday, October 8, 1999, at 9:30 a.m., the Senate proceed to executive session for consideration of the Comprehensive Nuclear Test-Ban Treaty; that the treaty be advanced through the various parliamentary stages, up to and including the presentation of the resolution of ratification; that it be in order for the Majority Leader and the Democratic Leader to each offer one relevant amendment; that amendments must be filed at the desk 24 hours before being called up; and that there be a time limitation of four hours equally divided on each amendment.

Ordered further, That there be fourteen hours of debate on the resolution of ratification equally divided between the two Leaders, or their designees; that no other amendments, reservations, conditions, declaration, statements, understandings or motions be in order.

Ordered further, That following the use or yielding back of time and the disposition of the amendments, the Senate proceed to vote on adoption of the resolution of ratification, as amended, if amended, all without any intervening action or debate.

So if one reads the agreement, it is obvious that the treaty itself will not be before the Senate for consideration. I allude to the words in the unanimous consent request, namely:

. . . that the treaty be advanced through the various parliamentary stages, up to and including the presentation of the resolution of ratification.

So the Senate will not have any opportunity to amend the treaty, itself, but it is the resolution of ratification that will be before the Senate.

Mr. President, the foregoing unanimous consent agreement may be expedient and there may be some who would even consider it to be a savvy way to dispose of a highly controversial and politically divisive issue in the least amount of time with the least amount of notoriety. The politics of this issue are of no interest to me. I am not interested in the politics of the issue. I have not been contacted by the administration in any way, shape, form, or manner. Nobody in the administration has talked with me about this. I am not interested in the politics of it. Not at all. There has been some politics, of course, abroad, about this agreement, but I am not a part of that. I did join in a letter to the chairman of the Foreign Relations Committee urging that there be hearings, but I have not been pressing for a vote on the treaty.

The politics of the issue do not interest me. But the propriety of this unanimous consent agreement does. Simply put, it is the wrong thing to do on a matter as important and as weighty as an arms control treaty.

The Senate Armed Services Committee began a series of hearings on the CTBT just this week, and I commend the distinguished chairman of the Committee, Senator WARNER, and the distinguished ranking member, Senator CARL LEVIN, for their efforts and commitment to bring this matter before the Senate and to have hearings conducted thereon.

The first hearing, on Tuesday, was a highly classified and highly informative briefing by representatives of the CIA and the Department of Energy. I wish that all of my colleagues had the opportunity to hear the testimony given at that hearing, and to question the witnesses. Unfortunately, only the members of the Senate Armed Services Committee were privy to that information. I should say the distinguished ranking member of the Senate Foreign Relations Committee, Mr. BIDEN, was present also.

The second hearing, yesterday, brought before the Committee Defense Secretary Bill Cohen; General Henry Shelton, the chairman of the Joint Chiefs of Staff; Dr. James Schlesinger, the former Secretary of Defense and Energy; and General John Shalikashvili, former Chairman of the Joint Chiefs. Again, their testimony was very illuminating. I wonder how many of my colleagues, outside of the Armed Services Committee, and Mr. BIDEN, had the opportunity to follow that hearing—which lasted almost five hours—given the crush of other important business on the Senate floor?

My coilleagues simply haven't had the opportunity to do it, other than those of us on the Armed Services Committee.

I wonder how many of my colleagues have had an opportunity, since the vote on the CTBT was scheduled last week, to analyze, question, and digest the testimony and the opinions of the distinguished officials that the Committee heard from yesterday? I wonder, for example, how many of my colleagues heard from Secretary Cohen that a new National Intelligence Estimate that will have a major bearing on the consideration of this Treaty is due to be completed early next year? It is my judgment that the Senate should have that assessment in hand before it considers imposing a permanent ban—a permanent ban—on nuclear testing.

The Armed Services Committee held its third, and I believe final, hearing on the CTBT this morning. The witnesses included Energy Secretary Bill Richardson, as well as the current directors of the nuclear weapons laboratories, and a selection of arms control experts, including a former director of one of the labs. Again, it was an extraordinarily informative hearing.

I was there for most of it. Unfortunately, I was scheduled to go elsewhere near the close of the hearing. But it was an extraordinarily informative hearing. The laboratory directors were candid and forthcoming in their observations. They raised a number of important issues. I wonder how many of our colleagues here, outside the membership of the Armed Services Committee, heard those.

I have attended every hearing and every briefing available this week in order to prepare myself for tomorrow's debate. But I did not prepare myself before this agreement was entered into. When the agreement came to my office and I objected and found that I objected too late, then I bestirred myself to learn more about this treaty. I have listened to witnesses, and I have questioned witnesses. I still have many questions—more now than when I started.

I wonder how many of my colleagues—particularly those who have not had the same entree that members of the Senate Armed Services Committee have had to this week's hearings—have questions about this treaty. With the exception of Senator BIDEN—and, incidentally, Senator BIDEN is very knowledgeable about the treaty. He has studied it thoroughly and is very conversant with the details of the treaty. Perhaps some of the other members of the Foreign Relations Committee have done likewise. But other than that committee and the Committee on Armed Services, I daresay that few Senators have had an opportunity to engage themselves in a study of the treaty and even fewer, perhaps, have had the opportunity to hear witnesses and to question those witnesses.

But, with the exception of Senator BIDEN, not even the members of the Senate Foreign Relations Committee have had the opportunity to hear and question the witnesses who appeared before the Armed Services Committee this week. I wonder how many of my colleagues will participate in the debate tomorrow and how many will participate in the debate next Tuesday. These days are bookends around the holiday weekend when no votes are scheduled after this evening until 5:30 p.m. Tuesday at the earliest. I am confident that many Senators have important commitments in their home States that may conflict with this debate. Does anyone in this Chamber seriously believe we can give the Comprehensive Test Ban Treaty the consideration it deserves in the amount of time that has been set aside to debate it?

Beyond the question of time, Mr. President, is an even more disturbing question: The propriety of considering a major treaty under the straitjacket of procedural constraints in which only two amendments, one by each leader, will be in order. I have questions since I have read this treaty. I have reservations. Perhaps they will be put to rest by the debate. Or, it may be, as I continue to study the treaty and listen to the debate, that I would want to offer an amendment myself. I might want to offer an understanding or a condition.

I might want to offer a reservation. I have done so on other treaties. It may be that some of my colleagues would wish to do likewise. We do not have that opportunity under this unanimous-consent agreement, with the exception of our two fine leaders. I know that they will go the extra mile, as they always do, to accommodate the concerns of the Members. But they, too, are in a cul-de-sac—only one way in, one way out. They are limited to one amendment each. Without exception, the other 98 Members of the Senate are effectively shut out from expressing, in any meaningful and binding way, reservations or concerns about this treaty.

Mr. President, that is not the way to conduct the business of weighing a resolution dealing with the supreme law of the land. We might do that on an agriculture bill. We might do it on a bill making appropriations for the Department of the Interior. But this is a treaty we are talking about. A law can be repealed a year later but not a treaty.

For the good of the Nation, this unanimous consent agreement ought to be abandoned, and there are ways to do it. It is a unanimous-consent agreement, I understand that, and ordinarily a unanimous-consent agreement can only be vitiated by unanimous-consent, or it can be modified by unanimous consent. But there are ways to avoid this vote. I urge my colleagues to put politics aside in this instance, at least, and to seek a consensus position on considering a comprehensive test ban treaty that upholds the dignity of the United States Senate and accords the right to United States Senators to debate and to amend.

One need only read Madison's notes concerning the debates at the Convention to understand the importance of treaties in the minds of the framers.

We are talking here not about an appropriations bill; we are not talking about a simple authorization bill; we are talking about something that affects the checks and balances, the separation of powers that constitutes the cornerstone of our constitutional system in this Republic. This is one of those checks and balances; this involves the separation of powers. The Senate, under the Constitution, has a voice in the approval of treaties. The President makes the treaty, by and with the consent of the United States Senate.

I was here when we considered the Test Ban Treaty of 1963. I was on the Armed Services Committee at that time. I listened to Dr. Edward Teller, an eminent scientist who opposed that treaty. I voted against that treaty in 1963. I opposed it largely on the basis of the testimony of Dr. Edward Teller.

We need to listen to the scientists. We need to listen to others in order that we might make an appropriate judgment. Who knows how this will affect the security interests of the United States in the future. This is a permanent treaty. It is in perpetuity, so it is not similar to a bill. As I say, we can repeal a law. But not this treaty. This treaty is in perpetuity—permanent. Maybe that is all right, but we need more time to study and consider it.

We are told that the polls show the people of the Nation are overwhelmingly in favor of this treaty. I can trust the judgment of the people generally, but the people have not had the opportunity to study the fine print in this treaty. Most Senators have not. This is not a responsibility of the House of Representatives. This is the responsibility solely of the Senate under the Constitution of the United States. It is a great burden, a great responsibility, a very high duty, and we must know what we are doing.

I have heard dire warnings as to what a rejection of the treaty might mean. One way to have it rejected fast, I am afraid, is to go through with this vote. But then how can we make up for it if we find we have made a mistake? If we find that we are wrong, it may be too late then. We had better stop, look, and listen and understand where we are going. We need more hearings.

I hope we will put politics aside in this instance and seek a consensus position on considering a comprehensive test ban treaty that upholds the dignity of the United States Senate. I am an institutionalist. I have an institutional memory. I have been in this body for 41 years, and I have taken its rules seriously. I believe the framers knew what they were doing when they vested the responsibility in the Senate to approve or to reject treaties. We ought not take that responsibility lightly. The very idea of the unanimous-consent request says Senators cannot offer reservations; they cannot offer conditions; they cannot offer amendments; they cannot offer understandings.

Let us so act that we reflect the importance of the treaty. Reject it if you will or approve it if you will, but let's do it with our eyes open. Let's not put on blinders. Let's not bind our hands and feet and mouths and ears and minds with a unanimous-consent agreement that will not allow unfettered debate or amendments.

Let the Senate be the institution the framers intended it to be.

I have not said how I shall vote on the treaty. I want to understand more about it. But I want other Senators to have an opportunity to understand it as well.

Mr. President, I thank Senators for listening, and for their patience in indulging these remarks.

I yield the floor.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER (Mr. ALLARD). The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, first let me commend the distinguished Senator from West Virginia for those very thoughtful remarks on the Comprehensive Test Ban Treaty.

I share his concern about the timing of the vote. I think the Senate is not yet ready to vote. My view is that there should have been hearings a long time ago. I attended part of the hearings—closed-door hearings—in S–407 on Tuesday of this week. They lasted about 5 hours.

I concur with the Senator from West Virginia that it is a very complex subject. I had studied the matter and had decided to support it. But I do think more time is necessary for the Senate as a whole—not just to have a day of debate on Friday and a day of debate on Tuesday and to vote on it. I think the Senate ought to ratify, but only after adequate consideration has been given to it. While the United States has been criticized for not taking up the treaty, if we were to reject it out of hand on what appears to be a partisan vote, it would be very disastrous for our foreign policy.

So I thank the Senator from West Virginia for his customary very erudite remarks on the Senate floor.

Mr. BYRD. I thank the distinguished Senator for his enlightened remarks. And, as always, he approaches a matter with an open mind, devoid of politics, and with only the interest of doing good, not harm; and that is his response in this instance.

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2000—Continued

Mr. SPECTER. Mr. President, we are now prepared to move on to our next amendment. I ask unanimous consent that there be 30 minutes equally divided prior to a motion to table on the amendment to be offered by the distinguished Senator from New Hampshire, Mr. SMITH, relative to Davis-Bacon, and no amendments be in order prior to a vote in relation to the amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. SMITH of New Hampshire addressed the Chair.

The PRESIDING OFFICER. The Senator from New Hampshire.

AMENDMENT NO. 1844

(Purpose: To limit the applicability of the Davis-Bacon Act in areas designated as disaster areas)

Mr. SMITH of New Hampshire. Mr. President, I call up my amendment No. 1844 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Hampshire (Mr. SMITH) proposes an amendment numbered 1844.

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

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

The amendment is as follows:

At the appropriate place, insert the following:

SEC. . No funds appropriated under this Act may be used to enforce the provisions of the Act of March 3, 1931 (commonly known as the Davis-Bacon Act (40 U.S.C. 276a et seq.)) in any area that has been declared a disaster area by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.).

Mr. SMITH of New Hampshire. Mr. President, this is a very simple, straightforward amendment that would prohibit enforcing Davis-Bacon prevailing wage requirements in areas designated by the President as natural disaster areas. Section 6 of the Federal Davis-Bacon Act allows the President to suspend this act in the event of a national emergency.

I think all of us would agree, especially those Senators in North Carolina and in Virginia as well, that we did have a national emergency with Hurricane Floyd.

Pursuant to this authority, President Bush suspended Davis-Bacon in 1992 to help speed up and lower the cost of rebuilding the communities ravaged by Hurricanes Andrew and Iniki.

So Hurricane Floyd has dealt this tremendous blow to the residents of the eastern seaboard, from Florida to North Carolina, even as far as New York. FEMA has called this one of the biggest multistate disasters in U.S. history. Many States believe cleanup costs from Hurricane Floyd will far exceed the costs of either Hurricanes Fran or Hugo. So relaxing the Davis-Bacon provisions in these hard-hit States will lower tremendously the cost of rebuilding these communities and help create job opportunities for those in need of work.

Many people come to these communities and volunteer their time to help their friends and relatives and neighbors in need, and others cut their costs of services to help these unfortunate

victims of the hurricanes. Davis-Bacon's prevailing wage requirements will increase the cost of construction, forcing the taxpayers to pay more and receive less in return. Not only that, it will cost the victims more. So that is why there is a provision, a waiver provision, the President may exercise to bring these costs down in times of disasters.

Government estimates, economic studies, and those involved in the construction industry believe Davis-Bacon actually inflates the cost of a construction project by an estimated 5 to 38 percent. For people who are the victims of these hurricanes—where there is Federal help—to have to pay more in these construction projects and for it to cost the taxpayers that much more money is outrageous. CBO estimates that Davis-Bacon adds $9.6 billion over 10 years to the cost of all Federal construction projects.

The historic floodwaters of Floyd have resulted in hundreds of millions of dollars in property damage and created a huge swath of human misery that will last for months. The Davis-Bacon Act should be suspended to aid disaster relief in the areas designated as natural disasters. It is reasonable. That is why there is a provision for a waiver. It is unfortunate President Clinton has decided not to waive it, or at least has not waived it to this point.

On September 21, 1999, the Wall Street Journal, in an editorial entitled ''Hurricane Davis-Bacon,'' stated:

Folks whose electricity shorted out when floodwaters hit their circuit box or shopkeepers sweeping the mud and debris out from once-vibrant businesses need no reminders about the costs imposed by Hurricane Floyd. But as they go about their repairs they may find that the destructive powers of Mother Nature are nothing compared with those of Washington.

Continuing to quote:

Start with the Davis-Bacon Act, which effectively requires that workers on federally subsidized construction projects receive union wages—even though only about a quarter of the construction industry is unionized. Davis-Bacon looms large in the wake of Floyd because so much disaster relief comes from the federal government. It was for precisely this reason in 1992 that President George Bush ordered the relaxation of Davis-Bacon rules to hasten repairs in Florida, Louisiana and Hawaii after hurricanes devastated those states.

Continuing to quote from the Wall Street Journal:

The happy result was twofold: Not only did the work get done faster, between 5,000 and 11,000 new construction jobs, mostly to semi-skilled minority workers, were created. Alas, the jobs didn't last long. Within days of becoming President in 1993, Bill Clinton revoked the Bush waivers on Davis-Bacon as a payback for organized labor's support. Mr. Clinton's continued defense is particularly galling to many minority workers, conscious of the law's origins in the Jim Crow attitudes of the 1930s. ''People can't see the jobs and buildings that aren't created because of Davis-Bacon, but it is a major factor in the low-income housing crisis,'' says Elzie Higginbottom, a low-income housing builder from Chicago's South Side.

Clearly the priority after any natural disaster must be getting help to the people who need it. But as we help the victims of Floyd pump water out of their basements and get their lives back on track, let's be careful not to contribute to the structural damage with . . . Davis-Bacon that only raise costs and make it that much harder to do the work that needs to be done.

I think that editorial sums it up about as well as it can be summed up. The bottom line is, this act, which, ironically, discriminated against minorities—and that was the purpose of the act when it was first originated—will cost taxpayers millions of dollars and take advantage of an unfortunate situation where people have suffered through a disaster.

I ask, what would be the problem of the President granting a waiver of Davis-Bacon? As I said before—and I think the Wall Street Journal said it better than I—the answer is, because the President owes a lot to organized labor, he is not about to do it. I think it is outrageous because the intent was clear.

I will read from a letter from 80 organizations in support of my amendment. The list includes a number of outstanding national organizations. It also includes several State organizations representing some of the States that have been hit hardest by Hurricane Floyd and other disasters. It is the Coalition to Repeal the Davis-Bacon Act.

It is unfair to further burden the local communities devastated by Hurricane Floyd and other disasters with the inflated costs of Davis-Bacon.

Mr. President, I think Senators will recognize some of the organizations—I will not read them all; there are 80—the American Society of Civil Engineers, the American Trucking Association, Associated Builders and Contractors, Citizens Against Government Waste, Citizens for a Sound Economy, Free Enterprise Institute, National Association of Home Builders, National Association of Manufacturers, National Center for Neighborhood Enterprise, National Federation of Independent Business, National League of Cities, National School Boards Association, National Tax Limitation Committee, National Taxpayers Union, U.S. Chamber of Commerce, to name a few of the 80.

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

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

COALITION TO REPEAL THE
DAVIS-BACON ACT,
October 5, 1999.

Hon. ROBERT C. SMITH,
U.S. Senate,
Washington, DC.

DEAR SENATOR SMITH: The Coalition to Repeal the Davis-Bacon Act urges you to support the amendment by Senator Bob Smith (R–NH) to relax the 1931 Davis-Bacon Act for disaster stricken areas across the country, during the debate on the Fiscal Year 2000 Labor/Health and Human Services and Education Appropriations legislation.

Hurricane Floyd has devastated states along the eastern seaboard, from Florida to North Carolina to New York, which now face major reconstruction demands. It is clearly one of the largest multi-state disasters in U.S. history. Relaxing Davis-Bacon in these hard hit states will lower the cost of rebuilding these communities and will help create job opportunities for those in need of work.

Section 6 of the Davis-Bacon Act [40 U.S.C. 276a-5], allows the suspension of the Act in the event of a ''national emergency.'' Pursuant to this, President George Bush relaxed Davis-Bacon rules in 1992 to hasten repairs in Florida, Louisiana and Hawaii and lower the cost of rebuilding the communities ravaged by Hurricanes Andrew and Iniki. As a result, the work was completed faster and between 5,000 and 11,000 new construction jobs were created, mostly to semi-skilled minority workers.

It is unfair to further burden the local communities devastated by Hurricane Floyd and other disasters with the inflated costs of Davis-Bacon. The Davis-Bacon Act has been demonstrated to inflate construction costs by 5 to 38 percent above what the project would have cost in the private sector. Lifting Davis-Bacon restrictions would reduce unnecessary federal spending and guarantee more construction for the dollar as communities try to rebuild in the wake of devastating disasters. Forcing disaster stricken communities to be saddled with Davis-Bacon will just raise their costs and make it harder to do the work that needs to be done.

The September 21, 1999, editorial in The Wall Street Journal, ''Hurricane Davis-Bacon'' summarized, ''Clearly the priority after any natural disaster must be getting help to the people who need it. But as we help the victims of Floyd pump the water out of their basements and get their lives back on track, let's be careful not to contribute to the structural damage with . . . Davis-Bacon that only raise costs and make it that much harder to do the work that needs to be done.''

We strongly urge you to waive Davis-Bacon and truly help communities that are trying to reconstruct their public infrastructure after a disaster.

Sincerely,

APAC, Inc.
APAC Alabama, Inc.
APAC Arkansas, Inc.
APAC Carolina, Inc.
APAC Florida, Inc.
APAC Georgia, Inc.
APAC Mississippi, Inc.
APAC Tennessee, Inc.
APAC Virginia, Inc.
American Concrete Pipe Association
American Legislative Exchange Council
Amerian Society of Civil Engineers
American Trucking Associations
Americans for Responsible Privatization
Ashburn & Gray Construction
Associated Builders & Contractors
Associated General Contractors of the Carolinas
BE & K, Inc.
Barrus Construction Company
Brick Institute
Business Leadership Council
Cajun Contractors, Inc.
Capital City Asphalt Company
Citizens Against Government Waste
Citizens for a Sound Economy
Complete Building Services—A division of the Donahoe Co.
Construction Industry Manufacturers Association
Contract Services Association
Council of 100
Council of State Community Development Agencies
Finley Construction
Fluor Corporation
Free Enterprise Institute

Harmony Corporation
Hays Mechanical Contractors
Hodges Construction
Independent Bakers Association
Independent Electrical Contractors, Inc.
Institute for Justice
ITT
Joule, Inc.
KCI Constructors, Inc.
Labor Policy Association
Land Improvement Contractors of America
Lauren Constructors, Inc.
Louisiana Association of Business and Industry
MacGougald Construction
McClinton Anchor Construction
M.W. Kellogg Company
N.C. Monroe Construction Company
National Aggregates Association
National Association of Home Builders
National Association of Manufacturers
National Association of the Remodeling Industry
National Center for Neighborhood Enterprise
National Federation of Independent Business
National Frame Builders Association
National Industrial Sand Association
National League of Cities
National Ready Mixed Concrete Association
National School Boards Association
National Slag Association
National Society of Professional Engineers
National Stone Association
National Tax Limitation Committee
National Taxpayers Union
Niagara County Business Association
Printing Industries of America
Public Service Research Council
Reno Construction Company
Repcon, Inc.
Small Business Survival Committee
Southern Roadbuilders
Southern Roadbuilders Concrete Paving
Texas Bitulithic Construction Company
Thompson-Arther Construction
Thompson & Thompson
TIC/The Industrial Company
Trotti & Thomson Construction Co.
U.S. Business and Industrial Council
U.S. Chamber of Commerce
Wilkerson Maxwell Construction

Mr. SMITH of New Hampshire. Mr. President, I am going to reserve the remainder of my time. It is my understanding that each side has 15 minutes on this debate; is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. SMITH of New Hampshire. How much do I have remaining?

The PRESIDING OFFICER. The Senator has 6½ minutes.

Mr. SMITH of New Hampshire. I will yield the floor at the moment.

The PRESIDING OFFICER. Who seeks recognition? The Senator from Massachusetts.

Mr. KENNEDY. How much time do we have, Mr. President?

The PRESIDING OFFICER. Fifteen minutes.

Mr. SPECTER. How much time does the Senator from Massachusetts want?

Mr. KENNEDY. I will take 6 minutes.

Mr. SPECTER. Fine.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, as we get started with this debate on the question of Davis-Bacon, it is kind of interesting. Over the course of recent days, we see a series of actions that have been directed at working families. The problem that most working families in our Nation face is that they have not participated in the great economic surge we have seen over recent times. Nonetheless, there is a continued effort to undermine their wages.

Let's start with the continuing denial by the majority to permit us a vote on the minimum wage. Then everyone in the country saw the actions of the Republican leadership recently, diverting the earned-income tax credit in order to be used for balancing the budget. We have had recent debates on the floor of the Senate about undermining the National Labor Relations Board, which tries to work out legitimate disputes on the basis of laws that have been in effect for years. There was also action taken on the floor of the Senate which cut back on the total number of OSHA inspections to protect workers in their workplaces in this country.

Beyond that, there have been the efforts to pass what is called comp time, which would have eliminated the 40-hour workweek and abolished overtime. All of that has been happening over the last 2 years.

I don't know why the other side has it in for, in this instance, construction workers. But the attacks seem to be fairly uniform, if we look over the facts of the record in terms of working families. That is true with regard to pensions as well. We will have another time to debate and discuss this. But those are the facts.

Rather than speculate on what is in an editorial or what is in a particular report, the best way to look at this is, first, the average wage of a construction worker in this country is $28,000 a year. Maybe that is too much for some Members of this body, but that is the average in terms of a construction worker. Yet the Senator from New Hampshire, in this amendment, says, in some parts of this country that isn't necessary for a worker to be able to bring up a family. It seems to me that $28,000, which is the average construction wage, is not an excessive wage in this country.

Secondly, if you read the Davis-Bacon Act you will see that the President already has discretion to suspend the Davis-Bacon Act if he believes there is a national emergency and its in the national interest. Presidents have in fact exercised this authority: President Bush waived the Davis-Bacon Act in 1992 after Hurricanes Andrew and Iniki. So the President has some flexibility if there are particular emergencies, but that is effectively being denied with the amendment of the Senator from New Hampshire.

Thirdly, if you look at various studies on Davis Bacon, including one by the University of Utah looking at 9 States that have repealed State Davis-Bacon laws, you see two very important facts: No. 1, there is a dramatic reduction in terms of training programs for construction workers; and, No. 2, the quality of the work by construction workers deteriorates, so the cost of doing business, rather than going down, actually goes up. Isn't that interesting? Now, with the amendment, we are trying to effectively undermine the wages construction workers would receive in these circumstances.

And what do we find in the States that have actually repealed State Davis-Bacon? They may get a little bump in the first few months in terms of some bidding, but what happens is, with the dramatic reduction in training programs and dramatic reduction in skill, the costs of various contracts go up. We will have a chance to go through that.

That is the issue: Whether at this time we are going to say men and women who are earning $28,000 a year are to see their wages cut. Many of them lost their homes, too; many of the workers who would be affected by this amendment live in areas where there has been devastation; many of these people have been wiped out completely and now, not only are they trying to get back on their feet, but as a result of this amendment, they will be denied at least the reasonable compensation which they had received at other times. Of course, this has implications in terms of the payment of taxes. This has important implications in terms of health care costs because in most of these contracts where you have Davis-Bacon, they have health care insurance.

You are going to find additional kinds of burdens on local communities. This hasn't been talked about. Workers will see insufficient payments into their pension funds, which is going to mean that retirement programs for these various workers are going to be compromised, all under the guise that somehow we are helping the areas where many of our fellow citizens have suffered and suffered extensively as a result of these extraordinary acts of nature.

I am all set to support whatever is necessary to help those families in any of these areas—and no one can watch what has happened to people in North Carolina and along those flood zones and not be moved—but let us do it right. Let us do it correctly, and let us not take it out on construction workers who, in many instances, have been devastated. Let us make sure they are going to get a reasonable day's pay for a reasonable day's work.

If I may have 30 more seconds, I want to include in the RECORD that after Hurricane Andrew, in 1992, the GAO tried to assess the savings from suspending Davis-Bacon, but the GAO report was unable to conclude there were any savings.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition? Who yields time?

Mr. SPECTER. How much time does the Senator from Minnesota want?

Mr. WELLSTONE. Five minutes.

Mr. SPECTER. We only have 15 minutes. How much time remains, Mr. President?

The PRESIDING OFFICER. Eight minutes 26 seconds remain.

Mr. WELLSTONE. I will use 3 minutes.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I find this amendment to be very troubling, and I hope colleagues will support our effort to table it. This amendment plays off hard-working people who are trying to make a decent wage against people in communities that are faced with disaster.

In 1999, so far, there have been 72 disaster declarations in 36 States, including Minnesota. The Smith amendment would suspend the Davis-Bacon application to all contracts in these areas for the entire year.

I think what people in Minnesota and in our country are saying to us is, when there is a disaster in our community and we need the help, please help us. I think what people in Minnesota and in the country are saying to us is that the prevailing wage is important, a living wage is important, a family wage is important, so please don't go cutting our wages.

There is absolutely no reason in the world to play off construction workers and the need to make a decent wage and support your family with whether or not we are going to be able to provide disaster relief to communities. This is a false choice. It is, in many ways, an outrageous choice. This amendment should be defeated.

The PRESIDING OFFICER. Who yields time?

Mr. SMITH of New Hampshire. Mr. President, I find some of the remarks of my colleagues very interesting. To say this is a partisan attack against working people is so outrageous and so untrue that it barely deserves a response. People who don't belong to unions also have families. They also need to feed those families. Let's understand what is happening, if we can tone down the rhetoric a little bit. Nonunion workers who want to stand side by side with the volunteers, who perhaps are putting sandbags up to stop the floodwaters from coming into somebody's home, are asking to work at a lesser wage than the union worker to help these people out. And they can't do it under the Davis-Bacon provision.

That is what we are talking about. There is no concern expressed on the other side about the nonunion worker's family; it is only the union worker's family. We have people who are volunteering for no money, no pay, to stand and help these victims of floods and other disasters, and then we have nonunion people who are saying, look, maybe I am off from school, or maybe I am taking off a few days from my own job to help my friends, and I am willing to work for $5, $6, or $7 an hour, something less than the prevailing union wage. They can't do it. That is what we are talking about. This is the issue.

This is nothing more than a payback for the huge contributions that come in from the labor unions, pure and simple. That is all it is. There is no excuse for this. The provisions in the law are very clear. The President could easily waive Davis-Bacon under the law, if he wished, but he doesn't want to do that. That is what we are hearing from the other side—lack of concern for the working man, unless he is a union man. If he is a union man, we have to protect him. If he is a nonunion man, who cares, we don't care about his family.

Mr. President, I will submit for the RECORD a September 30 letter to President Clinton, interestingly, signed by 20 Members of Congress, including 7 from flood-damaged North Carolina. I ask unanimous consent that it be printed in the RECORD, along with an editorial from the Washington Times.

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

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, September 30, 1999.

Hon. WILLIAM JEFFERSON CLINTON,
President of the United States of America,
The White House, Washington, DC.

DEAR MR. PRESIDENT: We are writing to urge you to relax Davis-Bacon prevailing wage requirements to facilitate repairs in states hardest hit by Hurricane Floyd. As you know, Hurricane Floyd has dealt a devastating blow to residents along the eastern seaboard from Florida to North Carolina to New York. The Federal Emergency Management Agency (FEMA) has called this one the biggest multi-state disasters in U.S. history. Many states believe that clean-up costs from Hurricane Floyd will far exceed the cost of either Hurricane Fran or Hugo.

In North Carolina some 1,000 roads and 40 bridges remain closed, as are sixteen school systems. Thousands remain without electricity and an estimated 30,000 homes were damaged or destroyed by the storm and flooding with 1,600 beyond repair. Agricultural impacts are estimated at more than $1 billion in North Carolina with more than 110,000 hogs and 1,000,000 chickens and turkeys killed by the storms. Water systems in nine counties are contaminated and many wastewater treatment plants are wholly or partly out of operation. FEMA estimates that nearly 7,100 homes are reported to be either destroyed or heavily damaged in South Carolina, Virginia, Pennsylvania, and other states. And while nearly a week has gone by since Floyd's arrival, it is anticipated that even more damage will be uncovered as the flood waters retreat.

As you may recall, President George Bush suspended to the Davis-Bacon Act in 1992 to help speed up and lower the cost of rebuilding the communities ravaged by Hurricanes Andrew and Iniki. President Bush took this action pursuant to Section 6 of the Act [40 U.S.C. 276a–5] which allows the President to suspend the Act in the event of a ''national emergency.''

The economic effects of this hurricane are significant. Many businesses have been damaged or destroyed. Thousands of individuals have either lost their livelihoods or can not make it to work because of impassable roads. It may be months or years before these communities are rebuilt and a record amount of federal assistance will be needed to do so.

Relaxing Davis-Bacon in these hard hit states will lower the cost of rebuilding these communities and will help create job opportunities for those in need of work. Davis-Bacon prevailing wage requirements increase the cost of construction—forcing taxpayers to pay more and receive less in return. Government estimates, economic studies, and those involved in the construction industry believe that the Davis-Bacon Act inflates the cost of a construction project by an estimated 5 to 38 percent. The Congressional Budget Office estimates that Davis-Bacon adds about $9.6 billion (over 10 years) to the cost of all federal construction projects.

The historic floodwaters of Floyd has resulted in hundreds of millions of dollars in property damage and created a huge swath of human misery that will last for months. We urge you to suspend the application of Davis-Bacon for disaster relief in the areas affected by Hurricane Floyd.

Sincerely,

Bill Goodling, Bill Barrett, Vernon J. Ellers, Sue Myrick, Charles H. Taylor, ———— ————, Matt Salmon, ———— ————, Tillie K. Fowler, Pete Hoekstra, Cass Ballenger, Richard Burr, Walter B. Jones, Howard Coble, Joe Knollenberg, Ron Paul, Tom Tancredo, Bob Schaffer, Robin Hayes, Nathan Deal.

[From the Washington Times, October 1999]

FLOOD RELIEF FOR UNIONS

Bailing out after Hurricane Floyd was bad enough. What the Federal Emergency Management Agency called one of the biggest disasters in history destroyed or damaged more than 30,000 homes and closed some 1,000 roads, 40 bridges and 16 school systems in North Carolina alone. But now the victims of Hurricane Floyd must also deal with a man-made problem: North Carolina residents and those of other states may have to endure union attempts to gouge them out of their flood relief. The Davis-Bacon Act dictates that persons working on federally subsidized projects receive the so-called prevailing wage. In practice, of course, that means the prevailing union wage, which is invariably higher than whatever wage employer and employee might agree to without government interference. Big Labor's friends in Congress passed Davis-Bacon to price out of the market low-wage competition and thereby protect the union cartel on federal projects.

So effective has this union-only requirement been that by some government estimates Davis-Bacon arbitrarily boosts the price of construction projects as much as 38 percent. Since taxpayers rather than lawmakers must absorb the cost of this shakedown, Congress has seen little need for reform.

But applying Davis-Bacon to flood-relief work necessarily means shifting flood relief from persons in desperate need of help to paychecks for organized labor. Some lawmakers have now written to President Clinton asking him to relax Davis-Bacon for flood relief so hurricane victims, not unions, are its beneficiaries. ''The economic benefits of this hurricane are significant,'' said lawmakers in their Sept. 30 letter. ''Many businesses have been damaged or destroyed. Thousands of individuals have either lost their livelihoods or cannot make it to work because of impassable roads. It may be months or years before these communities are rebuilt and a record amount of federal assistance will be needed to do so. Relaxing Davis-Bacon in these hard-hit states will lower the cost of rebuilding these communities and will help create job opportunities for those in need of work.'' Among the signatories are North Carolina lawmakers Sue

Myrick, Charles Taylor, Cass Ballenger, Walter Jones, Howard Coble, Robin Hayes and Richard Burr.

There is a precedent for relaxing Davis-Bacon. President George Bush suspended the law in 1992 to speed relief work in communities rebuilding after hurricanes Andrew and Iniki. The statute provides that the president may suspend the law in the event of a national emergency.

On the off chance that Mr. Clinton may be more sensitive to the pleas of campaign supporters in organized labor than he is to those of persons in need of flood aid, Sen. Bob Smith has said he would offer an amendment to the Department of Labor appropriations bill forbidding the department from using federal funds to enforce Davis-Bacon in places the president has designated as natural disaster areas, including North Carolina and other hard-hit states. A vote could come as early as today. Says Mr. Smith, ''The historic floodwaters of Floyd have resulted in hundreds of millions of dollars in property damage and created a huge swath of human misery that will last for months,'' says Mr. Smith. ''The Davis-Bacon Act should be suspended to aid disaster relief.

It should not be a difficult vote, nor should it be a difficult decision for Mr. Clinton, to agree to protect flood victims from union gouging. With the national spotlight focused on the anguish of those in North Carolina and elsewhere, do the Clinton administration and its supporters want to argue that Big Labor's bottom line is the only line that matters? It's time to show some compassion. It's time to suspend Davis-Bacon.

Mr. SMITH of New Hampshire. Mr. President, I yield the floor.

Mr. SPECTER. Mr. President, I am opposed to the amendment offered by the distinguished Senator from New Hampshire.

The Davis-Bacon Act was passed in 1931, and it was enacted in order to see to it that the Federal projects would not pay lower than the prevailing wage rate in a given area. That is not necessarily a union rate, but may be a nonunion rate as well. The Federal Government has moved in this direction in order to assure the quality of the work that would be done. In order to have quality work done and to see to it that people in a local area receive the work, the Federal Government has established this standard.

Federal contracts are awarded on a low bid proposition, to who makes the lowest bid. If an out-of-area contractor were to come forward and make a lower bid, that would deprive people in the area of that employment and would not provide the kind of quality work that would be assured.

Robert Reischauer, head of the CBO, testified a few years ago that the payment of the prevailing wage rate is designed to help the Federal Government get the kind of quality necessary. This was the quote of the Director of the Congressional Budget Office, Robert Reischauer, when he testified before Congress on May 4, 1993.

Higher rates do not necessarily increase costs. If these differences in wages were offset by hiring more skilled and productive workers, no additional construction costs would be involved.

It is also important to note that Davis-Bacon creates a financial incentive for contractors to fund and support apprenticeship training by allowing them to pay employees in registered apprenticeship programs less than the prevailing wage rate otherwise required.

When we have had votes on this matter—and I have looked for a contested vote—as recently as 1996, there was bipartisan support to uphold Davis-Bacon. There is also a concern that if this exception were to be enacted on disaster areas, there would be a problem in finding skilled workers to come into the disaster areas and do the work. Thirty-seven States are involved in disaster areas, including my State of Pennsylvania; and if the prevailing wage rate were to be disrupted for the purposes of their Federal contracts, it would not be possible to get the same skilled laborers from the immediate area to come in and perform the necessary services.

As I say, Davis-Bacon has been enacted since 1931. It has a very important purpose—for the Federal Government to get quality work, including the considerations advanced by others on paying a fair wage. It has been challenged from time to time, and while I respect the arguments made by Senator SMITH, it seems to me that this amendment ought to be rejected.

Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator has 3 minutes 10 seconds.

Mr. SPECTER. Mr. President, I thank the Senator.

The PRESIDING OFFICER. The Senator from New Hampshire has 3 minutes 21 seconds.

Mr. SPECTER. Mr. President, I yield 1 minute to Senator REID of Nevada.

Mr. REID. Mr. President, what this amendment would do is a number of things that are not good for working men and women. It would be an automatic suspension of the Davis-Bacon enforcement in areas where there have been disasters. It would mean hundreds of thousands of construction workers who typically go to these areas to work would lose the wage protections currently afforded them under the law. The President of the United States already has the authority to waive Davis-Bacon in the event of a national emergency.

So far this year disasters have been declared in 36 States, including Nevada.

This amendment is ill timed, ill advised, especially in light of the disasters that we had to deal with throughout the country.

Mr. SMITH of New Hampshire. Mr. President, it is interesting that in those 36 disasters that the Senator from Nevada spoke of, the President has not decided to waive Davis-Bacon.

The history on it is remarkable. We have had bipartisan votes on this floor on Davis-Bacon in the past in terms of some disasters. Presidents Roosevelt and Nixon also suspended Davis-Bacon to alleviate administrative confusion and delay, and to control inflation.

There is a long—as I mentioned earlier, President Bush—history of bipartisan waivers and relaxation of the Davis-Bacon provisions.

There is also an interesting editorial in the Detroit News. I ask unanimous consent to have it printed in the RECORD after my remarks.

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

(See Exhibit 1.)

Mr. SMITH of New Hampshire. Mr. President, I will read a brief excerpt from that editorial, called ''End of Payoff.'' It says:

Here in Michigan, former deputy state treasurer and Hillsdale College economics professor Gary Wolfram has estimated that the prevailing wage law costs State taxpayers $70 million to $100 million more than they would necessarily have to pay each year for State and local public works projects.

I am having a hard time understanding how it helps working men and women to increase their taxes to pay to clean up disaster areas. If somebody could explain that to me, I might exchange my position.

For the life of me, I don't understand how it makes sense to charge the taxpayers more money to clean up in unfortunate situations where we have disasters. It makes no sense to me.

I conclude by saying that the Davis-Bacon Act is a Depression-era wage subsidy law. Its intent was demonstrated in the CONGRESSIONAL RECORD, which was to preserve northern construction jobs for white union men, and to prevent them from being taken by less expensive southern black labor.

That was the original intent of that law, and its impact on taxpayers wastes valuable Federal tax dollars. It is a discriminatory law that limits equal access to work opportunities.

Finally, no one should take unfair advantage of people who are the victims of disasters.

As I said to you earlier, volunteers give their time, and nonunion people would like to come and help. They are going to be denied the right. They are not going to be able to work for the taxpayers or the Federal Government at a wage less than the prevailing union wage. It is going to cost the taxpayers.

Those people who would like to help and who also have families to feed are going to be denied work. They are going to be told: Go home. You can't work because we have to pay a wage higher than for which you are willing to work.

That is un-American. In America, it is an agreement between the employer and the employee. If an employee wants to work for less, then the employee has the right to do it.

I urge support of my amendment and oppose the motion to table.

EXHIBIT 1

END THE PAYOFF

For close to 35 years, Michigan taxpayers have been paying more than they should for public works projects because of a political

payoff known as Public Act 166 of 1965, commonly called the ''prevailing wage'' law. State Rep. Wayne Kuipers has proposed an elegant solution to this problem. Rep. Kuipers has a bill that simply states that Public Act 166 of 1965 ''is repealed.''

Rep. Kuipers' bill, HB 4193, should be promptly enacted. The prevailing wage law requires that all state and local governments pay union wages on their public works projects, regardless of whether they can get the work done using less costly nonunion labor. It is an act of pure economic protectionism for one special interest.

In fact, it is a clone of the federal Davis-Bacon Act, adopted by Congress in the 1930s for the odious purpose of freezing lower-wage minority bidders out of federal public works contracts. The U.S. General Accounting Office has long advocated the repeal of the Davis-Bacon Act.

Here in Michigan, former deputy state treasurer and Hillsdale College economics professor Gary Wolfram has estimated that the prevailing wage law costs state taxpayers $70 million to $100 million more than they would necessarily have to pay each year for state and local public works projects.

The law was held in abeyance between 1994 and 1997. A federal judge in Midland threw out the prevailing wage act, but in 1997 a federal appellate court panel reinstated it. During the interregnum, several school districts sold construction bonds. When the law was upheld, they were left with shortages because their bonds did not account for the prevailing wage requirement.

The Legislature, instead of repealing the act, voted to make up the difference for the affected school districts at a cost of $20 million over 10 years. As we noted at the time, this amounted to a $20 million bribe to organized labor interests.

The Michigan Supreme Court, in a particularly benighted and anti-taxpayer ruling last year, extended the prevailing wage law to the construction of a student activity center, funded by student fees and other nonstate appropriations, at Western Michigan University. The court's majority acknowledged that it was overturning a trial judge and two rulings by the state Court of Appeals as well as a longstanding state Labor Department interpretation, to reach this ruling.

Unions contend that the premium pay supported by the prevailing wage is the result of their better-trained workers and the superior quality of their work. Rep. Kuipers, R-Holland, a former contractor has a different opinion: Let the unions prove their case by competing for public construction dollars without the artificial support of the prevailing wage act.

The bill is in the House Employment Relations Committee. Surely, this measure is one of the reasons for a Republican-controlled Legislature.

OUR VIEW

The prevailing wage act imposes unnecessary costs on taxpayers and should be repealed.

OPPOSING VIEW

The act guarantees high-quality workmanship on public works projects.

Mr. SPECTER. Mr. President, by way of a very brief reply, I think that Davis-Bacon is American. It has been American since 1931, almost as long as I have been in America; right about the same time. It has worked very well.

There is merit to what the Senator from New Hampshire has argued in some respects. But to say that it is not American, this has been the Federal law for a very long time.

How much time remains, Mr. President?

The PRESIDING OFFICER. Forty-five seconds.

Mr. SPECTER. I yield the remainder of time to the Senator from Massachusetts.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, prevailing wage means just that. That is in a given area. The fact is that the average, as I mentioned, construction worker who will be affected by this earns $28,000 a year. That is what it comes down to.

I refer to that University of Utah study which showed that injuries went up and the cost of the buildings went up because there was a deterioration in productivity and the skills that were necessary for completion.

It doesn't make any sense to bring this up as an amendment on this particular bill.

Let's bring it back to committee. If the Senator has an argument to make, let's follow the regular legislative process. Let us table this amendment.

Mr. SPECTER. Mr. President, I move to table the amendment, and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to table amendment No. 1844. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative assistant called the roll.

Mr. REID. I announce that the Senator from Connecticut (Mr. DODD) is absent because of family illness.

The result was announced—yeas 59, nays 40, as follows:

[Rollcall Vote No. 320 Leg.]

YEAS—59

Abraham	Feinstein	Moynihan
Akaka	Fitzgerald	Murkowski
Baucus	Gorton	Murray
Bayh	Graham	Reed
Biden	Harkin	Reid
Bingaman	Hollings	Robb
Boxer	Inouye	Rockefeller
Breaux	Jeffords	Santorum
Bryan	Johnson	Sarbanes
Byrd	Kennedy	Schumer
Campbell	Kerrey	Shelby
Cleland	Kerry	Smith (OR)
Conrad	Kohl	Snowe
Daschle	Landrieu	Specter
DeWine	Lautenberg	Stevens
Domenici	Leahy	Torricelli
Dorgan	Levin	Voinovich
Durbin	Lieberman	Wellstone
Edwards	Lincoln	Wyden
Feingold	Mikulski	

NAYS—40

Allard	Crapo	Inhofe
Ashcroft	Enzi	Kyl
Bennett	Frist	Lott
Bond	Gramm	Lugar
Brownback	Grams	Mack
Bunning	Grassley	McCain
Burns	Gregg	McConnell
Chafee	Hagel	Nickles
Cochran	Hatch	Roberts
Collins	Helms	Roth
Coverdell	Hutchinson	Sessions
Craig	Hutchison	Smith (NH)
Thomas	Thurmond	
Thompson	Warner	

NOT VOTING—1

Dodd

Mr. KENNEDY. Mr. President, I move to reconsider the vote.

Mr. COVERDELL. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. SPECTER. Mr. President, I believe we are near the conclusion of this bill. We are about to move to the Wellstone amendment. We are very close to completion of this bill. We are now going to move to the Wellstone amendment, and there are no further amendments on the Republican side.

Mr. REID. I say to the manager of the bill, on this side, we have the Wellstone amendment we need to complete and the manager of the bill has an amendment. I say to the manager, we also have Bingaman-Domenici which needs to be worked out or offered.

Mr. SPECTER. We are very close, Mr. President. I ask unanimous consent that there be 1 hour of debate equally divided in relation to the Wellstone amendment on mental health prior to a motion to table.

Mr. REID. Reserving the right to object. I ask the Senator be allowed to offer his amendment before we enter into the time agreement. We will do that as soon as he offers the amendment.

Mr. WELLSTONE. If I may offer the second-degree amendment——

The PRESIDING OFFICER (Mr. THOMAS). The Senator from Pennsylvania has the floor.

Mr. SPECTER. Mr. President, I yield so the Senator may offer his amendment, and then I will repropound the unanimous consent request.

AMENDMENT NO. 1880

(Purpose: to increase funding for the mental health services block grant)

Mr. WELLSTONE. Mr. President, I call up my amendment No. 1880.

The PRESIDING OFFICER. The clerk will report.

The legislative assistant read as follows:

The Senator from Minnesota [Mr. WELLSTONE] proposes an amendment numbered 1880.

Mr. WELLSTONE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

On page 31, line 9, strike ''$2,750,700,000'' and insert ''$2,799,516,000, of which $70,000,000 shall be made available to carry out the mental health services block grant under subpart I of part B of title XIX of the Public Health Service Act, and''.

AMENDMENT NO. 2271 TO AMENDMENT NO. 1880

(Purpose: To increase funding for the mental health services block grant)

Mr. WELLSTONE. Mr. President, I send a second-degree amendment to the desk.

The PRESIDING OFFICER. Without objection, the clerk will report.

The legislative assistant read as follows:

The Senator from Minnesota [Mr. WELLSTONE] proposes an amendment numbered 2271 to amendment No. 1880.

Mr. WELLSTONE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

Beginning on page 1 of the amendment, strike ''$70,000,000'' and all that follows and insert the following: ''$358,816,000 shall be made available to carry out the mental health services block grant under subpart I of part B of title XIX of the Public Health Service Act ($48,816,000 of which shall become available on October 1, 2000 and remain available through September 30, 2001), and''.

Mr. SPECTER. Mr. President, I ask unanimous consent that there be 1 hour of debate equally divided in relation to the Wellstone amendment on mental health prior to a motion to table.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. SPECTER. Mr. President, for the information of all Senators, it is not anticipated that this side of the aisle will use very much time. So Senators should be prepared to vote perhaps even in advance of 5 o'clock.

Mr. WELLSTONE. I say to my colleague, I will be pleased to use his additional time if he wants me to.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I will shortly outline my amendment, which is a very important amendment dealing with community block grant mental health services. I want to start out, however, in a very personal way.

Mr. President, the Governor of Minnesota, Governor Ventura, in an interview with Playboy magazine said that he did not read books by Ernest Hemingway because the writer killed himself. And he want on to say:

I've seen too many people fight for their lives. I have no respect for anyone who would kill himself. If you're a feeble, weak-minded person to begin with, I don't have time for you.

At Harvard University yesterday Governor Ventura was asked about his remarks, that suicide was for the feeble, weak-minded. And he said:

I do upwards of 25 interviews a week . . . over 1,000 interviews a year. I'm human. You got good days; you got bad days.

He continued:

I don't have sympathy, is what my feelings are on suicide. . . . To me it's something that doesn't have to happen if people take a positive attitude on life like I do.

Today the Surgeon General, David Satcher, gave a very eloquent speech. Today is the ninth annual National Depression Screening Day. He pointed out that suicide is the ninth leading cause of mortality in the United States, responsible for 31,000 deaths.

Mr. President, 85 Americans die every day having taken their lives. Suicide is the fourth leading cause of death for children ages 10 to 14.

I want to respond to these remarks by Governor Ventura because I have devoted so much of my work as a Senator in the mental health area, with Senator DOMENICI, my colleague from New Mexico, who is a Republican, and Senator REID from Nevada.

First of all, let me acknowledge the work of Al and Mary Kluesner. The Kluesners are wonderful people. Al and Mary Kluesner started an organization 10 years ago called SA/VE. This is an organization made up of family members. Many of them are parents who have lost their children. Al and Mary Kluesner have lost two children to suicide.

The Governor of Minnesota and all Americans need to understand that suicide is directly linked to mental illness. The form of mental illness we are talking about is severe depression. When people struggle with severe depression, they lose hope.

I want the Governor of Minnesota to understand that this mental illness is not a moral failing. I want Governor Ventura to understand that all these families that have gone through so much pain need support. They do not need ridicule.

Today is the ninth annual National Depression Screening Day. This is when communities set up free confidential screening opportunities for people to talk privately with mental health professionals, receive educational material about the symptoms and treatment for depression and, when appropriate obtain referrals for care.

Clinical depression is one of the most common illnesses. It affects more than 19 million Americans a year. These educational programs are to be commended. But if we do not have the resources to fund proper treatment for mental health illnesses, then all of this research and all of this education and all of this information may be for nothing.

The clinical care that is needed may never reach those who need it the most.

Why? Because they cannot afford it.

Why? Because we do not have fairness—parity—in mental health coverage.

Why? Because we drastically underfund public programs for mental health care, such as the mental health block grant program.

Why? Because of problems with mental health services provided through the Medicaid programs, which represent 19 percent of nationwide mental health care.

Why? Because it seems we would rather incarcerate children with mental illness than to provide community treatment programs that are so desperately needed.

Why? Because we do not provide coverage for medication in so many health care programs.

Untreated mental illness so often leads to tragedy such as suicide. We know from today's congressional briefing on depression and the elderly an outstanding fact: The highest suicide rate—often the result of undiagnosed and untreated depression—is for white men over 85 years old—65.3 per 100,000 persons.

Suicide is the third leading cause of death among young people ages 15 to 24.

We need to increase funding for mental health services, not decrease it.

This amendment, which I will summarize in a moment——

Mr. REID. Will the Senator yield for a question?

Mr. WELLSTONE. I am pleased to yield for a question.

Mr. REID. I have heard with—I do not know if the word is ''horror'' but certainly with disgust the statements made by the Governor of Minnesota. The Senator knows—because we have spoken—that 31,000 people each year kill themselves. The Senator knows that; isn't that true?

Mr. WELLSTONE. That is true.

Mr. REID. Isn't it true that during the time we are going to be debating this very important matter, there will be four people in our country during this hour's period of time who will kill themselves?

Mr. WELLSTONE. That is correct.

Mr. REID. And for the Governor of the State of Minnesota to say—I am sorry to report—that these people in effect deserve to die because they have problems, is not understandable. The Senator understands. We have held hearings in the Senate dealing with suicide. We have heard from academics, we have heard from people from the entertainment industry, we have heard from people from all walks of life because suicide does not discriminate among people; it does not affect only one age group; it does not affect one economic group more than others; it affects everyone.

It is true, is it not, I say to my friend, that the vast majority of suicides could be avoided if that person had some counseling and many times a little bit of medication? Isn't that true?

Mr. WELLSTONE. My colleague from Nevada is absolutely correct. That is why I had to respond to these comments by Governor Ventura from Minnesota. This is an illness. This is an illness that affects many Americans. This is an illness that has led to such pain for so many families.

I mentioned Al and Mary Kluesner from Minnesota who started an organization. Sheila and I have been to their gatherings, I say to my colleague, for the last 3 years. Hundreds of people come, including parents who have lost their children to suicide. They do not need ridicule. We need to understand this is not a moral failing. This is an illness. Suicide is the result of this illness. With treatment, we can prevent these deaths.

Mr. REID. I will make one last statement, if I could.

The illness that leads people to commit suicide, it is no different than someone that has tuberculosis, someone who has cancer; isn't that true?

Mr. WELLSTONE. Mr. President, I say to my colleague from Nevada, he is absolutely correct. The research over especially this last decade—which has focused on brain diseases—over and over and over again points out that these diseases are comparable to physical illnesses. They are diagnosable and they are treatable, but the big challenge for us is to overcome the stigma, to overcome the discrimination. That is why I am so outraged by these remarks by Governor Ventura.

Mr. REID. Mr. President, I very much appreciate, admire, and respect the Senator from Minnesota, who is on the floor now talking about these issues. We need to talk more about them.

We don't know why people kill themselves. We have some understanding, but we need to study this. Thank goodness the Centers for Disease Control is now studying suicide. The Federal Government, for the first time, has directed research to determine why 31,000 Americans, young and old, kill themselves every year.

Again, I appreciate very much the Senator from Minnesota having the courage to talk about an issue some people refuse to acknowledge.

Mr. WELLSTONE. I thank my colleague.

I point out to the Senator from Nevada, this is the fourth leading cause of death among children, ages 10 to 14, suicide, among white males. There are other populations as well. The rate of suicide among African American males, ages 15 to 19, has increased 105 percent between 1980 and 1996.

Senator SPECTER and Senator HARKIN have done a yeoman's job of getting more support for these mental health services. What I am trying to do is take this mental health performance partnership block grant program, which supports comprehensive community-based treatment for adults with serious mental illnesses and children with serious emotional disturbances, back to the level of funding the President requested. This is administered through the Substance Abuse and Mental Health Services Administration, SAMHSA.

I say to my colleague from Pennsylvania, if I could have 5 more minutes to summarize this, we want to go to a voice vote, and this amendment will be accepted. I will be honored.

Let me simply talk about the services that are so important. This is funding for communities for programs that include treatment, rehabilitation, case management, outreach for homeless individuals, children's mental health services, and community-based treatment services that have everything in the world to do with providing treatment to people and enabling people to live lives with as much independence and dignity as possible.

Right now the mental health block grant is funded at $310 million. That is a small amount compared to the tremendous need. This amendment would add $50 million. With this amendment, we could provide support for some important community services that would make a tremendous amount of difference.

I went over some of the gaps earlier. My colleague from Pennsylvania, who is managing this bill on the Republican side, said there is an indication to accept this amendment. I will be very pleased. I know colleagues want to move this along.

I say to my Republican colleagues and Democratic colleagues, I appreciate the support for this. I know Senator SPECTER is committed to this. I know Senator HARKIN is as well. I would like to have this amendment approved. I would like to see the additional resources. This is an extremely important program. We have to do a lot better in this area. We can do it at the community level, but for those adults—and we are, in particular, talking about adults with serious mental illnesses and children with serious emotional disturbances—all too often, they wind up out on the streets or they wind up in prison or they wind up not receiving the care. So much of this illness is diagnosable. So much of it is treatable. There are so many ways we can help people.

I think accepting this amendment and making sure we can keep this level of funding as we go to the conference committee would be extremely important.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. SPECTER. Mr. President, we have been reviewing this amendment for additional funding for the mental health block grant. It is obviously a good program, beyond any question. The key issue is how far we can stretch in this bill. I have talked to the Senator from Minnesota and told him that after consulting with some of my colleagues on this side of the aisle, we would be prepared to accept it on a voice vote.

The PRESIDING OFFICER. Is all time yielded back?

Mr. SPECTER. I yield back my time.

Mr. WELLSTONE. I yield back my time.

The PRESIDING OFFICER. The question is on agreeing to the second-degree amendment No. 2271.

The amendment (No. 2271) was agreed to.

The PRESIDING OFFICER. The question is on agreeing to the first-degree amendment No. 1880.

The amendment (No. 1880) was agreed to.

Mr. WELLSTONE. Mr. President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Utah.

APPOINTING JUDICIAL NOMINEES

Mr. HATCH. Mr. President, the Constitution provides that the President ''shall nominate, and by and with the Advice and Consent of the Senate, shall appoint * * * Judges of the Supreme Court, and all other Officers of the United States * * *'' Thus, the President has the power to nominate persons to serve as federal judges and the Senate has the power to render advice and consent on these nominations. And the Constitution requires that the President's power to nominate be exercised ''with'' the Senate's power to advise and consent in order for a final appointment to be made. To the extent such cooperation occurs, the appointment process will be fair, orderly, and timely. To the extent such cooperation does not occur, the appointment process will break down.

When I assumed the Chair of the Judiciary Committee, I inherited a process rocked by public strife and private in-fighting. I was determined to lower the temperatures on both sides of the Committee and to preside over a process that did not allow personal attacks on a nominee's character. To accomplish this I turned to the Constitution itself and its requirement that the President and the Senate work ''with'' each other in the appointment process and the Constitution's limits on the power of federal judges.

And it has worked. When the President has consulted with the Committee and with home-state Senators, a nominee has moved through the process smoothly. Under my Chairmanship, the Committee has focused its review on each nominee's, integrity, temperament, competence, and respect for the rule of law. To date Republicans have confirmed 325 of President Clinton's nominees to the federal bench.

When there have been problems with a nominee, or a potential nominee, the President's consultation with the Committee has enabled us to address those problems privately. For example, a senator on the Committee recently asked me to examine a potential nominee, and when there were problems with that nominee, that Senator and I were able to deal with the problem privately and I expect another candidate will be forthcoming soon. Thus, the process has worked without damaging a candidate's reputation or his family.

When the President works with the Senate the process will adequately staff the federal Judiciary. Indeed, after last year's extraordinary number of confirmations, the vacancy rate in the federal Judiciary was reduced to a very low 5.9%. The Chief Justice in his most recent report on the state of the federal Judiciary congratulated the President and the Senate, stating ''I am pleased to report on the progress

made in 1998 by the Senate and the President in the appointment and confirmation of judges to the federal bench ....''

As of today, the Judiciary Committee has held 5 hearings for judicial nominees and have reported 30 nominees to the floor of the Senate. There are currently just 62 vacancies, yielding a vacancy rate of only 7.4%. This is 1 vacancy less than existed at the end of the 103rd Congress when Democrats controlled the Judiciary Committee. Further, should the Senate confirm the 8 nominees that are currently on the floor and the 4 nominees for which we held a hearing today, the number of vacancies will fall to 51, yielding a vacancy rate of just 6%. This will be the lowest vacancy rate for any first session of Congress since the expansion of the judiciary in 1990. Moreover, it is virtually equivalent to the vacancy rate at the end of the last Congress, which was the lowest vacancy rate for any session of Congress since the expansion of the judiciary in 1990. When the President works with us and respects the constitutional advice and consent duties of the Senate, the process has, in fact, worked smoothly.

When the President fails to work with the Senate, however, the process does not work smoothly. This was the unfortunate case with Judge Ronnie White. The record shows that Judge White is a fine man. However, he has written some questionable opinions on death penalty cases. The record resulted in both Missouri Senators opposing his nomination on the floor. This record resulted in local and national law enforcement agencies opposing his nomination as well. Here are just some of the letters expressing concern or opposition to Judge White's nomination:

The Missouri Federation of Police Chiefs oppose the nomination; the National Sheriff's Association opposed the nomination; the Mercer County, Missouri prosecutor opposed the nomination; the Missouri Sheriffs' Association expressed deep concern over one of Judge White's dissents in a death penalty case involving the murder of one sheriff, two deputies, and the wife of another sheriff, and asked the Senate to consider that dissent in voting on Judge White's nomination. Indeed, 77 of 114 of Missouri's sheriffs asked for serious consideration of Judge White's record. The sheriff of Moniteau County, Missouri, whose wife was murdered by the criminal for whom Judge White would have reversed the death sentence wrote in opposition to the nomination.

Mr. President, I ask unanimous consent that these letters be printed in the RECORD.

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

NATIONAL SHERIFFS' ASSOCIATION,
Alexandria, VA, October 4, 1999.

Hon. JOHN ASHCROFT,
U.S. Senate, Washington, DC.

DEAR SENATOR ASHCROFT: I am writing to ask you to join the National Sheriffs' Association (NSA) in opposing the nomination of Mr. Ronnie White to the Federal Judiciary. NSA strongly urges the United States to defeat this appointment.

As you know, Judge White is a controversial judge in Missouri while serving in the Missouri Supreme Court. He issued many opinions that are offensive to law enforcement; one on drug interdiction and several involving the death penalty. Judge White feels that drug interdiction by law enforcement is too intimidating. He is more concerned with his personal view of drug interdiction practices than with the legitimate law enforcement effort to prevent the trafficking of illegal drugs. Drug interdiction is a cornerstone in the fight against crime, and this reckless opinion undermines the rule of law.

Additionally, judge White wrote an outrageous dissenting opinion in a death penalty case. In 1991 Pam Jones, the wife of Sheriff Kenny Jones of Miniteau, Missouri, was gunned down with three other law enforcement officials while hosting a church service at home. The assailant, who was targeting the Sheriff, was tried and convicted of murder in the first degree. He was subsequently sentenced to death for the four murders. During the appeals process, the case came before the Missouri Supreme Court where six of the seven judges affirmed the conviction and the sentence. Judge White was the court's lone dissenter urging a lower legal standard to allow this brutal cop killer a second chance at acquittal. In our view, this opinion alone disqualifies Judge White from service in the Federal courts. He is irresponsible in his thinking, and his views against law enforcement are dangerous. Please read Judge White's dissenting opinion in this case.

We urge you in the strongest possible terms to actively oppose the nomination of Judge White. He is clearly an opponent of law enforcement and does not deserve an appointment to the Federal Judiciary. His views and opinions are highly insulting to law enforcement, and we look forward to working with you to defeat this nomination.

Respectfully,

PATRICK J. SULLIVAN, Jr.,
Sheriff, Chairman, Congressional Affairs Committee and Member, Executive Committee of the Board of Directors, NSA.

SHERIFF'S DEPARTMENT,
MONITEAU COUNTY,
California, MO, August 11, 1999.

DEAR FELLOW SHERIFF: I am writing to you about Judge Ronnie White of the Missouri Supreme Court, who has been nominated to be a federal district judge. As Sheriffs' we go to work for the people of Missouri every day. Our lives are on the line. Every law enforcement, and every law-abiding citizen, needs judges who will enforce the law without fear or favor. As law enforcement officers, we need judges who will back us up, and not go looking for outrageous technicalities so a criminal can get off. We don't need a judge like Ronnie White on the federal court bench.

In addition to being Sheriff of Moniteau County, I am a victim of violent crime. So are my children. In December 1991, James Johnson murdered my wife, Pam, the mother of my children. He shot Pam by ambush, firing through the window of our home during a church function she was hosting. Johnson also killed Sheriff Charles Smith of Cooper County. Deputy Les Roark of Moniteau County and Deputy Sandra Wilson of Miller County. He was convicted and sentenced to death. When the case was appealed and reached the Missouri Supreme Court, Judge White voted to overturn the death sentence of this man who murdered my wife and three good law officers. He was the only judge to vote this way.

Please read Judge White's opinion. It is a slap in the face to crime victims and law enforcement officers. If he cared about protecting crime victims and enforcing the law, he wouldn't have voted to let Johnson off death row.

The Johnson case isn't the only anti-death penalty ruling by Judge White. He has voted against capital punishment more than any other judge on the court. I believe there is a pattern here.

To me, Ronnie White is clearly the wrong person to entrust with the tremendous power of a federal judge who serves for life. Please write to our U.S. Senators, Christopher S. Bond and John Ashcroft, and ask them to oppose the White nomination. Ask them to persuade other Senators to do likewise. Effective law enforcement saves lives. The deterrent value of capital punishment saves lives. As a federal judge, Ronnie White would hurt law enforcement and he would oppose effective death penalty enforcement.

You can write to Senator Bond and Senator Ashcroft at U.S. Senate, Washington, DC 20510. Please speak up before it's too late.

Sincerely,

KENNY JONES,
Moniteau County Sheriff.

MISSOURI FEDERATION OF
POLICE CHIEFS,
St. Louis, MO, September 2, 1999.

Senators JOHN ASHCROFT, and CHRISTOPHER BOND,
Kansas City, MO.

DEAR SENATOR ASHCROFT AND SENATOR BOND: We have just learned of the nomination of Judge Ronnie White to be a federal district judge.

After reading Sheriff Kenny Jones' letter and seeing Judge White's record, we were absolutely shocked that someone like this would even be nominated to such an important position.

We want to go on record with your offices as being opposed to his nomination and hope you will vote against him. A copy of Sheriff Jones' letter is attached.

Sincerely,

BRYAN KUNZE,
Vice President, MFPC.

MISSOURI SHERIFFS' ASSOCIATION,
Jefferson City, MO, September 27, 1999.

Sen. ORRIN HATCH,
Chairman, Senate Judiciary Committee, Washington, DC.

DEAR SENATOR HATCH: Attached please find a copy of the dissenting opinion rendered by Missouri Supreme Court Judge Ronnie White in the case State of Missouri, Respondent, v. James R. Johnson, Appellant.

Also, please find attached a copy of a petition signed by 92 law enforcement officers in Missouri, including 77 Missouri sheriffs.

In December 1991, James Johnson murdered Pam Jones, wife of Moniteau County Sheriff Kenny Jones. He shot Pam by ambush, firing through the window of her home during a church function she was hosting. Johnson also killed Sheriff Charles Smith of Cooper County, Deputy Les Roark of Moniteau County and Deputy Sandra Wilson of Miller County. He was convicted and sentenced to death. When the case was appealed and reached the Missouri Supreme Court, Judge White voted to overturn the death sentence of this man who murdered Mrs. Jones and three good law officers.

As per attached, the Missouri sheriffs strongly encourage you to consider this dissenting opinion in the nomination of Judge

Ronnie White to be a U.S. District Court Judge.

Sincerely,

JAMES L. VERMEERSCH,
Executive Director.

We, the undersigned, understand that Judge Ronnie White of the Missouri Supreme Court, has been nominated to be a United States District Court Judge.

We need judges who can balance the duty of the law enforcement officer to enforce the law with the preservation of the Constitutional rights of the accused.

In 1993, one James Johnson was convicted and sentenced to death for the ambush and murder of Pam Jones, the wife of the Moniteau County Sheriff Kenny Jones and three other law enforcement officers. Judge White rendered the only dissenting opinion to reverse this conviction.

We respectfully request that consideration be given to this dissenting opinion as a factor in the appointment to fill this position of U.S. District Judge.

Position Agency:

Sheriff, Mississippi County; Sheriff, Pulaski County; Dade County Sheriff; Sheriff of Vernon County.; Barry County Sheriff; Barry County Deputy Sheriff; Franklin County Sheriff; Sheriff, Mercer County.

MERCER COUNTY
PROSECUTING ATTORNEY,
Princeton, MO, September 3, 1999.

Hon. JOHN D. ASHCROFT,
U.S. Senator, Washington, DC 20510

DEAR SENATOR ASHCROFT: As Missouri Prosecutors, we work to enforce the laws of our cities, counties, and the state of Missouri on a daily basis. We are aware of significant concern among law enforcement officials regarding the nomination of Missouri Supreme Court Judge Ronnie White to the federal bench. We share this concern.

Judge White's record is unmistakably anti-law enforcement, and we believe his nomination should be defeated. His rulings and dissenting opinions on capital cases and on Fourth Amendment issues should be disqualifying factors when considering his nomination.

Judge White has evidenced clear bias against the death penalty from his seat on the Missouri Supreme Court. He has voted against the death penalty more than any other judge has. In capital cases, he has dissented more than any other judge. Further, he has filed more lone dissents in capital cases than any other judge. Without question Judge White has displayed an anti-capital punishment bias that is second to none on the Missouri Supreme Court.

One of the most terrible examples of this bias came in State v. Johnson, when Judge White filed a lone dissent, supporting reversal of the capital sentence imposed on Jim Johnson. Johnson was sentenced to death for the murders of Cooper County Sheriff Charles Smith, Moniteau County Deputy Les Roark, Miller County Deputy Sandra Wilson, and Pam Jones, the wife of Moniteau County Sheriff Kenny Jones. Except for Judge White's dissent, the ruling against this brutal cop killer was unanimous. Judge White was the lone member of the Court to vote to give Johnson a new trial and a second chance to go free.

In State v. Damask, and State v. Alvarez, the Supreme Court ruled 6–1 that drug checkpoints on main highways in Franklin and Texas Counties were constitutional. Judge White, again, disagreed alone. Judge White voted to throw out evidence against accused drug traffickers who were arrested at checkpoints on Interstate 44 and U.S. 60.

Another troubling concern, while not in itself sufficient reason to disqualify, is Judge White's lack of significant experience in trial courts. Certainly the nomination would be less flawed if he had significant experience as either a criminal litigator or trial judge. He has neither.

On the Missouri Supreme Court, the other six members of the Court routinely override Judge White's outlandish dissenting opinions. In Missouri, we are fortunate to have a Supreme Court that is sympathetic to law enforcement, and prone to interpreting the law as it is written. However, if Judge White is placed on the federal bench, he will be a one-person majority. His flawed opinions will be the only ones that count, and barring an appeal to higher courts, he will be accountable to no one.

People in the law enforcement community are rightly concerned by Judge White's votes in cases like Johnson and Damask. We urge you to show your support for the hard work of Sheriffs, police officers, prosecutors, and other law enforcement officials, and help defeat the nomination of Judge White to the federal bench.

JAY HEMENWAY,
Mercer County Prosecuting Attorney.

TEXAS COUNTY PROSECUTING ATTORNEY,
Houston, MO, October 4, 1999.

Hon. JOHN ASHCROFT,
U.S. Senator, Washington, DC.

SENATOR ASHCROFT, It is my understanding that the nomination of Ronnie White to the United States Federal Court is coming up for a vote soon in the United States Senate. I have serious concerns about this nomination.

Judge White's voting record has given law enforcement officials cause for alarm. While on the Supreme Court he has consistently voted against use of the death penalty, even in the most brutal and clear-cut cases. In fact, White has voted against use of the death penalty more than any other judge on the Court.

White's was also the lone dissenting vote on the case allowing drug checkpoints of major highways in our state. There are other causes of concern, but I think it is best summed up as follows: The Judiciary exists to interpret the law, not make it. Judge White's opinions as a member of the Missouri Supreme Court have caused me to fear more judicial activism and pro-criminal jurisprudence that would run contrary to the will of our founding fathers and to the good of our country.

Please examine Judge White's record closely, Senator. This is an enormously important decision with the most serious of implications. Thank you for taking the time and making the effort to cast a wise vote on the nomination.

Most sincerely,

DOUG GASTON.

Mr. HATCH. Mr. President, had the White House worked with these home-State Senators and with other Senators to achieve broad support for the nominee, perhaps Judge White would not have been defeated. I don't know. I might add, had both home-State Senators been opposed to Judge White in committee, Judge White would never have come to the floor under our rules. I have to say, that would be true whether they are Democrat Senators or Republican Senators. That has just been the way the Judiciary Committee has operated. Had the President diligently worked with Senators to determine that there would not be broad support for the candidate, he could have found an alternative, consensus candidate. But the President did not. Thus, Judge White's nomination failed on the floor of the Senate.

To compound the problem, the President and some of my colleagues in this body made the grave error of suggesting that race was the reason that Senate Republicans voted against Judge White. This transparently political accusation has, as the administration is well aware, no basis in fact. The Judiciary Committee, under my chairmanship, has not kept formal statistics on the race of any of these nominees, nor would we have informed Democrat or Republican members that Judge White is an African American. Many of my Republican colleagues were literally unaware of Judge White's race, and that is the way it has been. We just haven't made notice of anybody's race as we have confirmed these 325 judges that President Clinton has nominated.

Instead, they were aware of his record in death penalty cases. I admit that that awareness happened at a relatively late time in this matter. It caught me by surprise as well—the opposition at least. They were aware of the opposition of State and national law enforcement communities that arose after his committee hearing. They were aware of the opposition of both home-State Senators that was announced after his hearing. Indeed, I even had a Democratic Senator inform me that had that Senator known of the recent law enforcement opposition to Judge White's nomination, that Senator would have opposed the nomination as well. Senator BOND did support this judge at the hearing but later changed his position on this as he became more and more aware of the opposition by law enforcement. It was not race that defeated Judge White; it was his record and the opposition of the elected leaders of his State.

These same Republican Senators who opposed Judge White overwhelmingly supported the nomination of Charles Wilson, an African American, to the Eleventh Circuit Court of Appeals in Florida. While Senate Republicans were mostly unaware of Judge Wilson's race, Members were informed of his outstanding record as a Federal Magistrate and U.S. Attorney, the strong Florida support for Mr. Wilson, and the support of both home-State Senators—1 Republican and 1 Democrat—for Mr. Wilson. Most members were not informed of his race. But these home-State Senators were for Mr. Wilson. And there was broad support in the Senate for Mr. Wilson's candidacy. It was not race that confirmed Mr. Wilson; it was his record and the support of the elected leaders of his State.

The same is true for other minority nominations. To mention a few, Victor Marrero, Carlos Murguia, Adalberto Jordan—nominees whose records show they were qualified and respected the rule of law, who had the support of home-State Senators, and who had broad support in the Senate. Thus, the suggestion that the Republicans in this

body voted against Judge White on the basis of race is no more true than a parallel accusation that my Democratic colleagues voted against Clarence Thomas because of his race. I don't think any of us have made that suggestion.

I am also deeply disappointed by the patently false suggestions from the administration, and some in this body, that Republicans intentionally delay the processing of minority and women nominees based on their race and gender. This would be a surprise to Charles Wilson, who was nominated on May 27, reported by the Judiciary Committee to the floor of the Senate on July 22, and confirmed on July 30. This would also be a surprise to Marryanne Trump Barry, who was nominated on June 17, reported by the Judiciary Committee to the floor of the Senate on July 29, and confirmed on September 13. Both of these nominees had outstanding records reflecting respect for the law, strong home-State support, the support of both home-State Senators, and broad support in the Senate. Mr. Wilson, Judge Barry, and most of these other nominees proceeded smoothly through the confirmation process because the President worked with the Senate, not against the Senate.

The administration is very proud of its record of placing women and minorities on the bench, and it makes a point of informing the public of its work in this regard. In an address to the American Bar Association this summer, President Clinton called the collection of judges he has nominated to the Federal bench ''the most diverse group in American history.'' Nearly half are women and minorities, he said.

But each of these judges was confirmed by the Senate, and all were confirmed with Republican support. How can it be that a Senate which has directly participated in this record of accomplishment can become an institution of bias simply by opposing one nominee—a nominee opposed by both home-State Senators and by an overwhelming number of State and national law enforcement leaders? It cannot be. It simply cannot be. The record and the Department of Justice's own numbers speak for themselves.

According to the Clinton administration's own data, the Senate—whether it was under Democratic or Republican control—has done its duty and confirmed qualified women and minorities. For example, in 1998, based on Department of Justice data, approximately 32 percent of judicial nominees were women, and 21.5 percent were minorities. Even though the committee does not keep formal statistics, I had my staff manually compute the proportion of women and minorities reported to the Senate floor. So far this year, over 45 percent of the judicial nominees reported to the Senate floor are women or have been minorities.

Yes, some nominees take longer than others—but it is not because of their race or gender. My colleagues, I believe, know that. I believe the President and his people at the White House know that. Indeed, several of the nominees of the past that took longer to confirm had my strong support. These included Anne Aiken, Margaret Murrow, and Susan Mollway. I have been condemned for that by certain people on the far right almost on a daily basis ever since.

In the end, those who make these troubling accusations either, one, believe them to be true or, two, know they are not true, but want to politicize the issue. Either motivation is evidence of a serious problem within our noble institution, which I hope we, as leaders, can work to rectify. That is one reason I am taking this time today. Using race as a political tactic to advance controversial nominees is especially troubling. I care too much about the Senate and the Federal judiciary to see these institutions become the victims of base, cheap, wedge politics.

I would urge my colleagues and the President to reconsider this destructive and dangerous ploy. Instead, they should put aside this destructive rhetoric and work with us to do what is best for the Judiciary, the Senate, and the American people.

The Ronnie White nomination is an unfortunate example of what I believe is an increasing pattern on the part of the Clinton White House. I am referring to what appears to be a fire-sale strategy of knowingly sending up nominees who lack home-State support. Some time ago, I sent the White House Counsel a letter stating clearly that consultation was an essential prerequisite to a smoothly functioning confirmations process. But over the past several months, a number of nominees have been forwarded to the Senate over the objection—both private and public—of home-State Senators. Is this a pattern the aim of which is to get nominees confirmed, or is this a strategy, the object of which, is to create a political show down with the Senate. My concern is with the latter.

To find the answer to the current political crisis, I turn once again to the Constitution and its requirement that the President and the Senate work ''with'' each other in the nomination and advice and consent process. To enable us to return to working together instead of against each other, I propose that we take time for both sides to cool off. The President and the Senate should take a step back, cool off, and then return to working with each other in the nomination and confirmation process as the Constitution so plainly requires.

Mr. President, we have worked well with this President up to now. I have certainly taken my share of criticism for being as fair to this administration as I can possibly be. But this administration knows the rules up here—that when two home State Senators oppose a district court nominee, that district court nominee is not going to make it. That is the way it is. There is nothing I can do to change that because it is the correct rule. It is important that we work together and work with home State Senators in order to resolve this.

I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, I thank the distinguished chairman of the Judiciary Committee for that statement. I have just a word or two to say about the same subject.

The White House made a comment—Mr. Lockhart—that I was one of three Republican Senators who voted for Judge White in committee and then voted against him on the floor. It is inaccurate to say I voted for him in committee because I did not. What happened was, the Judiciary Committee had a very abbreviated session off the floor and I went there to see if there was a quorum. When there was a quorum, Justice White was voted out of committee on a voice vote, but I was not present for that voice vote.

I was especially sensitive to Judge White because Judge Massiah-Jackson came before the Senate last year and withdrew her nomination in the face of very considerable opposition by the State District Attorneys Association.

So I took a close look at the letters, and even had a brief conversation with the ranking Democrat before casting my vote, which I did at the tail end of the vote on Justice White.

But contrary to what Mr. Lockhart of the White House said, and contrary to what has appeared in a number of press accounts, I did not vote for Justice White in the committee.

DEPARTMENT OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS ACT, 2000—Continued

Mr. SPECTER. Mr. President, I ask unanimous consent that we turn to the Senator from——

Mr. REID. Mr. President, will the Senator yield?

Mr. SPECTER. Florida for 15 minutes.

Mr. REID. Mr. President, will the Senator yield for a brief statement?

Mr. SPECTER. Pardon me. I withdraw that because the Senators from New Mexico were here sequenced ahead of Senator GRAHAM.

Mr. REID. Mr. President, I appreciate the statements of the chairman of the Judiciary Committee and the statement of the Senator from Pennsylvania on the judicial controversy. I hope we can end all of that this afternoon and get this bill completed because now we have people on our side wanting to come and talk about this matter dealing with Judge White. I hope we can move and get this bill finished before we have further speeches on this judicial controversy.

Mr. SPECTER. Mr. President, I ask unanimous consent that the remainder

of the time on this bill be directed to the amendment of the Senators from New Mexico, then 15 minutes to Senator GRAHAM of Florida, then 10 minutes to be equally divided between the managers of the bill, and then go to final passage.

Mr. REID. Reserving the right to object, if the ranking member of the Judiciary Committee wants to come over and speak on the judicial controversy, I want him to have 15 minutes, the same amount of time the chairman of the Judiciary Committee had.

Mr. SPECTER. I incorporate that in the unanimous consent request.

Mr. KENNEDY. If I could have 2 minutes.

Mr. SPECTER. Two minutes for Senator KENNEDY.

Mr. INHOFE. Mr. President, reserving the right to object, for what purpose would the Senator be yielding to the Senator from Florida? Are we back on the judicial nominations?

Mr. SPECTER. He is speaking on the bill.

Mr. INHOFE. Is this on the nomination?

Mr. SPECTER. Unless Senator LEAHY comes and claims the time which Senator REID has asked for.

Mr. INHOFE. No objection.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Reserving the right to object.

Mr. SPECTER. We added 5 more minutes for Senator HARKIN: the managers, 15 minutes; Senator HARKIN, 10; myself, 5.

Mr. REID. And Senator KENNEDY for 2 minutes.

Mr. DOMENICI. I ask if Senator KENNEDY is on the bill or something else?

Mr. KENNEDY. All I want to do, indirectly on the bill, is just to announce that the House of Representatives passed the Patients' Bill of Rights 275–149.

This is a hard-won victory for millions of patients and families throughout America, and a well-deserved defeat for HMOs and the Republican extremists in the House who put managed care profits ahead of patients' health.

The Senate flunked this test in July, but the House has given us a new chance to do the right thing. The House-Senate conference should adopt the Norwood-Dingell provisions, without the costly and ineffective tax breaks added by House Republicans.

Mr. DOMENICI. The Senator did it. Does he still need the 2 minutes?

Mr. KENNEDY. No. I don't need the 2 minutes. I thank the Senator very much.

Mr. SPECTER. Mr. President, exclude Senator Kennedy from the unanimous consent request.

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

Mr. SPECTER. Mr. President, I ask that we turn to the Senators from New Mexico.

Mr. DOMENICI. Senator BINGAMAN has the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

AMENDMENT NO. 2272

(Purpose: To require the Secretary of Health and Human Services to conduct a study on the geographic adjustment factors used in determining the amount of payment for physicians' services under the medicare program)

Mr. BINGAMAN. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico (Mr. BINGAMAN), for himself, and Mr. DOMENICI, proposes an amendment numbered 2272.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

At the end of title II, add the following:

SEC. 216. STUDY AND REPORT ON THE GEOGRAPHIC ADJUSTMENT FACTORS UNDER THE MEDICARE PROGRAM.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on—

(1) the reasons why, and the appropriateness of the fact that, the geographic adjustment factor (determined under paragraph (2) of section 1848(e) (42 U.S.C. 1395w–4(e)) used in determining the amount of payment for physicians' services under the medicare program is less for physicians' services provided in New Mexico than for physicians' services provided in Arizona, Colorado, and Texas; and

(2) the effect that the level of the geographic cost-of-practice adjustment factor (determined under paragraph (3) of such section) has on the recruitment and retention of physicians in small rural states, including New Mexico, Iowa, Louisiana, and Arkansas.

(b) REPORT.—Not later than 3 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

Mr. BINGAMAN. Mr. President, this is an amendment that Senator DOMENICI and I are offering to direct the Secretary of Health and Human Services to conduct a study of and the appropriateness of the geographic adjustment factor that is used in Medicare reimbursement calculations as it applies particularly to our State of New Mexico.

We have a very serious problem in our State today; many of our physicians are leaving the State. The reimbursement that is available under Medicare, and accordingly under many of the health care plans in our State, is less for physicians performing procedures and practicing medicine in our State than it is in all of our surrounding States. We believe this is traceable to this adjustment factor, this geographic adjustment factor.

This is a system that was put into place in 1992. It now operates, as I understand it, such that we have 89 geographic fee schedule payment areas in the country. We are not clear on the precise way in which our State has been so severely disadvantaged, but we believe it is a serious problem that needs attention.

Our amendment directs that the Secretary conclude this study within 90 days, or 3 months, report back, and make recommendations on how to solve the problem. We believe it is a very good amendment. We recommend that Senators support the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, first, I am pleased to say I am a cosponsor of this amendment. I have helped Senator BINGAMAN with it.

This is a good amendment. We aren't asking for any money. We are not asking that any law be changed. We are merely saying that something is not right for our State.

The reimbursement—or some aspect of how we are paying doctors under Medicare—is causing us to have much lower fees than the surrounding States, and as a result two things are happening: One, doctors are leaving. In a State such as ours, we can ill afford that. Second, we are being told it is harder and harder to get doctors to come to our State. That was not the case years ago. They loved New Mexico. They came for lots of reasons. But certainly we cannot be an underprivileged State in terms of what we pay our doctors—be a poor State in addition—and expect our citizens to get good health care.

We want to know what the real facts are: Why is this the case? Is it the result of the way the geographic evaluation is applied to our State because maybe rural communities aren't getting the right kind of emphasis in that formula?

Whatever it is, we want to know. When we know, fellow Senators, we can assure Members, if we find out it is not right and it is not fair, we will be on the floor to talk about some real changes. Until we have that, we ask Members for help in obtaining a study.

I yield the floor.

Mr. SPECTER. The managers have taken a look at this amendment and are prepared to accept it. It is a good amendment.

There is one concern, and that is a jurisdictional concern with respect to the Finance Committee. We have attempted to contact the chairman of the Finance Committee to see if there was any substantial reason we should not accept it. If it went to a vote, it would clearly be adopted. It merely asks for a report for a very good purpose. Therefore, the amendment is accepted.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 2272) was agreed to.

Mr. DOMENICI. I move to reconsider the vote.

Mr. SPECTER. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, I am here today, as I was in July, to point out to my colleagues another stealth effort to kill competition within the Medicare program. Title I, section 214, buried in the middle of this long appropriations bill on page 49, carries the following statement:

None of the funds provided in this Act or in any other Act making appropriations for fiscal year 2000 may be used to administer or implement in Arizona or in Kansas City, Missouri or in the Kansas City, Kansas area the Medicare Competitive Pricing Demonstration Project operated by the Secretary of Health and Human Services under authority granted in the Balanced Budget Act of 1997.

If that statement sounds familiar, it is. Almost the same language was buried in the HMO Patients' Bill of Rights bill as it passed the Senate back in July. It passed then undebated and undiscussed as to its implications—just as we are about to do here tonight. July's action was outrageous. This action is even more so.

There is a certain irony here. We have just heard that the House of Representatives passed, by an overwhelming vote, a version of the HMO Patients' Bill of Rights which is very similar to the bipartisan bill offered but not considered in the Senate. Our bipartisan bill was strongly opposed by the HMO industry. Their basic argument is: let's keep government out of our business, let us operate based on a competitive model that will allow the consumer, the beneficiary of the HMO contract, to negotiate without government standards, without government sanctions for failure to deliver on those standards with the HMO industry. They wanted to have laissez-faire free enterprise; Adam Smith roams the land.

However, today we are about to pass a provision that says when the HMOs are dealing with their pocketbook and the question of how they will get reimbursed, how much money they are going to get paid from Medicare, they don't want to have a free market of competition; they don't want to have a means by which the taxpayers can be assured what they are paying for the HMO product is what the market says they should be paying.

There is a certain amount of irony there which I think underscores the motivations of a significant portion of this industry. There also is a procedural ploy here. If this provision I just quoted were to be offered as an amendment to this bill, it would be ruled out of order under rule XVI in part because it purports not only to control action in this act but in any other act that Congress might consider making in an appropriations bill. But this is not an amendment; this is in the bill itself as it has come out of the Appropriations Committee, and therefore rule XVI does not apply.

Normally under the procedures the Congress has followed traditionally, we would be dealing with a House bill because the House traditionally has led in the appropriations process; therefore, we would be amending a House bill. Thus, we could have excised this provision. However, because we are violating tradition and taking up a Senate bill first, we do not have the opportunity to remove it by a point of order.

I will state for the record that henceforth, when it is proposed we take up a Senate appropriations bill before a House bill, I am going to stand here and object. This is exactly the kind of procedural abuse we can expect in the future as is happening right now.

If that isn't bad enough, this is just plain bad policy. It stifles innovation by eliminating the competitive demonstration which hopefully would have led to a competitive process of compensating HMOs. It forces Medicare to pay more than necessary for some services in certain areas of the country while it denies managed care to other areas of the country.

This HMO pricing is not without its own history. The Balanced Budget Act of 1997 included the competitive pricing demonstration program for Medicare. That provision was fought in the committee and fought in the Senate in 1997 by the HMO industry and certain Members of this body, but it prevailed. One by one, the HMO industry has been able to kill or has attempted to kill demonstrations which have been scheduled in many communities across the country. Today it is Arizona and Kansas City.

The equation is pretty simple. It does not take rocket science to understand what is happening. Who benefits by continuing a system of paying Medicare HMOs that are not subject to competition? The HMOs benefit. Who loses when the same system is open to competition? The HMOs, because they no longer have the gravy train that exists today. Who gains by competition? Beneficiaries gain, particularly in rural areas which don't have managed care today. It would be the marketplace that would be establishing what the appropriate reimbursement level should be for an HMO in a currently unserved or underserved rural area—not a formula which underpays what the real cost of providing managed care would be in such an area. And the taxpayers lose because they do not get the benefit of the marketplace as a discipline of what the HMO's compensation should be.

It is curious that out of one side of their mouth, they are screaming the current system of reimbursement is putting them out of business and causing them to have to leave hundreds of thousands of former HMO beneficiaries high and dry and also to curtail benefits such as prescription drugs, but at the same time, they are saying out of the left side of their mouth they are doing everything they can to prevent the insertion of competitive bidding as a means of establishing what their HMO contracts are really worth and what they should be paid.

They cannot have it both ways.

It takes a certain degree of political courage to make this reform happen. Let me give an example. In my own State of Florida, we were part of this demonstration project. We were selected to have a demonstration for Part B services for what are referred to as durable medical equipment. Lakeland, FL, was selected as the place to demonstrate the potential savings for medical equipment such as oxygen supplies and equipment, hospital beds and accessories, surgical dressings, enteral nutrition, and urological supplies.

The savings that have been achieved in this project are impressive.

They are 18-percent savings for oxygen supplies. I know the Senator from Iowa has stood on this floor and at times has even wrapped himself in medical bandages to demonstrate how much more Medicare was paying than, for instance, the Veterans' Administration for the same items. This competitive bidding process is attempting to bring the forces of the market into Medicare, and an 18-percent savings by competitively bidding oxygen supplies and equipment over the old formula we used to use. There were 30-percent savings for hospital beds and accessories, 13-percent savings for surgical dressings, 31 percent for enteral nutrition products, and 20 percent for urological supplies. It has been estimated if that Lakeland, FL, project were to be applied on a nationwide basis, the savings over 10 years would be in excess of $1 billion. We are not talking about small change.

Beneficiaries have saved money from this demonstration, and access and quality have been preserved and protected.

I find it troubling we are again today, as we were in July, debating, at the end of a major piece of legislation, a silently, surreptitiously included item which has the effect of sheltering HMOs from the marketplace. We might find some HMOs cannot compete and others will thrive, but that is what the marketplace should determine. That is what competition is all about.

I urge my colleagues to examine this provision, to examine the implications of this provision in this kind of legislation and the restraints it imposes upon us, as Members of the Senate, to excise it as inappropriate legislative language on an appropriations bill.

I hope our conferees, as they meet with the House, will resist the inclusion of this in the final legislation we might be asked to vote upon when this measure comes back from conference. This disserves the beneficiaries of the Medicare program. It disserves the taxpayers of America. It disserves the standards of public policy development by the Senate. I hope we will not have a further repetition of this stealth attack on the Medicare program.

Mr. ASHCROFT. Mr. President, I took great interest in the statement that Senator from Florida (Mr. GRAHAM) made expressing his displeasure that this legislation contains

a provision—Section 214—halting implementation of the Medicare Prepaid Competitive Pricing Demonstration Project both in Arizona and in the Kansas City metropolitan area.

The Senator from Florida claimed that the inclusion of this provision was accomplished by HMOs. I would like to take this opportunity to point out to him that it was Medicare beneficiaries and doctors who alerted me to their grave concerns that the project would create huge patient disruption in the Kansas City area.

In fact, after the Senator from Florida made similar remarks during debate on the Patient's Bill of Rights legislation regarding a similar provision in that bill, the Metropolitan Medical Society of Greater Kansas City wrote him a letter conveying their concerns with the implementation of the demonstration project in Kansas City, and expressing support for congressional efforts to stop the demonstration in their area. I ask unanimous consent that a copy of this letter be inserted in the record at the conclusion of my remarks.

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

(See exhibit 1.)

Mr. ASHCROFT. After hearing from a number of doctors and patients in my State over the past few months, I concluded that Kansas City is an inappropriate location for this project and that it will jeopardize the health care benefits that seniors currently enjoy in the area. I believe that halting this project is necessary to protect the health care of senior citizens and to assure that Medicare beneficiaries continue to have access to excellent health care at prices they can afford. HCFA's project is a clear and present danger to the health and well-being of my constituents.

The Balanced Budget Act of 1997 created the Medicare Prepaid Competitive Pricing Demonstration Project to use competitive bidding among Medicare HMOs. Through the appointment of a Competitive Pricing Advisory Committee, HCFA was to select demonstration sites around the nation. Kansas City was one of the selected cities.

As I understand it, the intent of the project was to bring greater competition to the Medicare managed care market, to address concerns that Medicare HMO reimbursement rates in some areas are too high, to expand benefits for Medicare HMO enrollees, and to restrain the cost of Medicare to the taxpayers. When considering these factors, it is clear that the Kansas City metropolitan area is not an appropriate choice for this demonstration.

First, managed care competition in the Kansas City market is already vigorous, with six managed care companies currently offering Medicare HMOs in the area. Participation in Medicare HMOs is also high: As of July 1 of this year, nearly 23% of Medicare recipients in the Kansas City metropolitan area were in Medicare+Choice plans—approximately 50,000 of 230,000 total beneficiaries. Nationally, only 17% of Medicare recipients are enrolled in such plans.

Second, Medicare managed care payments in the Kansas City area are below the national average. According to a recent analysis by the Congressional Research Service of the Library of Congress, 1999 payment rates per Medicare+Choice enrollee in Kansas City are $511, while the national rate is $541. Documents provided to me by HCFA also demonstrate that 75 other cities had a higher adjusted average per capita cost (AAPCC) rate for 1997 than Kansas City. I wonder why Kansas City was chosen for this experiment, when so many other cities have higher payment rates.

Third, I am concerned that this demonstration project will not provide expanded benefits to Medicare HMO enrollees, but will instead cause severe disruption of Medicare services. It is important to note that customer dissatisfaction is low in current Medicare managed care plans in the Kansas City area. Only one in twelve seniors disenrolls from Medicare HMOs each year.

Currently, 33,000, or 66% of the seniors in Medicare managed care plans in the Kansas City area do not pay any premium. Under the bidding process set up by CPAC for the demonstration, a plan that bids above the enrollment-weighted median—which becomes the reimbursement rate for all plans—will be forced to charge seniors a premium to make up the difference between the plan's bid and the reimbursement rate paid by the government. In essence, the penalty for a high bid will be imposed upon seniors. Under this scenario, it is virtually assured that some seniors who pay no premium today will be required to start paying one.

Moreover, seniors who cannot afford to pay a premium would be forced to abandon their regular doctor when it becomes necessary to change plans. Both individual doctors as well as the Metropolitan Medical Society of Greater Kansas City have warned that the demonstration could cause extreme disruption of beneficiaries away from current doctor-patient relationships.

I have also heard concerns that both health plans and physicians may withdraw from the Medicare program if reimbursements under the demonstration project prove financially untenable. As a result, Medicare beneficiaries may be left with fewer choices in care. This would be intolerable. I question why we should implement a project that will create more risk and uncertainty for my State's seniors, who are already satisfied with what they have.

Finally, I question how the demonstration project would be able to provide us with useful information on how to improve the Medicare program if fee-for-service plans—which are generally the most expensive Medicare option—are not included in the project. In its January 6, 1999 Design Report, the Competitive Pricing Advisory Committee expressed the judgment that the exclusion of fee-for-service might ''limit HCFA's ability (a) to measure the impact of competitive pricing and (b) to generalize demonstration results to the entire Medicare program.''

After studying this issue, I concluded that implementation of the Medicare Managed Care Demonstration Project in the Kansas City metropolitan area should be halted immediately. HCFA must not be allowed to risk the ability of my State's seniors to continue to receive high quality health care at affordable costs. I have been working closely with my Senate colleagues from Missouri and Kansas to protect our Kansas City area seniors from the dangers and uncertainty of a planned federal experiment with their health care arrangements.

So, I want to make clear to my colleague from Florida that patients and doctors speaking on behalf of their patients were the ones who approached me and asked for my assistance in stopping the Medicare managed care demonstration project in the Kansas City area. I heard from a number of individual doctors, as well as medical societies in the State, expressing grave concerns about the project. The President of the Metropolitan Medical Society of Greater Kansas City even made the prediction that the unintended risk of the demonstration ''could dictate 100% disruption of beneficiaries away from their current relationships'' with their doctors. Clearly, this is unacceptable.

Inclusion, Mr. President, I would like to quote from some of the letters I received from the seniors themselves, voicing their opposition to the Medicare managed care demonstration project coming to their area.

Elizabeth Weekley Sutton, of Independence, Missouri, wrote to me:

DEAR SENATOR ASHCROFT: We need help. My husband, my friends, and I are very concerned and worried that our health care will be very limited by the end of the Competitive Pricing Demonstration that will be starting in January. Of all the HMO's in the U.S., only the entire K.C. area and Maricopa County in Arizona will be conducting this competition for the next 5 years!

And here are some excerpts from a letter sent by Edward Smith of Platte City, Missouri:

I am totally opposed to the Health Care Financing Administration competitive pricing demonstration project to take place here in the Kansas City area. My health will not permit me to be a guinea pig for a total of five years when the rest of the country will have business as usual.

He continues:

Instead of the Health Care Financing Administration determining what is best for the beneficiaries I would prefer to do that myself.

And finally, Mr. Smith says:

If this plan is adopted my HMO could choose to leave the market. Then what is gained? Certainly not my health.

Mr. President, we need to listen to the voice of our seniors. We cannot afford to jeopardize their health with a

risky experiment that could raise costs, limit choices, and cause doctor-patient disruption. For this reason, I have continued—and will continue—to work to halt this project in its present form in the Kansas City area.

EXHIBIT 1

METROPOLITAN MEDICAL SOCIETY
OF GREATER KANSAS CITY,
July 21, 1999.

Hon. BOB GRAHAM,
U.S. Senate, Washington, DC.

DEAR SENATOR GRAHAM: I was concerned to read in the July 16, 1999, Congressional Record your dissatisfaction about the Senate's passage of the moratorium on the Medicare Prepaid Competitive Pricing Demonstration Project in Kansas City and Arizona. On behalf of the more than 2500 physicians of the Metropolitan Medical Society of Greater Kansas City and its affiliated organizations, I want to assure you that doctors strongly support the moratorium that was passed in the Senate Patient Bill of Rights legislation last week.

The physicians of Kansas City have expressed serious concerns about the demonstration project since April, and we continue to be concerned. We believe the experiment will bring unacceptable levels of disruption to our Medicare patients and the local health care market. Additionally, I worry that quality care, which is often more expensive, will be less available to Medicare patients. In Kansas City, the opposition to the project is widespread. Our senators acted on behalf of our entire health care community, including patients, doctors, hospitals, and health care plans.

The medical community has participated in the discussions about the demonstration with the Health Care Financing Administration (HCFA) and the local Area Advisory Committee for the demonstration project. Despite these discussions, problems with the experiment remain. We support congressional efforts to stop the demonstration project in the Kansas City area.

I remain concerned that under-funded HMOs place our most vulnerable Medicare recipients at risk of getting less attention to their health care needs. I expect to hear more cases of catastrophes to Medicare recipients when the care given is too little, too late. You may be aware that Jacksonville, Florida is another potential site for the demonstration.

Thank you for your consideration of my concerns. I hope I've helped to clarify the existence of broad based support in Kansas City for the moratorium on the competitive pricing demonstration.

Sincerely,

RICHARD HELLMAN, MD,
President-Elect and Chair, National Government Relations Committee.

AMENDMENT NO. 1845

(Purpose: To express the sense of the Senate regarding school infrastructure)

The PRESIDING OFFICER (Mr. SMITH of Oregon). The Senator from Iowa.

Mr. HARKIN. Mr. President, Senator ROBB and I have an amendment at the desk. I call it up at this time, No. 1845.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. HARKIN], for himself, and Mr. ROBB, proposes an amendment numbered 1845.

Mr. HARKIN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

At the end of title III, add the following:

SEC. ___. SENSE OF THE SENATE REGARDING SCHOOL INFRASTRUCTURE.

(a) FINDINGS.—The Senate makes the following findings:

(1) The General Accounting Office has performed a comprehensive survey of the Nation's public elementary and secondary school facilities and has found severe levels of disrepair in all areas of the United States.

(2) The General Accounting Office has concluded that more than 14,000,000 children attend schools in need of extensive repair or replacement, 7,000,000 children attend schools with life threatening safety code violations, and 12,000,000 children attend schools with leaky roofs.

(3) The General Accounting Office has found the problem of crumbling schools transcends demographic and geographic boundaries. At 38 percent of urban schools, 30 percent of rural schools, and 29 percent of suburban schools, at least one building is in need of extensive repair or should be completely replaced.

(4) The condition of school facilities has a direct affect on the safety of students and teachers and on the ability of students to learn. Academic research has provided a direct correlation between the condition of school facilities and student achievement. At Georgetown University, researchers have found the test scores of students assigned to schools in poor condition can be expected to fall 10.9 percentage points below the test scores of students in buildings in excellent condition. Similar studies have demonstrated up to a 20 percent improvement in test scores when students were moved from a poor facility to a new facility.

(5) The General Accounting Office has found most schools are not prepared to incorporate modern technology in the classroom. Forty-six percent of schools lack adequate electrical wiring to support the full-scale use of technology. More than a third of schools lack the requisite electrical power. Fifty-six percent of schools have insufficient phone lines for modems.

(6) The Department of Education has reported that elementary and secondary school enrollment, already at a record high level, will continue to grow over the next 10 years, and that in order to accommodate this growth, the United States will need to build an additional 6,000 schools.

(7) The General Accounting Office has determined the cost of bringing schools up to good, overall condition to be $112,000,000,000, not including the cost of modernizing schools to accommodate technology, or the cost of building additional facilities needed to meet record enrollment levels.

(8) Schools run by the Bureau of Indian Affairs (BIA) for Native American children are also in dire need of repair and renovation. The General Accounting Office has reported that the cost of total inventory repairs needed for BIA facilities is $754,000,000. The December 1997 report by the Comptroller General of the United States states that, ''Compared with other schools nationally, BIA schools are generally in poorer physical condition, have more unsatisfactory environmental factors, more often lack key facilities requirements for education reform, and are less able to support computer and communications technology.''.

(9) State and local financing mechanisms have proven inadequate to meet the challenges facing today's aging school facilities. Large numbers of local educational agencies have difficulties securing financing for school facility improvement.

(10) The Federal Government has provided resources for school construction in the past. For example, between 1933 and 1939, the Federal Government assisted in 70 percent of all new school construction.

(11) The Federal Government can support elementary and secondary school facilities without interfering in issues of local control, and should help communities leverage additional funds for the improvement of elementary and secondary school facilities.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Congress should provide at least $3,700,000,000 in Federal resources to help communities leverage funds to modernize public school facilities.

Mr. HARKIN. Mr. President, Senator ROBB and I are going to take a few minutes. I know the time is late. I know people want to get to a final vote on this. I want to talk about how good this bill is and to urge people to vote for it.

This is a sense-of-the-Senate resolution. I will not go through the whole thing. It basically is a sense-of-the-Senate resolution saying Congress should appropriate at least $3.7 billion in Federal resources to help communities leverage funds to modernize public school facilities, otherwise known as public school construction.

What we have in this country is schools that are on the average 40 to 50 years old. We are getting great teachers, new methodologies, new math, new science, new reading programs, and the schools are crumbling down around us. They are getting older every day. Day after day, kids go to schools with leaky ceilings, inadequate heat, inadequate air conditioning for hot summer days and the fall when the school year is extended. They are finding a lot of these buildings still have asbestos in them, and it needs to be taken out. Yet we are shirking our responsibilities to refurbish, renovate, and rebuild the schools in this country. The General Accounting Office estimates 14 million American children attend classes in schools that are unsafe or inadequate. They estimate it will cost $112 billion to upgrade existing public schools to just ''good'' condition.

In addition, the GAO reports 46 percent of schools lack adequate electrical wiring to support the full-scale use of technology. We want to get computers in the classrooms, we want to hook them to the Internet, and yet almost 50 percent of the schools in this country are inadequate in their internal wiring so kids cannot hook up with the Internet.

The American Society of Civil Engineers reports public schools are in worse condition than any other sector of our national infrastructure. Think about that. According to the American Society of Civil Engineers—they are the ones who build our buildings, build our bridges and roads and highways and streets and sewers and water systems, and our schools—they say our schools are in the worst state of any part of the physical infrastructure of this country.

Mr. HARKIN. Mr. President, if the nicest things our kids ever see or go to

is shopping malls and sports arenas and movie theaters, and the most run-down places are their schools, what kind of signal are we sending them about the value we place on education and their future?

This is a sense-of-the-Senate resolution which simply outlines the terrible situation we have in this country and calls on the Senate and the Congress to respond by providing at least $3.7 billion, a small fraction of what is needed but a step in the right direction—$3.7 billion in Federal resources to modernize our Nation's schools.

I yield the floor to my distinguished colleague and cosponsor, Senator ROBB.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. ROBB. Mr. President, I thank my friend and colleague from Iowa. Senator HARKIN and I have offered a sense of the Senate amendment relating to school construction, as Senator HARKIN has just explained. The amendment is not unlike the amendment Senators LAUTENBERG, HARKIN, and I offered to the Budget Resolution earlier this year. That amendment assumed that given the levels in the budget resolution, Congress would enact ''legislation to allow States and school districts to issue at least $24.8 billion worth of zero-interest bonds to rebuild and modernize our nation's schools, and to provide Federal income tax credits to the purchasers of those bonds in lieu of interest payments.'' The actual cost as it was scored was referred to by the Senator from Iowa. That amendment was accepted and put the entire Senate on record as supporting the concept of providing federal assistance in the area of school construction and renovation.

Understanding that Rule 16 prevents us from doing anything of significance at this time with respect to school construction, Senator HARKIN and I in just a moment will withdraw our amendment. But every day that passes, this Congress misses an opportunity to help our States and localities fix the leaky roofs, get rid of all the trailers, and install the wiring needed to bring technology to all of our children. These are real problems—problems that our nation's mayors, school boards, and families simply need some help in addressing.

While school infrastructure improvement is typically a local responsibility, it is now a national need. Our schools, as the Senator from Iowa has indicated, are over 40 years old, on average; our school-aged population is at record levels; and our States and localities can't keep up, despite their surpluses.

Abstract talk about State surpluses provides little solace to our nation's teachers and students who are forced to deal with wholly inadequate conditions. In Alabama, the roof of an elementary school collapsed. Fortunately, it occurred just after the children had left for the day. In Chicago, teachers place cheesecloth over air vents to filter out lead-based paint flecks. In Maine, teachers have to turn out the lights when it rains because their electrical wiring is exposed under their leaky roofs.

Mr. President, we are missing an opportunity to help our States and localities with a pressing need.

I will continue to work for and press forward on this issue because I think it's an area where the Federal Government can be extremely constructive. When our children are asked about ''Bleak House,'' they should refer to a novel by Dickens and not the place where they go to school.

In my own State of Virginia, there are over 3,000 trailers being used to educate students. And there are over $4 billion worth of unbudgeted, unmet needs for our schools. This is a problem that is not going to go away, and it's a problem that our nation's schools need our help to solve. And I regret that Rule 16 precludes us from considering legislation which would reaffirm the commitment that we made earlier this year.

I thank the distinguished Senator from Iowa for his continued work on the subject of school construction, and I yield the floor.

AMENDMENT NO. 1845 WITHDRAWN

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, I understand this amendment is not acceptable to the other side. It is late in the day. I know people have to get on with other things, and we want to get to a final vote on the bill. I believe strongly in this. It is a sense-of-the-Senate amendment. Also, Senators KENNEDY, REID, MURRAY, and JOHNSON are added as cosponsors.

In the spirit of moving this bill along and trying to wrap this up as quickly as possible, I ask unanimous consent to withdraw the amendment at this time, but it will be revisited.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. I thank my distinguished colleague. I am very sympathetic to the purpose of the sense-of-the-Senate amendment. He is correct; there would be objection, and I think it would not be adopted. I thank him for withdrawing the amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

AMENDMENTS NOS. 2273 THROUGH 2289, 1852, 1869, AND 1882

Mr. SPECTER. Mr. President, I now submit the managers' package which has been cleared on both sides.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Pennsylvania [Mr. SPECTER] proposes amendments numbered 2273 through 2289, 1852, 1869 and 1882.

The amendments are as follows:

AMENDMENT NO. 2273

At the appropriate place in the bill add the following:

SEC. . CONFOUNDING BIOLOGICAL AND PHYSIOLOGICAL INFLUENCES ON POLYGRAPHY.

(a) FINDINGS.—The Senate finds that—

(1) The use of polygraph tests as a screening tool for federal employees and contractor personnel is increasing.

(2) A 1983 study by the Office of Technology Assessment found little scientific evidence to support the validity of polygraph tests in such screening applications.

(3) The 1983 study further found that little or no scientific study had been undertaken on the effects of prescription and non-prescription drugs on the validity of polygraph tests, as well as differential responses to polygraph tests according to biological and physiological factors that may vary according to age, gender, or ethnic backgrounds, or other factors relating to natural variability in human populations.

(4) A scientific evaluation of these important influences on the potential validity of polygraph tests should be studied by a neutral agency with biomedical and physiological expertise in order to evaluate the further expansion of the use of polygraph tests on federal employees and contractor personnel.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that the Director of the National Institutes of Health should enter into appropriate arrangements with the National Academy of Sciences to conduct a comprehensive study and investigation into the scientific validity of polygraphy as a screening tool for federal and federal contractor personnel, with particular reference to the validity of polygraph tests being proposed for use in proposed rules published at 64 Fed. Reg. 45062 (August 18, 1999).

AMENDMENT NO. 2274

(Purpose: To provide funding for a dental sealant demonstration program)

At the end of title II, add the following:

DENTAL SEALANT DEMONSTRATION PROGRAM

SEC. ___. From amounts appropriated under this title for the Health Resources and Services Administration, sufficient funds are available to the Maternal Child Health Bureau for the establishment of a multi-State preventive dentistry demonstration program to improve the oral health of low-income children and increase the access of children to dental sealants through community- and school-based activities.

AMENDMENT NO. 2275

(Purpose: To limit the withholding of substance abuse funds from certain States)

At the end of title II, add the following:

WITHHOLDING OF SUBSTANCE ABUSE FUNDS

SEC. ___. (a) IN GENERAL.—None of the funds appropriated by this Act may be used to withhold substance abuse funding from a State pursuant to section 1926 of the Public Health Service Act (42 U.S.C. 300x-26) if such State certifies to the Secretary of Health and Human Services that the State will commit additional State funds, in accordance with subsection (b), to ensure compliance with State laws prohibiting the sale of tobacco products to individuals under 18 years of age.

(b) AMOUNT OF STATE FUNDS.—The amount of funds to be committed by a State under subsection (a) shall be equal to one percent of such State's substance abuse block grant allocation for each percentage point by which the State misses the retailer compliance rate goal established by the Secretary of Health and Human Services under section 1926 of such Act, except that the Secretary may agree to a smaller commitment of additional funds by the State.

(c) SUPPLEMENT NOT SUPPLANT.—Amounts expended by a State pursuant to a certification under subsection (a) shall be used to supplement and not supplant State funds

used for tobacco prevention programs and for compliance activities described in such subsection in the fiscal year preceding the fiscal year to which this section applies.

(d) The Secretary shall exercise discretion in enforcing the timing of the State expenditure required by the certification described in subsection (a) as late as July 31, 2000.

AMENDMENT NO. 2276

(Purpose: To express the sense of the Senate that funding for prostate cancer research should be increased substantially)

At the appropriate place add the following:

SEC. ___. (a) FINDINGS.—Congress makes the following findings:

(1) In 1999, prostate cancer is expected to kill more than 37,000 men in the United States and be diagnosed in over 180,000 new cases.

(2) Prostate cancer is the most diagnosed nonskin cancer in the United States.

(3) African Americans have the highest incidence of prostate cancer in the world.

(4) Considering the devastating impact of the disease among men and their families, prostate cancer research remains underfunded.

(5) More resources devoted to clinical and translational research at the National Institutes of Health will be highly determinative of whether rapid advances can be attained in treatment and ultimately a cure for prostate cancer.

(6) The Congressionally Directed Department of Defense Prostate Cancer Research Program is making important strides in innovative prostate cancer research, and this Program presented to Congress in April of 1998 a full investment strategy for prostate cancer research at the Department of Defense.

(7) The Senate expressed itself unanimously in 1998 that the Federal commitment to biomedical research should be doubled over the next 5 years.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) finding treatment breakthroughs and a cure for prostate cancer should be made a national health priority;

(2) significant increases in prostate cancer research funding, commensurate with the impact of the disease, should be made available at the National Institutes of Health and to the Department of Defense Prostate Cancer Research Program; and

(3) these agencies should prioritize prostate cancer research that is directed toward innovative clinical and translational research projects in order that treatment breakthroughs can be more rapidly offered to patients.

AMENDMENT NO. 2277

On page 59, line 25, strike ''$1,404,631,000'' and insert ''$1,406,631,000'' in lieu thereof.

On page 60, before the period on line 10, insert the following: '': *Provided further,* That $2,000,000 shall be for carrying out Part C of Title VIII of the Higher Education Amendments of 1998.''

On page 62, line 23, decrease the figure by $2,000,000.

AMENDMENT NO. 2278

(Purpose: To clarify provisions relating to the United States-Mexico Border Health Commission)

At the appropriate place, insert the following:

SEC. . The United States-Mexico Border Health Commission Act (22 U.S.C. 290n et seq.) is amended—

(1) by striking section 2 and inserting the following:

''SEC. 2. APPOINTMENT OF MEMBERS OF BORDER HEALTH COMMISSION.

''Not later than 30 days after the date of enactment of this section, the President shall appoint the United States members of the United States-Mexico Border Health Commission, and shall attempt to conclude an agreement with Mexico providing for the establishment of such Commission.''; and

(2) in section 3—

(A) in paragraph (1), by striking the semicolon and inserting ''; and'';

(B) in paragraph (2)(B), by striking ''; and'' and inserting a period; and

(C) by striking paragraph (3).

AMENDMENT NO. 2279

On page 50, line 17, strike ''$459,000,000'' and insert in lieu thereof ''$494,000,000''.

AMENDMENT NO. 2280

On page 66, line 24, strike out all after the colon up to the period on line 18 of page 67.

AMENDMENT NO. 2281

On page 42, before the period on line 8, insert the following: '': *Provided further,* That sufficient funds shall be available from the Office on Women's Health to support biological, chemical and botanical studies to assist in the development of the clinical evaluation of phytomedicines in women's health''.

AMENDMENT NO. 2282

(Purpose: To provide for a report on promoting a legal domestic workforce and improving the compensation and working conditions of agricultural workers)

On page 19, line 6, insert before the period the following: '': *Provided further,* That funds made available under this heading shall be used to report to Congress, pursuant to section 9 of the Act entitled 'An Act to create a Department of Labor' approved March 4, 1913 (29 U.S.C. 560), with options that will promote a legal domestic work force in the agricultural sector, and provide for improved compensation, longer and more consistent work periods, improved benefits, improved living conditions and better housing quality, and transportation assistance between agricultural jobs for agricultural workers, and address other issues related to agricultural labor that the Secretary of Labor determines to be necessary''.

AMENDMENT NO. 2283

(Purpose: To express the sense of the Senate concerning women's access to obstetric and gynecological services)

Beginning on page 1 of the amendment, strike all after the first word and insert the following:

___. SENSE OF THE SENATE ON WOMEN'S ACCESS TO OBSTETRICAND GYNECOLOGICAL SERVICES.

(a) FINDINGS.—Congress makes the following findings:

(1) In the 1st session of the 106th Congress, 23 bills have been introduced to allow women direct access to their ob-gyn provider for obstetric and gynecologic services covered by their health plans.

(2) Direct access to ob-gyn care is a protection that has been established by Executive Order for enrollees in medicare, medicaid, and Federal Employee Health Benefit Programs.

(3) American women overwhelmingly support passage of federal legislation requiring health plans to allow women to see their ob-gyn providers without first having to obtain a referral. A 1998 survey by the Kaiser FamilyFoundation and Harvard University found that 82 percent of Americans support passage of a direct access law.

(4) While 39 States have acted to promote residents' access to ob- gyn providers, patients in other State- or in Federally-governed health plans are not protected from access restrictions or limitations.

(5) In May of 1999 the Commonwealth Fund issued a survey on women's health, determining that 1 of 4 women (23 percent) need to first receive permission from their primary care physician before they can go and see their ob-gyn provider for covered obstetric or gynecologic care.

(6) Sixty percent of all office visits to ob-gyn providers are for preventive care.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Congress should enact legislation that requires health plans to provide women with direct access to a participating health provider who specializes in obstetrics and gynecological services, and that such direct access should be provided for all obstetric and gynecologic care covered by their health plans, without first having to obtain a referral from a primary care provider or the health plan.

Mrs. MURRAY. Mr. President, included in the Manager's amendment is an important provision relating to women's health and access to reproductive health care services. I am pleased to have worked with the managers of this bill to send a strong message on the importance of direct access for women to their OB/GYN.

I was disappointed that we were unable to address the rule XVI concerns with the amendment I had originally filed. My original amendment would simply allow women and their OB/GYNs to make important health care decisions without barriers or obstacles erected by insurance company policies. My amendment would have required that health plans give women direct access to their OB/GYN for all gynecological and obstetrical care and would have prohibited insurance companies from standing between a woman and her OB/GYN.

However, it has been determined that my amendment would violate rule XVI. As a result of the announcement by the chairman of the Senate Appropriations Committee that he will make a point of order against all amendments that may violate rule XVI, I have modified my amendment. The modification still allows Members of the Senate to be on record in support of women's health or in opposition to removing barriers that hinder access for women to critical reproductive health care services.

I am offering a sense-of-the-Senate that puts this question to each Member. I realize that this amendment is not binding, but due to opposition to my original amendment, I have been forced to offer this sense-of-the-Senate.

I am disappointed that we could not act to provide this important protection to women, but I do believe this amendment will send an important message that the U.S. Senate does support greater access for women to quality health care benefits.

I have offered this amendment due to my frustration and disappointment with managed care reform. I have become frustrated by stalling tactics and empty promises. The managed care reform bill that passed the Senate has

been referred to as an empty promise for women. I can assure my colleagues that women are much smarter than they may expect and will not be fooled by empty promises or arguments of procedural discipline. When a woman is denied direct access to the care provided by her OB/GYN, she will not be interested in a discussion on ERISA or rule XVI. She wants direct access to her OB/GYN. She needs direct access, and she should have direct access.

My amendment also reiterates the importance of ensuring that the OB/GYN remains the coordinating physician. Any test or additional referral would be treated as if made by the primary care physician. This amendment does not call for the designation of an OB/GYN as a primary care physician, it simply says that if the OB/GYN decides additional care is necessary, the patient is not forced to seek approval from a primary care physician, who may not be familiar with her overall health care status.

Why is this amendment important? The number one reason most women enter the health care system is to seek gynecological or obstetric care. This is the primary point of entry for women into the health care system. For most women, including myself, we consider our OB/GYN our primary care physician—maybe not as an insurance company defines it—but, in practice, that's the reality.

Does a woman go to her OB/GYN for an ear infection? No. But, does a pregnant woman consult with her OB/GYN prior to taking any antibiotic for the treatment of an ear infection? Yes, most women do.

I know the policy endorsed in this amendment has in the past enjoyed bipartisan support. The requirements are similiar to S. 836, legislation introduced by Senator SPECTER and cosponsored by several Senators both Republican and Democrat. This amendment is similar to language that was adopted during committee consideration in the House of the fiscal year 1999 Labor, HHS appropriations bill. A similar directive is contained in the bipartisan House Patients' Bill of Rights legislation. It has the strong support of the American College of Obstetricians and Gynecologists and I know I have heard from several OB/GYNs in my own state testifying to the importance of direct access to the full range of care provided, not just routine care.

I would also like to point out to my colleagues, that 39 states have similar requirements and that as participants in the Federal Employees Health Benefit Plan, all of us—as Senators—have this same guarantee as well as our family members. If we can guarantee this protection for ourselves and our families, we should do the same for women participating in a manager care plan.

I realize that this appropriations bill may not be the best vehicle for offering this amendment. However, I have waited for final action on a Patients' Bill of Rights for too long. I have watched as patient protection bills have been stalled or delayed. Last year we were told that we would finish action on a good Patients' Bill of Rights package prior to adjournment.

Well, here we sit—almost 12 months later—with little hope of finishing a good, comprehensive managed care reform bill prior to our scheduled adjournment this year.

I also want to remind my colleagues that we have in the past used appropriations bills to address deficiencies in current law or to address an urgent need for action. I believe that addressing an urgent need in women's health care qualifies as a priority that we must address. I realize that the authorizing committee has objected to the original amendment I filed. As a member of the authorizing committee as well, I can understand this objection. But, again I have little choice but to proceed on this appropriations bill.

We all know that it was only recently on the fiscal year 1999 supplemental appropriations bill that we authorized a significant change in Medicaid recoupment provisions despite strong objections from the Finance Committee.

In last year's omnibus appropriations bill, we authorized a requirement that insurance companies must cover breast reconstruction surgery following a mastectomy. I can assure my colleagues that this provision never went through the authorizing committee. I would also point out that there are several antichoice riders contained in this appropriations bill that represent a major authorization.

As these examples show, when we have to address these types issues through appropriations bills—we can do it. We have done it in the past, and we should do it today to meet this need.

I urge my colleagues to support this amendment. We all talk about the need to ensure access for women to health care. I applaud Chairman SPECTER's efforts in this appropriations bill regarding women's health care. Adopting this amendment gives us the opportunity to do something that does ensure greater access for women. This is what women want. This is the chance for Senators to show their commitment to this critical benefit.

I would like to quote a statement made by our subcommittee chairman that I believe more eloquently explains why I am urging this amendment. ''I believe it is clear that access to women's health care cuts across the intricacies of the complicated and often divisive managed care debate.'' I could not agree more.

We know from the current state requirement and the Federal Employee Health Benefit Program requirement, this provision does not have a significant impact on costs of health care. We also know from experience that it has a positive impact on health care benefits. Since 60 percent of office visits to OB/GYNs are for preventive care, we could make the argument that adoption of this policy would reduce the overall costs of health care.

I urge my colleagues to support this amendment and ask that we do more than simply make empty promises to women. We need an honest and fair debate on this policy.

I would ask my colleagues to seek further education or advice from women as to the importance of direct access and ask their female constituents about the relationship they have with their own OB/GYN. Let women speak for themselves. If you listen, you will hear why this policy is so important and why women trust their OB/GYN far more than their insurance company or their Member of Congress.

Mr. ROBB. Mr. President, I want to discuss my support for an amendment Senator MURRAY and I offered which puts the entire Senate on record in favor of removing one of the greatest obstacles to quality care that women face in our insurance system today: inadequate access to obstetricians and gynecologists.

I understand that our provision will be included in the manager's amendment to this bill, and I want to thank the chairman of the Senate Appropriations Subcommittee on Labor, HHS and Education, Senator SPECTER, for his work both in including our amendment in his bill, as well as his leadership on this issue. He has been one of the most outspoken members in this body in favor of helping women have better access to women's health servvices.

We know today that for many women, their OB/GYN is the only physician they see regularly. While they have a special focus on women's reproductive health, obstetricians and gynecologists provide a full range of preventative health services to women, and many women consider their OB/GYN to be their primary care physician.

Unfortunately, some insurers have failed to recognize the ways which women access health care services. Some managed care companies require a woman to first visit a primary care doctor before she is granted permission to see an obstetrician or gynecologist. Others will allow a woman to obtain treatment directly from her OB/GYN, but then prohibit her from obtaining any follow-up care that her OB/GYN recommends without first visiting a primary care physician who serves as a ''gatekeeper''.

This isn't just cumbersome for women, it's bad for their health. According to a survey by the Commonwealth Fund, women who regularly see an OB/GYN are more likely to have had a complete physical exam and other important preventative services like mammograms, cholesterol tests and Pap smears. At a time when we need to direct our health care dollars more toward prevention, allowing insurers to

restrict access to the health professionals most likely to offer women preventative care only increases the possibility that greater complications—and greater expenditures—will arise down the road. We ought to grant women the right to access medical care from obstetricians and gynecologists without any interference from remote insurance company representatives.

Earlier this year, Senator MURRAY and I offered an amendment which would do just that. Unfortunately, a number of my colleagues from the other side of the aisle objected to some of the specific wording in our bill, and the amendment was defeated.

Since that vote, we have reworked our amendment to address these concerns. We had hoped to offer an amendment which was identical to language included in a patient protection bill crafted by a Republican Congressman, CHARLIE NORWOOD, and that was approved by the House earlier today by an overwhelming vote of 275–151.

Yet despite this consensus on this issue by Republicans and Democrats on the House side, my colleagues from the other side of the aisle threatened to challenge our amendment under Senate Rule 16. Senator MURRAY and I are cognizant of the problem this created, and we've opted to offer a Sense of the Senate resolution in place of the amendment we had hoped to see approved.

This Sense of the Senate, which has been accepted by both sides, puts the entire Senate on record in favor of legislation which requires health plans to provide women with direct access to obstetrical and gynecological services, without first having to obtain a referral from a primary care provider or their health plan. It is a strong step forward in our efforts to improve women's access to the type of health care they need.

To my Republican colleagues who objected, I say: your party joined with Democrats to hammer out this compromise language on the House side. Now that the Senate is on record as well, let's get behind this same amendment at the earliest available opportunity in the Senate and pass a provision which will help all women in this country get better care.

AMENDMENT NO. 2284

(Purpose: To extend filing deadline for compensation of worker exposed to mustard gas during World War II)

At the appropriate place, insert the following:

SEC. . The applicable time limitations with respect to the giving of notice of injury and the filing of a claim for compensation for disability or death by an individual under the Federal Employees' Compensation Act, as amended, for injuries sustained as a result of the persons exposure to a nitrogen or sulfur mustard agent in the performance of official duities as an employee at the Department of the Army's Edgewood Arsenal before March 20, 1944, shall not begin to run until the date of enactment of this Act.

AMENDMENT NO. 2285

(Purpose: To correct a definition error in the Workforce Investment Act of 1998)

At the appropriate place in TITLE V—GENERAL PROVISIONS of the bill insert the following new section:

SEC. 5 . Section 169(d)(2)(B) of P.L. 105–220, the Workforce Investment Act of 1998, is amended by striking ''or Alaska Native villages or Native groups (as such terms are defined in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1602)).'', and inserting in lieu thereof,'' or Alaska Natives.''

AMENDMENT NO. 2286

(Purpose: To increase funds for the Centers for Disease Control and Prevention to provide grants regarding childhood asthma)

At the end of title II, add the following:

CHILDHOOD ASTHMA

SEC. . In addition to amounts otherwise appropriated under this title for the Centers for Disease Control and Prevention, 8.7 in addition to the $1 million already provided for asthma prevention programs which shall become available on October 1, 2000 and shall remain available through September 30, 2001, and be utilized to provide grants to local communities for screening, treatment and education relating to childhood asthma.

Mr. DURBIN. Mr. President, I rise today to offer this amendment regarding childhood asthma. For the next 15 minutes imagine breathing through a tiny straw the size of a coffee stirrer, never getting enough air. Now imagine suffering through this process three to six times a day. This is asthma.

Today, asthma is considered the worst chronic health problem plaguing this nation's children, affecting nearly 15 million Americans. That figure includes more than 700,000 Illinoisans, of whom 213,000 are children under the age of 18. Illinois has the nation's highest asthma-related death rate for African-American males, and Chicago has one of the highest rates of childhood asthma in the country.

During a recent visit to Children's Memorial Hospital in Chicago, I met a wonderful little boy whose life is a daily fight against asthma. He told me he can't always participate in gym class or even join his friends on the playground. Fortunately, Nicholas is receiving the medical attention necessary to manage his asthma. Yet for millions of children, this is not the case. Their asthma goes undiagnosed and untreated, making trips to the emergency room as common as trips to the grocery store.

In an effort to help the millions of children who live every day with undiagnosed or untreated asthma, I am offering this amendment with my colleague Sen. MIKE DEWINE. It would provide $50 million in grants through the Center for Disease Control, for community-based organizations including hospitals, community health centers, school-based programs, foster care programs, childhood nutrition programs to support asthma screening, treatment, education and prevention programs.

Despite the best efforts of the health community, childhood asthma is becoming more common, more deadly and more expensive. In the past 20 years, childhood asthma cases have increased by 160 percent and asthma-related deaths have tripled despite improved treatments.

Chicago has the dubious distinction of having the second highest rate of childhood asthma in the country. Only New York City has higher rates. According to a study published by the Annals of Allergy, Asthma & Immunology, of inner-city school children in Chicago, researchers found that the prevalence of diagnosed asthma was 10.8 per cent, or twice the 5.8 per cent the federal Centers for Disease Control and Prevention estimates in that age group nationally. The study also found that most of the children with diagnosed asthma were receiving medical care, but it may not be consistent with what asthma care guidelines recommend. Researchers questioned parents of kindergartners and found 10.8 per cent of the children had been found to have asthma. The researchers estimated an additional 6 to 7 percent had undiagnosed asthma. By comparison, the nationwide asthma rate for children 5 to 14 is 7.4 per cent. Moreover, many of the asthma cases were severe: 42 per cent had trouble sleeping once or twice a week because of wheezing, and 87 per cent had emergency room visits during the previous year.

Asthma disproportionately attacks many of society's most vulnerable those least able to fight back, children and minorities. A recent New York Times article described a study in the Brooklyn area where it was found that a staggering 38 per cent of homeless children suffer from asthma.

Some of the factors known to contribute to asthma such as poor living circumstances, exposure to cockroach feces, stress, exposure to dampness and mold are all experienced by homeless children. They are also experienced by children living in poor housing or exposed to urban violence. There are other factors such as exposure to second hand smoke and smog that also exacerbate or trigger asthma attacks.

For minorities, asthma is particularly deadly. The Asthma death rate for African-Americans is more than twice as high as it is for other segments of the population. Illinois has the highest asthma-related death rate in the country for African-American males. The death rate is 3 times higher than the asthma-related death rate for whites in Illinois. Nationwide, the childhood asthma-related death rate in 1993, was 3 to 4 times higher for African Americans compared to Caucasian Americans. The hospitalization rate for asthma is almost three times as high among African-American children under the age of 5 compared to their white counterparts The increased disparity between death rates compared to prevalence rates has been partially explained by decreased access to health care services for minority children.

Even though asthma rates are particularly high for children in poverty,

they are also rising substantially for suburban children. Overall, the rates are increasing. Every one of us knows of a child whether our own, a relative's or a friend's who suffers from asthma.

Asthma-related death rates have tripled in the last two decades. My state of Illinois has the highest asthma-related deaths in the country for African American men.

The effects of asthma on society are widespread. Many of you may be surprised to learn that asthma is the single most common reason for school absenteeism. Parents miss work while caring for children with asthma. Beyond those days missed at school and parents missing work, there is the huge emotional stress suffered by asthmatic children. It is a very frightening event for a small child to be unable to breathe. A recent US News article quoted an 8-yr old Virginian farm girl, Madison Benner who described her experience with asthma. She said ''It feels like something was standing on my chest when I have an asthma attack.'' This little girl had drawn a picture of a floppy-eared, big footed elephant crushing a frowning girl into her bed.

In many urban centers, over 60 per cent of childhood admissions to the emergency room are for asthma. There are 1.8 million emergency room visits each year for asthma. Yet the emergency room is hardly a place where a child and the child's parents can be educated in managing their asthma. In 1994, 466,000 Americans were hospitalized with asthma, up from 386,000 in 1979.

Asthma is one of the most common and costly diseases in the US. In contrast to most other chronic diseases, the health burden of asthma is increasing rapidly. The financial burden of asthma was $6.2 billion in 1990 and is estimated to increase to more than $15 billion in 2000.

Most children who have asthma develop it in their first year, but it often goes undiagnosed or as the study I mentioned earlier, the children may not receive the best treatment. The National Institutes of Health is home to the National Asthma Education and Prevention board. This is a large group of experts from all across the fields involved in health care and asthma. They have developed guidelines on both treating asthma and educating children and their parents in prevention. It is very important that when we spend money on developing such guidelines that they actually get out to communities so that they can take advantage of this research.

CDC has been working in collaboration with NIH to make sure that health professionals and others get the most up to date information. My amendment could further help this effort by providing grantees with this information.

We do have treatments that work for most people. Early diagnosis, treatment and management are key to preventing serious illness and death. There are several wonderful models for success already available to some communities. Take for example the ''breathmobile'' program in Los Angeles that was started 2 years ago. This program provides a van that is equipped with medical personnel, asthma education materials, and asthma treatment supplies. It goes out to areas that are known to have a high incidence of childhood asthma and screens children in those areas. This ''Breathmobile'' program has reduced trips to the emergency room by 17 per cent in the first year of operation. This program is being expanded to sites in Phoenix, Atlanta, and Baltimore. I hope that we can be as successful in Illinois and other parts of the country. Children in these Breathmobile programs are also enrolled in the Children's Health Program if they are income eligible. We have all heard of how slow enrollment in the children's health program has been and anything that we can do to speed enrollment up is vitally important.

In West Virginia, a Medicaid ''disease management'' program which seeks to coordinate children with asthma's care so that they get the very best care has been found to be very cost effective. It has reduced trips to the emergency room by 30 per cent.

In Illinois, the Mobile CARE Foundation is setting up a program in Chicago based on the Los Angeles initiative. In addition, the American Association of Chest Physicians has joined with other groups to form the Chicago Asthma Consortium to provide asthma screening and treatment. Efforts like these need our amendment. This Childhood Asthma Amendment would expand these programs to help ensure that no child goes undiagnosed and every asthmatic child gets the treatment he or she needs.

I am offering this amendment here today with my colleague from Ohio, so that we can expand these programs to other areas of the country. It is a very simple amendment. It adds $10 million to the Centers for Disease Control's appropriations for local community grants to screen children for asthma and if they are found to have it, to provide them with treatment and education into how to manage their asthma.

CDC has current authority to carry out such programs and as the Bill Report already notes on page 93 of the report: ''The Committee is pleased with the work that CDC has done to address the increasing prevalence of asthma. However the increase in asthma among children, particularly among inner-city minorities, remains alarming. The Committee urges CDC to expand its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at risk minority populations in underserved communities.'' I couldn't agree more. We do need to do more in this area.

No child should die from asthma. We need to make sure that people understand the signs of asthma and that all asthmatic children have access to treatment and information on how to lessen their exposure to things that trigger asthma attacks.

My amendment responses to the alarming increase in childhood asthma cases and asthma-related deaths. It would provide funds to community and state organizations that serve areas with the largest number of children who are at risk of developing asthma and areas with the highest asthma-related death rates. The grantees could use the funds to develop programs to best meet the needs of their residents. The funds could be targeted to those communities where there are the highest number of children with asthma or where there is the highest number of asthma-related deaths.

This amendment is a small step toward addressing this the single greatest chronic health illness of children today. $10 million is a pretty small sum. I am glad that this amendment has been accepted.

The Amendment is supported by the American Lung Association, the National Association for Children's Hospitals and Research Institutions, the Academy of Pediatrics, the Asthma and Allergy Foundation of America and others who support children's health.

I thank my colleagues on behalf of the 5 million children who suffer from asthma today in America for accepting this amendment that can make some progress to combat this the most preventable childhood illness.

Mr. DEWINE. Mr. President, today I rise to support the Durbin-DeWine pediatric asthma amendment. This amendment would appropriate $10 million for the Centers for Disease Control and Prevention, CDC, to award grants to local communities for screening, treatment, and education relating to childhood asthma.

On May 5th of this year, the Allergy and Asthma Network's Mothers of Asthmatics organized an asthma awareness day to educate everyone about asthma. As most of you probably know, asthma is a chronic lung disease caused by inflammation of the lower airways. During an asthma attack, these airways narrow—making it difficult and sometimes impossible to breathe. Fortunately, we have the ''tools'' to handle asthma attacks once they occur. The most common way, of course, is to use an asthma inhaler that millions of us use every day. We also know a lot about how to prevent asthma attacks in the first place—through drug therapy and by avoiding many well-known asthma triggers.

With asthma prevalence rates—and asthma death rates—on the rise, especially in inner-city populations, it is important for us to raise national awareness, so we can educate families on how to detect, treat, and manage asthma symptoms. Of the more than 15 million Americans who suffer from asthma, over five million are children.

The American Lung Association estimates that in my home state of Ohio, 212,895 children under the age of 18 suffer from asthma. That's about two percent of the entire population in Ohio. Asthma is the most common chronic illness affecting children and is the leading cause of missed school days due to chronic illness.

Asthma is hitting the youngest the hardest. Nationwide, the most substantial prevalence rate increase for asthma occurred among children 4 years-old and younger. Hospitalization rates due to asthma were also highest in this young age group, rising 74 percent between 1979 and 1992. These increases in hospitalization rates are especially affecting the inner city populations, where asthma triggers, like air pollutants, are more concentrated.

An August 29 Akron Beacon Journal article cites statistics from the CDC that show the ratio of children under age four with asthma increased from one in forty-five in 1980 to one in seventeen in 1994. Every year, more than 5,000 Americans die from this disease—these are PREVENTABLE deaths. A July 27 New York Times article described the results of a study performed by a team at the Center for Children's Health and the Environment at Mount Sinai School of Medicine. This study found that hospitalization rates were as much as 21 times higher in poor, minority areas than in the hardest-hit areas of wealthier communities. The article quotes Dr. Claudio, an assistant professor in the division of neuropathology at Mount Sinai, who said, ''The outcomes in the poor Latino and African-American areas, especially among children, are tragic.'' This Mount Sinai report cited previous studies that suggest that poor African-American and Latino children are suffering at higher rates because the poor often rely on care in emergency rooms, where doctors have little time to educate families on how to control the disease and where there is little follow-up care. Without receiving adequate care and medication, the asthma victims eventually suffer such severe attacks that they need immediate hospitalization.

Those are some of the reasons why I joined my colleague, Senator DURBIN, in introducing S.805, the ''Children's Asthma Relief Act.'' This bill will help ensure that children with asthma receive the care they need to live normal lives. It provides grants that will be used to develop and expand asthma services to children, equip mobile health care clinics that provide diagnosis and asthma-related health care services, educate families on asthma management, and identify and enroll uninsured children who are eligible for, but not receiving, health coverage under Medicaid or the State Children's Health Insurance Program. By requiring coordination with current children's health programs, this bill will help us identify children—in programs such as supplemental nutrition programs, Maternal and Child Health Programs, child welfare and foster care and adoption assistance programs—who are asthmatic, but might otherwise remain undiagnosed and untreated.

By increasing local asthma surveillance activities through legislation, such as S.805, and by better educating the public on the importance of asthma awareness and management through events like Asthma Awareness Day, we can help reverse the distressing increase in hospitalization rates and mortality rates due to asthma. As a person with asthma, and as the father of 3 children with asthma, I know first-hand how important diagnosis, treatment, and management are to ensuring that this manageable disease will not prevent children and adults from carrying on normal lives. We can make a big difference.

Asthma is a serious health concern that simply must be addressed.

I commend my colleague, Senator FRIST, for the outstanding children's health hearing that his Public Health Subcommittee held on September 16. A very articulate 13-year old named Robert Jackson from South Euclid, OH, testified at that hearing. He described how important early diagnosis and treatment plans are for children who suffer from asthma. According to Robert, doctors at Rainbow Babies and Children's Hospital in Cleveland explained to him how he could avoid asthma ''triggers''—like cigarette smoke and strong odors like bleach—to avoid having serious asthma attacks. By learning how to manage his asthma through an asthma treatment plan, Robert now plays sports, attends school regularly, and maintains a newspaper route.

At a time when States, like Ohio, finally are passing laws that allow students to take their asthma inhalers to school, we need to provide the federal public health dollars to the CDC for childhood asthma screening, treatment, and education. The states gradually are realizing the severity of this disease and the need for children to access their inhalers to manage their asthma. It is now time for the Federal Government to help local communities stem the rising prevalence of the worst chronic health problem affecting children.

I commend my colleagues for supporting this very important amendment as it will help the nearly 5 million children who have been diagnosed with asthma, as well as those children who suffer from asthma, but remain undiagnosed and—sadly—untreated.

AMENDMENT NO. 2287

(Purpose: To rename the Centers for Disease Control and Prevention as the Thomas R. Harkin Centers for Disease Control and Prevention)

At the appropriate place, insert the following:

SEC. (a) The Centers for Disease Control and Prevention shall hereafter be known and designated as the ''Thomas R. Harkin Centers for Disease Control and Prevention''.

(b) Effective upon the date of enactment of this Act, any reference in a law, document, record, or other paper of the United States to the ''Centers for Disease Control and Prevention'' shall be deemed to be a reference to the ''Thomas R. Harkin Centers for Disease Control and Prevention''.

(c) Nothing in this section shall be construed as prohibiting the Director of the Thomas R. Harkin Centers for Disease Control and Prevention from utilizing for official purposes the term ''CDC'' as an acronym for such Centers.

AMENDMENT NO. 2288

(Purpose: To designate the National Library of Medicine building in Bethesda, Maryland, as the ''Arlen Specter National Library of Medicine'')

At the appropriate place, insert the following:

SEC. ___. DESIGNATION OF ARLEN SPECTER NATIONAL LIBRARY OF MEDICINE.

(a) IN GENERAL.—The National Library of Medicine building (building 38) at 8600 Rockville Pike, in Bethesda, Maryland, shall be known and designated as the ''Arlen Specter National Library of Medicine''.

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the building referred to in subsection (a) shall be deemed to be a reference to the Arlen Specter National Library of Medicine.

AMENDMENT NO. 2289

(Purpose: To increase funding for senior nutrition programs and rural community facilities, offset with administrative reductions)

On page 39, line 8, strike ''$6,682,635,000'' and insert ''$6,684,635,000''.

On page 40, line 20, strike ''$928,055,000'' and insert ''$942,355,000''.

On page 41, line 14, reduce the figure by $10,300,000.

On page 62, line 23, strike ''$378,184,000'' and insert ''$372,184,000''.

AMENDMENT NO. 1852

(Purpose: To express the sense of the Senate concerning needlestick injury prevention)

At the appropriate place, insert the following:

SENSE OF THE SENATE ON PREVENTION OF NEEDLESTICK INJURIES

SEC. ___. (a) FINDINGS.—The Senate finds that—

(1) the Centers for Disease Control and Prevention reports that American health care workers report more than 800,000 needlestick and sharps injuries each year;

(2) the occurrence of needlestick injuries is believed to be widely under-reported;

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

(4) more than 80 percent of needlestick injuries can be prevented through the use of safer devices.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Senate should pass legislation that would eliminate or minimize the significant risk of needlestick injury to health care workers.

Mr. ENZI. Mr. President, I rise in opposition to Senator REID's amendment No. 1852 as offered to S. 1650. As chairman of the Senate Subcommittee on Employment, Safety and Training, I have had the opportunity to follow this issue first-hand. Make no mistake, ensuring the safety of our Nation's health

care workers is a priority—as it is for all of our Nation's workforce. How we can best capitalize on occupational safety, however, is the basis for my opposition to this amendment. I do not feel that this amendment is appropriate on a spending bill. Nor is our agreeing to future legislation—sight unseen. Moreover, the Occupational Safety and Health Administration is already examining this matter and has not commented to my request as to why legislation is now warranted.

''Sharp'' injuries by exposed needles have a long history. Not only has Senator REID been interested in occupational injuries caused by unprotected syringes, but Senator BOXER has also shared her concerns as well. As chairman of the subcommittee with jurisdiction, I am a bit disappointed that my colleagues have yet to approach me on this issue. I am always eager to discuss occupational safety with members of this body. Instead, I first learned of this issue when the San Francisco Chronicle ran a series of articles in April, 1998. One article depicted a nurse practitioner who tried to catch three blood-collection tubes as they rolled toward a counter's edge. At the same time, she held a syringe in her right hand that had just drawn blood from a patient infected with HIV. The exposed needle pierced the side of her left index finger. Working with HIV infected patients is dangerous business, but the risk compounds when medical devices designed to improve health care end up doing just the opposite.

At the request of the Service Employees International Union (SEIU) and other interested groups representing health care workers, federal OSHA announced last year that it was issuing a formal request for information pertaining to injuries caused by unprotected syringes. Senators JEFFORDS, FRIST and I wrote to Secretary Herman. We sought answers concerning potential enforcement action by OSHA with regard to medical devices that could conflict with FDA's traditional and statutory jurisdiction. The FDA is statutorily charged with the nationwide regulation of medical devices. All syringes are defined as Class II medical devices in Section 513(a)(1) of the Federal Food, Drug and Cosmetic Act. According to Sections 510(k), 519(e) and 705(a), the FDA has the statutory jurisdiction to review, approve and recall medical devices as well as to disseminate information regarding the potential health dangers caused by any medical device.

FDA's jurisdiction over medical devices pertains to the patient. Since OSHA's jurisdiction covers workers, the agency is already moving forward to modify its Bloodborne Pathogens Standard to include regulation of medical ''sharp'' devices. In terms of worker safety, we are talking about nurses, doctors and other health care professionals and workers that regularly use or handle these medical devices. The regulatory lines between the two agencies are difficult to define in this setting. Moreover, the question of reusing medical devices designed for one-time use only is also a matter that requires careful consideration. Generally speaking, safer devices cost more money—raising the potential for re-use by providers. The FDA has not yet indicated that it will begin to examine this issue, but it is certainly a matter of importance that includes the very medical devices we're debating in this amendment.

A medical device that has been determined by the FDA to meet the ''reasonable assurance of safety and efficacy'' standard of the Federal Food, Drug and Cosmetic Act can be lawfully marketed. Nonetheless, it is conceivable, given its authority over the domain of worker safety and health that OSHA might prevent the use of that medical device in the workplace, thereby creating an environment of confusion for the regulated public. This confusion could result in diminished worker safety and health and jeopardize patient safety as well. At the very least, this duplication of effort promises to waste the scarce resources of both the FDA and OSHA.

I recognize Section 4(b) of the Occupational Safety and Health Act of 1970 and the problems inherent in conflicting regulations which are promulgated by different federal agencies and affect occupational safety and health. Although OSHA arguably might have sufficient jurisdiction to proceed in the indirect regulation of the aforementioned medical devices, I feel that it would be the best course for OSHA and the FDA to delineate boundaries of jurisdiction and coordinate efforts pertaining to the regulation and use of these medical devices. This is of particular importance because the FDA has the specific scientific expertise in the evaluation of medial devices—not OSHA and not the National Institute for Occupational Safety and Health (NIOSH). Despite Secretary Herman's assurances that agency cooperation is ongoing, I am not convinced that these boundaries have been properly addressed at this time. This amendment does nothing to address the lack of communication between these agencies.

There are currently two manufacturers that are actively marketing protected syringes. If OSHA is instructed to regulate this matter by statutory instruction, I am concerned that a shortage of supply could occur. Not only does this raise questions of antitrust, it also places providers in the difficult position of being held liable for using medical devices that are short in supply. The market and what it can currently sustain would not be a matter of consideration if this amendment passes. Moreover, providers (hospitals) could be put in a position to determine what devices are safe and effective if their participation is not adequately included in this process.

As OSHA moves forward on its own accord in a fashion that could lead to its regulation of medical devices, Senator JEFFORDS and I continue to wait for a formal explanation from the agency as to how legislation would impact their current efforts to flush out many of the concerns I have raised. We are still waiting for that response. Moreover, Chairman JEFFORDS has voiced his interest in examining this issue within the authorizing committee. In doing so, we would be better positioned to address this emotional and complex issue rather than haphazardly legislating on an appropriations bill.

I am committed to finding ways to enhance worker safety. If I thought legislating through the appropriations process was such a wonderful option, I have a few bills that I wouldn't mind spending a little time debating on the floor of the Senate. In terms of improving occupational safety, I respect the role of our committee to examine these complex issues. Last Congress, I had the opportunity to amend the Occupational Safety and Health Act of 1970 three separate times. That was the first time the Act had been amended in 28 years. All of the bills were carefully considered prior to passage and not one of them were tagged to an appropriations bill. I ask that this issue be handled by its authorizing committee and not be attached to the underlying bill. I am committed to doing just that.

AMENDMENT NO. 1869

(Purpose: To increase funding for the leveraging educational assistance partnership program)

At the end of title III, add the following:

LEVERAGING EDUCATIONAL ASSISTANCE PARTNERSHIP PROGRAM

SEC. . (a) IN GENERAL.—Notwithstanding any other provision of this title, amounts appropriated in this title to carry out the leveraging educational assistance partnership program under section 407 of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) shall be increased by $50,000,000, and these additional funds shall become available on October 1, 2000.

Mr. REED. Mr. President, I am pleased that Chairman SPECTER and Ranking Member HARKIN as part of the managers amendment have included an additional $50 million for the Leveraging Educational Assistance Partnership (LEAP) program.

I had offered an amendment to provide this level of funding along with Senators COLLINS, GORDON SMITH, SNOWE, JEFFORDS, KENNEDY, MURRAY, LEVIN, CONRAD, HUTCHINSON, DEWINE, CHAFEE, BINGAMAN, KERRY, FEINGOLD, and LAUTENBERG.

Since 1972, the Federal-State partnership now embodied by LEAP, with modest federal support, has helped states leverage grant aid to needy undergraduate and graduate students.

When this program was funded at greater than $25 million, nearly 700,000 students across the nation, including almost 12,000 students from my home state of Rhode Island, benefitted from LEAP grants. At $25 million, the amount included in the Committee's

original bill, we estimate that many of these students lose their grants.

Without this important federal incentive, many states would not have established or maintained their need-based financial aid programs, and many students would not have attended or completed college.

Indeed, as my colleagues, students, parents, and those involved in higher education know, the purchasing power of our main need-based aid program—the Pell Grant, created by and named for my predecessor, Senator Claiborne Pell—has fallen drastically in comparison to inflation and skyrocketing education costs.

Students have searched for other sources of need-based higher education grants and have come to rely on LEAP.

Two years ago, this program was on the brink of elimination. But it was this body which recognized the importance of LEAP and overwhelmingly voted—84 to 4—for an amendment I offered with my colleague from Maine, Senator COLLINS, to save it from elimination.

Then, just last year, the Senate reaffirmed its support for LEAP by approving the Higher Education Act Amendments of 1998, which updated and added several key reforms to this program to leverage additional state dollars for grant aid.

Prior to the reforms, federal funding for LEAP was matched by the states only on a dollar for dollar basis. Now, every dollar appropriated over the $30 million level leverages two new state dollars.

States in turn gain new flexibility to use these funds to provide a broader array of higher education assistance to needy students, such as increasing grant amounts or carrying out community service work-study activities; early intervention, mentorship, and career education programs; secondary to postsecondary education transition programs; scholarship programs for students wishing to enter the teaching profession; and financial aid programs for students wishing to enter careers in information technology or other fields of study determined by the state to be critical to the state's workforce needs.

The $25 million included in the Committee's bill falls far short of the funding level necessary to increase student aid and trigger the reforms included in the Higher Education Act Amendments of 1998.

In fact, LEAP, if funded at $75 million, as called for in our amendment, would leverage at least $120 million in new state funding—thereby securing almost $200 million in grant aid for our nation's neediest students.

Let me emphasize, LEAP is the only federal aid program that contains this leveraging component. It is the only program for needy college students that is a state-federal partnership.

The bill does provide increased funding for many of the other student aid programs, but without providing additional funding for LEAP, the Senate will miss an opportunity to expand access to college and make higher education more affordable for some of our neediest students.

LEAP is a vital part of our student aid package, which includes Pell Grants, Work Study, and SEOG, that make it possible for deserving students to achieve their higher education goals. All of the student aid programs must be well-funded if they are truly going to help students.

Moreover, since there are no federal administrative costs connected with LEAP, all grant funds go directly to students, making it one of the most efficient federal financial aid programs.

All higher education and student groups support $75 million in funding for LEAP, including the American Council on Education (ACE), the National Association of Independent Colleges and Universities (NAICU), the National Association of State Student Grant and Aid Programs (NASSGAP), the United States Student Association (USSA), and the U.S. Public Interest Research Group (USPIRG).

By providing $75 million for LEAP, the Senate has an opportunity to help states leverage even more dollars to help students go to college. As college costs continue to grow, and as the grant-loan imbalance continues to widen—just 25 years ago, 80% of student aid came in the form of grants and 20% in the form of loans; now the opposite is true—funding for LEAP is more important than ever.

I thank Chairman SPECTER and ranking member HARKIN for their willingness to accept this amendment. I look forward to working with them during the Conference to retain this level of funding, which is critical to providing greater access to higher education for our Nation's neediest students.

Mr. JEFFORDS. Mr. President, I express my appreciation to Senators SPECTER and HARKIN for including in the manager's package an amendment cosponsored by my colleague from Rhode Island, Senator REED, myself and others increasing funding for the LEAP program.

LEAP is an extraordinarily program that provides grant aid to needy undergraduate and graduate students. This federal program can be credited in large part with encouraging States to create, maintain and grow their own need-based financial aid programs. It is a program that relies on a partnership for its strength by matching the federal investment in grant aid with State dollars. The end result is a good one: increasing the pool of funds available to assist low income students who are struggling to pay for college.

As part of the 1998 Higher Education Amendments, we made significant changes to the LEAP program with the goal of making additional grant aid and a greater array of services available to post-secondary students. We challenged States to increase the match that they contribute by offering $2 for every one federal dollar that we make available for this program. With the additional funds, States will have greater flexibility to provide more services to meet the diverse needs of low income students who are working to make the dream of a higher education degree a reality.

I am proud to stand with the National Association of State Student Grant Aid, NASSGAP; the National Association of Independent Colleges and Universities, NAICU, the American Council on Education, ACE, the American Association of State Colleges and Universities, AASCU; the United States Public Interest Research Group, USPIRG; and the United States Student Association, USSA in support of this amendment that I believe will provide significant assistance to the students of this nation.

AMENDMENT NO. 1882

(Purpose: To express the sense of the Senate regarding comprehensive education reform)

At the appropriate place, insert:

SEC. , SENSE OF THE SENATE REGARDING COMPREHENSIVE PUBLIC EDUCATION REFORM.

(a) FINDINGS.—The Senate finds the following:

(1) Recent scientific evidence demonstrates that enhancing children's physical, social, emotional, and intellectual development before the age of six results in tremendous benefits throughout life.

(2) Successful schools are led by well-trained, highly qualified principals, but many principals do not get the training that the principals need in management skills to ensure their school provides an excellent education for every child.

(3) Good teachers are a crucial catalyst to quality education, but one in four new teachers do not meet state certification requirements; each year more than 50,000 under-prepared teachers enter the classroom; and 12 percent of new teachers have had no teacher training at all.

(4) Public school choice is a driving force behind reform and is vital to increasing accountability and improving low-performing schools.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the federal government should support state and local educational agencies engaged in comprehensive reform of their public education system and that any education reform should include at least the following principals:

(A) that every child should begin school ready to learn by providing the resources to expand existing programs, such as Even Start and Head Start;

(B) that training and development for principals and teachers should be a priority;

(C) that public school choice should be encouraged to increase options for students; and

(D) that support should be given to communities to develop additional counseling opportunities for at-risk students.

(E) school boards, administrators, principals, parents, teachers, and students must be accountable for the success of the public education system and corrective action in underachieving schools must be taken.

Mr. KERRY. Mr. President, I thank my distinguished colleagues, Mr. SPECTER from the State of Pennsylvania and Mr. HARKIN from the State of Iowa, for accepting in the manager's amendment of S. 1650 the sense of the Senate that my friend from Oregon, Mr. SMITH

and I offered on comprehensive education reform. Our amendment expresses the sense of the Senate that the federal government should support state and local efforts to reform and improve our nation's public schools, and further, that every child should begin school ready to learn; that training and development for principals and teachers should be a priority; that public school choice should be encouraged to increase options for students; that support should be given to communities to develop additional counseling opportunities for at-risk students; and that school boards, administrators, principals, parents, teachers, and students must be accountable for the success of the public education system.

I appreciate that my distinguished colleagues have acknowledged the importance of a bipartisan, comprehensive approach to reforming the public education system that emphasizes the principles enumerated above. If education reform is to succeed in America's public schools, we must demand nothing less than a comprehensive reform effort. We cannot address only one challenge in education and ignore the rest. We must make available the tools for real comprehensive reform so that every aspect of public education functions better and every element of our system is stronger. We must empower low-performing schools to adopt all the best practices of our nation's best schools—public, private, charter or parochial. We must give every school the chance to quickly and easily put in place the best of what works in any other school—and with decentralized control, site-based management, parental engagement, and real accountability. Numerous high-performance school designs have been created such as the Modern Red Schoolhouse program and the Success for All program. The results of extensive evaluations of these programs have shown that these designs are successful in raising student achievement.

We must also restore accountability in public education—demanding that each school embracing comprehensive reform set tangible, measurable results to gauge their success in raising student achievement. We must reward schools which meet high standards and demand that those which fall short of their goals take immediate corrective action—but the setting of high standards must undergird comprehensive reform.

In order to do this, we must break out of the ideological bind we have put ourselves in. We cannot only talk about education—it's more than an issue for an election—we must do something about it. We have the opportunity to implement comprehensive education reform at a time when the American people are telling us that—for their families, for their futures—in every poll of public opinion, in every survey of national priorities, one issue matters most, and it's education. That is good news for all of us who care about education, who care about our kids. But the bad news is, the American people are not so sure that we know how to meet their needs anymore. They are not even sure we know how to listen. Every morning, more and more parents—rich, middle class, and even the poor—are driving their sons and daughters to parochial and private schools where they believe there will be more discipline, more standards, and more opportunity. Families are enrolling their children in Charter schools, paying for private schools when they can afford them, or even resorting to home schooling—the largest growth area in American education.

Earlier in this debate, I supported two amendments offered by the distinguished Senator and my senior colleague from the State of Massachusetts, Mr. KENNEDY. I am deeply disappointed that neither of these worthy amendments were adopted by the Senate. Mr. KENNEDY's amendments would have exempted education from the across the board cuts in discretionary spending that Republicans have proposed and provided increased funding for teacher quality. We know the American people are willing to spend more on public education. Yet the Senate voted to allow cuts. And we know that the American people want qualified teachers in their children's schools. Yet the Senate did not appropriate the fully authorized level of the Teacher Quality Enhancement Grants program.

I am also distressed that an amendment offered by my distinguished colleagues, Mr. BINGAMAN and Mr. REED, and myself was not adopted by this body. Our amendment would have, for the first time, provided real accountability to poor children and ensure they attend successful schools. The American people have said time and again that education is their top policy concern. And we have heard time and again that the American people want their public schools held accountable. Yet we rejected this important amendment, that would have appropriated no new funding and would have ensured low-performing schools would be turned around, was rejected.

Given our inability to pass these important amendments, I am particularly pleased that Mr. SMITH and I could come together and offer this bipartisan amendment. The sense of the Senate we offered is the essence of our bill, S. 824, the ''Comprehensive School Improvement and Accountability Act.'' Our bill emphasizes the principles embodied in this sense of the Senate, such as early childhood development programs, challenge grants for professional development of principals, second chance schools for violent and disruptive students, and increased funding for the Title I program. We contend that these and other tenets are fundamental to the comprehensive reform of public schools.

The PRESIDING OFFICER. Without objection, the amendments are agreed to.

The amendments (Nos. 2273 through 2289, 1852, 1869, and 1882) were agreed to.

INDIAN-CHICANO HEALTH CENTER

Mr. KERREY. I thank the Chairman and Ranking Member of the Subcommittee for their continued support for community health centers and other programs within the consolidated health centers account. I firmly believe that these centers represent the best investment the Federal government can make in health care for under-served populations and under-served areas. These centers provide an invaluable service to our communities and our citizens—they provide comprehensive primary and preventive services to a broad spectrum of persons without health insurance and members of under-served populations. I note that the bill before us increases funding for these centers by nearly $100 million, and exceeds the President's request by $79 million.

It is my hope that the Department of Health and Human Services will use at least part of this new funding to establish new community health centers to address the needs of under-served populations. I am particularly interested in guaranteeing that a proposal from the Indian-Chicano Health Center of Omaha, Nebraska, be fully and fairly considered during any review of new health center applications. This organization has made an extraordinary effort to serve a unique community of low-income, uninsured Nebraskans who otherwise would go without health care.

Mr. SPECTER. The Labor/HHS/Education Subcommittee made a particular effort within the constraints of this bill to increase funding for the consolidated health centers account. The Subcommittee strongly supports the provision of comprehensive health services to persons without health insurance through these important providers. I am pleased that we were able to increase funding for these critical services, and I encourage HHS to consider the proposal from the Indian-Chicano Health Center.

Mr. HARKIN. I have long supported the work of the Iowa-Nebraska Primary Care Association and specific community health centers in the Midwest. These providers serve as models for effectively and efficiently providing access and quality care to under-served populations. I will also support full and fair consideration of the Indian-Chicano Health Center proposal.

THE MARYLAND CHILDREN'S HEALTH INSURANCE PROGRAM

Mr. SARBANES. Mr. President, as the Senate continues its consideration of the Labor-HHS Appropriations bill today, I rise to discuss a problem the State of Maryland is struggling to overcome as it seeks to extend health care coverage to the 158,000 uninsured children in our State. This issue is particularly timely in light of the Census

Bureau report issued earlier this week which shows that the ranks of the uninsured grew by approximately 1 million in 1998 to a total of 44.3 million. The Census report also shows that the number of uninsured children has not decreased despite the establishment of a new Federal program designed to encourage States to expand health insurance coverage to more low-income children. Moreover, Maryland experienced one of the highest increases in uninsured people last year bringing the total number of uninsured to 837,000 or one-sixth of the population. A quarter of these uninsured Marylanders are children.

To address the growing number of uninsured children throughout the United States, Congress enacted the Children's Health Insurance Program (CHIP) in 1997, and Maryland eagerly applied to participate in this new Federal-State partnership. However, over the past couple of years, Maryland has been penalized under this program for having previously extended partial Medicaid coverage under a five year demonstration program to a class of low-income children who would not otherwise have qualified for Medicaid. These children should now be eligible for CHIP funding, but the Department of Health and Human Services (HHS) is blocking Maryland from accessing its CHIP funds for the benefit of these kids.

The law establishing the CHIP program prohibits the States from enrolling children into the State's CHIP program if those children were previously covered by the State's Medicaid program. HHS has made the decision to treat all children once eligible for the Maryland demonstration program, called the Maryland Kids Count program, as though they were covered under Medicaid. As a result of this discretionary decision by HHS, the majority of Maryland's uninsured children are ineligible for CHIP funding. In addition, Maryland has been unable to access most of the CHIP funding allocated to it.

The Maryland demonstration program should not be used to disqualify the State from accessing its CHIP funds because this demonstration cannot be equated with covering this group of children with full Medicaid coverage. The Maryland demonstration offered only partial Medicaid benefits (primary and preventive care). Hospitalization as well as dental and medical equipment were not covered. Thus, for each child in the demonstration program, Maryland spent less than half the amount it would have spent had Medicaid been extended to these children.

In addition, this demonstration program was conducted under a time-limited waiver which was scheduled to expire at about the same time the CHIP program was launched. In fact, HHS informed Maryland that it would not renew the waiver because Congress was establishing a more comprehensive children's insurance program and also because the Maryland demonstration had been rather unsuccessful. Only 5,000 children were enrolled, largely because the benefits offered were so limited.

HHS has used its discretionary authority in implementing the CHIP program to equate the Maryland demonstration program with full Medicaid coverage. Since they used discretionary authority to make this erroneous determination, HHS clearly has the authority to reverse this decision administratively. Would the Senator from Delaware, the Chairman of the Finance Committee, agree that the Department of Health and Human Services has authority to allow Maryland to access its CHIP funds to extend health insurance coverage to those low-income children previously eligible for the Maryland Kids Count demonstration program without additional legislative action?

Mr. ROTH. I understand the Senator from Maryland's concerns. It is my view that the Secretary of Health and Human Services has authority, without additional legislative direction, to determine that children who had been covered under Maryland's expired, limited-benefit demonstration program were not receiving true Title XIX coverage, and could therefore be considered uninsured for the purposes of CHIP eligibility.

Mr. SARBANES. I thank the Chairman for that clarification. Do you agree that HHS may use its section 1115 waiver authority to allow Maryland to use its CHIP funds to cover those children previously eligible for the Maryland Kids Count program?

Mr. ROTH. I concur with the Senior Senator from Maryland that HHS could use its section 1115 waiver authority to address Maryland's concerns.

Mr. SARBANES. Thank you, Mr. Chairman.

DANIEL J. EVANS SCHOOL OF PUBLIC AFFAIRS

Mr. GORTON. Mr. President, the current political climate in our society is becoming increasingly disillusioned and thus less involved in public life and civil discourse. More than ever, we need public servants who combine vision, integrity, compassion, analytic rigor and practicality. As the first school of public affairs at a public university, the Graduate School of Public Affairs at the University of Washington has trained public servants and leaders in the Northwest for 37 years. The school's mission is motivating a new generation towards excellence in public and non-profit service and restoring the confidence, involvement and investment in public service.

Recently, the school was renamed for Daniel J. Evans, a longtime public servant for the people of Washington state who embodies the Graduate School of Public Affairs focus and values. As a governor, U.S. Senator and regent for the University of Washington, Dan Evans has stood for effective, responsible, balanced leadership. His public service legacy has touched so many citizens and has greatly impacted the state of Washington. Dan Evans' involvement in the Graduate School of Public Affairs will provide students the opportunity to learn from someone who represents effective, responsible and balanced leadership and who embodies the school's ideals.

The Graduate School of Public Affairs at the University of Washington has played a vital role in public policy and management and is now positioned to become the region's primary source of expertise and outreach on public issues. I have strongly endorsed these efforts and believe it is worthy of our support and investment.

Mr. SPECTER. There certainly is a need for additional leaders in public service. I appreciate the opportunity to learn about the work at the University of Washington and will take a close look at this worthwhile project during the conference with the House.

Mr. GORTON. I appreciate your commitment to developing highly skilled, principled individuals dedicated to service and leadership.

MEDICARE CONTRACTORS

Mr. CRAIG. I am concerned about the funding level for Medicare contractors. The Senate Committee mark reduced the FY 2000 funding level by $30 million below the President's Budget recommendation. I want to be sure that this funding reduction will not adversely impact fee-for-service claims processing activities or the ability of contractors to provide critical beneficiary and providers services.

In the recent past, we have seen the effect that inadequate funding levels can have on services. In 1998 payments were slowed down, and beneficiaries and providers were forced to deal with more voice mail rather than human beings when they called their contractors with questions about claims.

Looking only at numbers, I see funding $21 million less than FY 1999 and $30 million less than the President's request. However, I understand this funding level reflects $30 million in savings from changes in the processing of dates. Therefore, am I correct in saying this would reflect efficiency and technological improvement, not a policy change in fee-for-service claims processing or beneficiaries and provider services? Furthermore, this $30 million in savings should not result in decreased funding to services for beneficiaries or providers, should it?

Mr. DORGAN. I want to make it clear that funding to assure the timely and accurate processing of Medicare claims also is a high priority for me and the beneficiaries in my state.

I also would like a reassurance that the mark will not affect access to health care services in rural America.

Mr. SPECTER. The Senators have correctly described the Committee's intent. These savings would be realized as a result of a change in direction by HCFA for a managed care related project, and is not at all related to fee-

for-service Medicare. I understand the Senators' concerns and want to assure them Medicare contractor services will not be harmed. These savings of $30 million for HCFA's managed care project will not result in any related funding cut to the Medicare contractor budget.

I understand the issues both Senators are raising and the importance of adequately funding the Medicare contractor program. Let me assure my colleagues that the savings reflected in this bill will not hamper Medicare contractors' ability to fulfill their responsibilities as Medicare administrators.

PARKINSON'S RESEARCH

Mr. COCHRAN. Mr. President, I want to thank the Chairman for his strong leadership and support for the medical research in our nation. I strongly support his efforts to double funding for the National Institutes of Health, and I am heartened by the increases in this bill. I also want to thank him for his leadership in increasing funding for Parkinson's research and holding the September 28, 1999, hearing on the promise of Parkinson's research and the need for increased funding. Michael J. Fox put it best when he said that ''this is a winnable war'' as long as the funding is there to match the scientific promise.

Mr. SPECTER. Mr. President, that's right. Dr. Fischbach testified that he sincerely believes that we are close to solving Parkinson's. The scientific research community believes that it is realistic to think that we will conquer Parkinson's in 5 to 10 years. Dr. William Langston, President of the Parkinson's Institute told the Subcommittee at the hearing that we have an historic opportunity with Parkinson's because the research is at a point where a focused, adequately funded effort will produce a cure. He also testified that once we understand and unravel Parkinson's, we will have answers to many other neurodegenerative diseases such as Alzheimer's and Lou Gehrig's disease.

Mr. WELLSTONE. Mr. President, the Parkinson's hearing was great news for all those who suffer from this disease. The advocacy community was well-represented by actor Michael J. Fox, Joan Samuelson—President of the Parkinson's Action Network, and Jim Cordy—a Parkinson's advocate from Pennsylvania. Their personal stories underscore the need for Congress to ensure that there is increased funding for Parkinson's research. Parkinson's is the most curable neurological disorder and the one most likely to produce a breakthrough. Congress passed the Morris K. Udall Research Act, making clear that Parkinson's should receive the funding it needs to eradicate this truly dreadful disease. Now it is time to fulfill that promise.

Mr. COCHRAN. Mr. President, I agree. At the hearing, we were asked to increase funding for Parkinson's research $75 million over current funding levels by increasing funding levels at two institutes, the National Institute of Neurological Disorders and Stroke (NINDS) and the National Institute of Environmental Health Sciences (NIEHS), at $50 million and $25 million respectively. The research community thinks that this will provide enough funding to quicken seriously the pace of research on Parkinson's—a down payment, if you will—on a fully funded Parkinson's research agenda that scientific experts in the community conservatively estimate to be over $200 million. I believe NIH should be able to do this from the funds provided in our bill.

Mr. SPECTER. Mr. President, as I said at the hearing, I think the scientific community can find a cure in even less time, as few as 2 to 4 years, if they have the resources. With the overall $2 billion increase in NIH funding provided in this bill, those institutes will have sufficient funds to provide the increases to Parkinson's focused research.

Mr. HARKIN. As Ranking Member of the Subcommittee I want to express my strong support for substantially increasing NIH support for Parkinson's research. We have a tremendous opportunity for real break through in the fight against this horrible disease and we cannot pass that up.

YOUTH LEADERSHIP INITIATIVE

Mr. WARNER. Mr. President, I have a second degree amendment to Senator DEWINE's amendment on higher education, amendment No. 1847.

Senator SPECTER, Senator HARKIN and my other distinguished colleagues on the Labor, Health and Human Services, Education Subcommittee certainly have your work cut out in crafting S. 1650, the Labor-HHS appropriations bill. The subcommittee was faced with a difficult task of appropriating limited funds to hundreds of programs.

I commend the subcommittee for its hard work and for its dedication to education funding. This bill provides $37.6 billion for the Department of Education. This amount is more than $2 billion above fiscal year 1999 levels and $537 million above the Administration's request.

Of this $37.6 billion, the committee bill provides over $139.5 million for the fund for the improvement of education. This amount is $500,000 over fiscal year 1999 appropriations. These funds are provided to support significant programs and projects to improve the quality of education, help students meet high academic standards and contribute to the achievement of educational goals.

During the appropriations process, Senator SPECTER, I submitted a letter requesting that the subcommittee provide $1.5 million in funds for an innovative educational program known as the Youth Leadership Initiative (''YLI'') at the University of Virginia. I am thankful for the subcommittee's consideration of my request and am grateful that the subcommittee recognized the importance of YLI by including report language on this invaluable educational program.

The goal of YLI is to work with America's middle and high school students to prepare them for a lifetime of political participation. YLI seeks to transform the way students view their role in our democracy, develop their trust in and awareness of our system, and instill in our students the core values of good citizenship and democracy.

To achieve its goal, YLI teaches students in the functional components of America's political process. Among other things, YLI students will learn how to run student-forged mock campaigns, organize political events, conduct election analysis, and hold mock elections.

Senator SPECTER, these lessons need to be taught and are of paramount importance. In 1998, voter participation during the mid-term Congressional elections was the lowest since 1942. Almost every survey of public opinion shows growing disinterest in the American electoral process, and disinterest is strongest among our young people.

Thomas Jefferson once warned Americans about the ramifications of such disinterest in our political system, stating, ''Lethargy is the forerunner of death to other public liberty.'' America's form of government is uniquely dependent upon the active participation of its citizens. Therefore, if voter participation continues to decrease, then our democracy will suffer.

By combining academic excellence with hands-on civic activity, YLI will help turn our schools and communities into hotbeds for the rejuvenation of our democracy. Since its launch last spring, YLI has attracted national attention for its unique approach to teaching our young people about democracy. In a pilot program currently in progress in several Virginia communities, thousands of students in hundreds of classrooms are experiencing the wonders of this pioneering program. Students and teachers have participated in YLI training sessions and members of the inaugural class of youth leaders are already hard at work organizing public debates between actual legislative candidates which they will host in the coming weeks.

On Tuesday, October 26, 1999, nearly 35,000 middle and high school students will be eligible to participate in the largest internet ballot ever conducted. On this day, YLI students will be voting on-line using a secure, encrypted state-of-the-art ''cyber-ballot'' that is specifically tailored to each student's voting precinct.

These achievements are only the beginning. YLI is a national crusade. This year's pilot program in Virginia is laying the foundation for next year's expansion throughout Virginia. Plans are already underway to make this program available to every middle and high school in the United States soon after the 2000 elections.

YLI already has the financial support of the Commonwealth of Virginia and

many of America's leading corporations, foundations and individuals. YLI is a model public-private partnership that will make available to all Americans students a program which will increase participation in our democracy for future generations. Senator SPECTER, a small investment today will pay dividends for many generations to come.

Again, I say to the Senator from Pennsylvania, I certainly understand the difficult task facing your subcommittee in crafting a bipartisan, fiscally responsible appropriations bill. I know you recognize the importance of YLI and that's why report language was included in the Committee's report. I ask my distinguished colleague, however, to ensure that YLI receives the requested funding in the eventual bill that emerges from conference.

Mr. SPECTER. I thank my distinguished colleague for his kind remarks and for his strong statement in support of the Youth Leadership Initiative. The Youth Leadership Initiative is certainly an innovative program designed to enhance public participation in our democracy. I share the goal of enhancing participation in our democracy, and I recognize that this is a priority for the senior senator from Virginia. As we conference with the House, I will keep in mind that this project helps us achieve our mutual goal of increasing voter participation in our democracy.

Mr. WARNER. Thank you Senator SPECTER for your support of YLI.

STAR SCHOOLS GRANTS

Mr. BENNETT. Mr. President, there has been some uncertainty in my state about the continuation of Star School grants. For my colleagues who are not familiar with Star Schools, it is a grant program that has helped distance learning move forward in many parts of the country. The beneficiaries in my state include many students in the San Juan school district, a small, rural, and remote school district in southeastern Utah. Many Star School grants have been awarded to the winners of a competition. Often these grants are multi-year grants. Some recipients are fearful about losing funding for the continuation of their grants if new projects are funded. Is it the intent of the chairman that continuing grants will receive a high priority in funding allocations?

Mr. SPECTER. It was my intent to include enough funding in this bill to continue grants that have been awarded if at all possible. I believe the amount recommended by the Senate will provide the means to do so. While I do not know what the conference committee's final recommendation will be for Star Schools, it is my desire that there be enough dollars allocated to fund ongoing grants as planned.

Mr. BENNETT. I thank the chairman for clarifying his intent, and for his efforts to provide adequate funding for these projects.

HEARTLAND MANOR

Mr. LEVIN. Mr. President, Senator ABRAHAM and I have come to the floor to seek assurance from Senator ROTH and Senator SPECTER that they will include our amendment concerning Heartland Manor in any Medicare BBA fix bill that is taken up by the Finance Committee.

Mr. SPECTER. I understand the Finance Committee will be working on a Medicare BBA repair bill and will review this amendment for possible inclusion in any such legislation and I believe he will give you such assurance directly.

Mr. LEVIN. I appreciate the assurance that the Senator from Pennsylvania has given on this issue. I would like to ask the Chairman of the Finance Committee, Senator ROTH, will he review our amendment for possible inclusion in any Medicare BBA legislation that he takes up this year?

Mr. ROTH. Yes, we will review the amendment through the committee process to determine inclusion in any Medicare BBA package that the Finance Committee takes up this year. I recognize how important this amendment is to the Senators from Michigan.

Mr. LEVIN. I thank Senators ROTH and SPECTER for their help in this matter and I look forward to working with Senator ROTH as we move forward with this amendment.

Mr. ABRAHAM. I also thank Senators ROTH and SPECTER for their help and appreciate their assurances.

Mr. LEVIN. I would like to describe this amendment and why it is so necessary. Our amendment concerns Heartland Manor, a nursing home located in Flint, Michigan, that provides care to an underserved population. Heartland Manor is not out to make money—it is owned by the Hurley Foundation which is not for profit 501(c)(3) subsidiary of Hurley Medical Center. Hurley Medical Center is a not for profit public hospital with an excellent reputation. Hurley Medical Center is one of the few city owned hospitals left in the country, and it is the largest hospital in Flint, Michigan.

On July 27, 1989, Chateau Gardens, a privately owned nursing home facility, was terminated from the Medicare program. On January 1, 1994, Hurley Foundation, a not for profit 501(c)(3) subsidiary of Hurley Medical Center, purchased Chateau Gardens at the request of the state. In 1994 Heartland Manor applied for certification into the Medicare program as a new or prospective provider. Heartland Manor had never before entered into a Medicare participation agreement and had never been issued a provider number. However, HCFA treated Heartland as a re-entry provider and Heartland was subsequently denied participation into the Medicare program based in large part on violations which HCFA carried over from Chateau Gardens, the previous owner. If Heartland Manor had been treated as a new provider, it would have been approved and would presently be in the Medicare program.

This amendment would allow the facility to come into the Medicare program as a prospective provider which is exactly how the facility should be treated.

Heartland Manor has the backing of Citizens for Better Care, a nonprofit agency, funded by the United Way, which monitors nursing home care in Michigan. Moreover, the Mayor of Flint, Woodrow Stanley, the Congressman representing Flint, Representative DALE KILDEE, and State Senator BOB EMERSON all want to keep this nursing home open. These organizations and I wouldn't all be supportive of the facility if this nursing home were not meeting the needs of the Flint community.

I have visited Heartland manor and I believe that it should not be closed. I would not make such a bold assertion if I could not honestly say that this is a nursing home that has made great strides in recent years and which is now providing an important service to the Flint community.

Mr. President, I look forward to working with my colleagues to ensure that this amendment is part of any Medicare BBA package.

DENTAL SEALANTS

Mr. BINGAMAN. I rise today in strong support of the use of dental sealants for children for purposes of oral health promotion and disease prevention. They have been proven to be safe and effective in the prevention of dental caries in children, and when coupled with fluoridated water systems can virtually eliminate dental decay and reduce tooth loss. I believe that the most successful dental sealant programs for our children covered in the EPSDT programs in Medicaid could be those that are school linked and community based. Analyses show that an amount of $1,000,000 is a reasonable amount to begin a demonstration project such as this.

Mr. HARKIN. I am pleased that the Labor HHS Appropriations bill contains language to provide for a multistate dental sealant demonstration project. I feel that the Maternal Child Health Bureau of the Health Resources and Services Administration will be the most appropriate entity to conduct a quality demonstration program. I concur with the Senator from New Mexico that this amount seems reasonable.

Mr. SPECTER. I thank my colleague from New Mexico for raising this important public health matter. Prevention is a high priority for our subcommittee as we have invested significant amounts of resources in bolstering the agencies of the U.S. Public Health Service. The amount the Senator suggests is reasonable for a demonstration project and I concur that the Maternal Child Health Bureau of the Health Resources and Services Administration is an appropriate agency to conduct a quality demonstration program.

Mr. BINGAMAN. I thank the Senators from Pennsylvania and Iowa and urge the department to conduct the demonstration project in an expeditious manner. Despite the fact that

dental sealants have been available for over 25 years, their use remains low and children deserve this preventive service.

PEDIATRIC RESEARCH INITIATIVE

Mr. DEWINE. Mr. President, I rise to thank my colleague from Pennsylvania, Senator SPECTER, and his subcommittee, for the tremendous job they have done in putting together this $312 billion bill. It is not easy to work within tight budget caps and fund so many agencies and institutes at levels that will make all members—and constituents—happy. I'd like to take this opportunity to especially thank Senator SPECTER for his hard work and dedication in providing start-up funding for the Ricky Ray Fund. Even though we would have all liked to have seen full funding, I realize that Senator SPECTER and his subcommittee performed a monumental task in funding $50 million to make the Ricky Ray Fund a reality. I look forward to working with my colleagues next year to finish the job we are beginning in this appropriations bill and fund the remaining amounts for the Ricky Ray Fund that we authorized last year.

As for the appropriations bill that is before us, I would like to ask my colleague from Pennsylvania, Senator SPECTER, to clarify the ''Pediatric Research Initiative'' provision that is on page 138 of the Committee Report. It is my understanding that the Report should state that the ''Committee further encourages the Director of NIH to expand extramural research directly related to the illnesses and conditions affecting children.'' The Report currently states that the National Institute of Child Health and Human Development (NICHD) should expand extramural research, but it should state that the Committee encourages the Director of NIH to expand extramural pediatric research—is that correct?

Mr. SPECTER. Yes, that is correct. The Office of the Director currently funds the Pediatric Research Initiative at NIH, and we are encouraging the Director to expand extramural pediatric research.

Mr. DEWINE. The Committee Report also currently states that the Committee also encourages the Institute to provide additional support for institutional and individual research training grants for medical schools' departments of pediatrics. It is my sense that the Report should state that the Committee encourages the NICHD to provide additional support for institutional and individual research training grants for medical schools' departments of pediatrics. Is that correct?

Mr. SPECTER. Yes, my colleague is correct. The NICHD supports such pediatric research training grants, and the Committee is encouraging NICHD to expand its support for such pediatric research training grants. I will work to ensure that the Conference Report for this bill accurately reflects these clarifications, which my colleague from Ohio and I have just discussed.

Mr. DEWINE. Again, I thank my friend from Pennsylvania for his clarifications and for his tremendous effort in increasing the funds for NIH to ensure that medical research, including pediatric research, remains a top priority for our country.

TREATMENT OF CHILD AND ADOLESCENT VIOLENCE RELATED TRAUMA

Mr. KENNEDY. As you know, it is well documented that domestic, school, and community violence survived or witnessed by children and adolescents causes psychological trauma with very real and serious consequences. These consequences can be physical (changes in the brain, delayed development), psychological (anxiety, depression, learning difficulty), or interpersonal (aggressive and violent behavior, affected individuals passing on the problems to their children). Fortunately, there is a growing body of knowledge that attests to the effectiveness of treating this psychological trauma. While the course of treatment may vary depending on the type of trauma, the length of exposure, and the age of the child, it undoubtedly requires staff with the specialized training needed to identify the signs and symptoms of trauma, and to provide the appropriate therapeutic interventions. In the wake of the violent tragedies in schools, community centers, churches, and increasingly in communities and homes across this country, the desperate need to develop this specialized expertise and to make it more widely available could not be clearer.

Mr. STEVENS. I could not agree more with my friend from Massachusetts and I have been pleased to work with him on this vitally important issue. Research has shown that children exposed to negative brain stimulation in the form of physical abuse or community violence causes the brain to be miswired making it difficult for the child to learn, develop healthy family relationships, reduce peer pressure, and to control violent impulses. Early intervention and treatment is much more successful than adult rehabilitation. This certainly points to a need for more early intervention and treatment programs for children and adolescents who suffer from violence related trauma. It also highlights the need for more professional training in the best practices for treating this psychological trauma.

Mr. KENNEDY. I appreciate the remarks from my friend from Alaska and thank him for his interest in children and in child development. I would also like to thank my friend from Pennsylvania, the Chairman of the Labor-HHS-Education Sub-Committee, for his longstanding commitment to children. I understand that bill before us includes $10 million for the creation of national centers of excellence on youth violence. I also understand that a key aspect of these centers is going to be the development of effective treatments for violence related psychological trauma in children, youth, and families, and the provision of training and technical assistance needed to make these best practices more widely available. Is that the Sub-Committee Chairman's understanding.

Mr. SPECTER. Yes it is. My friend from Massachusetts has identified a critically important need and this activity is intended to be an integral function of these centers of excellence.

Mr. STEVENS. I have worked closely on this with both the Sub-Committee Chairman and Senator from Massachusetts, and this is certainly my understanding as well.

Mr. KENNEDY. I thank both the Full Committee Chairman and the Sub-Committee Chairman for that clarification, and I hope that as we move forward with this process, should additional funding become available, that it could be targeted to this effort. I thank my colleagues and I yield the floor.

GENDER-BASED DIGESTIVE DISEASES

Mr. REID. I rise today to address an issue of great concern to me. I was recently made aware of the findings contained in a recent report from the Office of Research on Women's Health (ORWH) regarding gender-based differences in digestive diseases. The report identifies irritable bowel syndrome, functional bowel disorder and colorectal cancer treatment and detection as serious health problems that disproportionately affect women.

Mr. SPECTER. I am aware of this report and also am very concerned about gender based differences in digestive diseases.

Mr. REID. The ORWH report recommends that Federal research efforts focus on the need to: (1) develop a better understanding of the mechanisms of gastrointestinal motility and altered sensitivity to sensory dysfunction that will help explain why irritable bowel syndrome so disproportionately affects women more than men; (2) examine the relationship between hereditary colon cancer and gynecologic malignancy in women; and (3) determine the relationship between functional bowel diseases and pelvic floor dysfunction. As a result of these findings and recommendations, I hope that the Office on Women's Health will work with NIDDK to address these digestive diseases that so disproportionately affect women.

Mr. HARKIN. I strongly believe that NIH should respond to the recommendations in this ORWH report and examine this problem as soon as possible.

CDC FUNDING

Mr. CLELAND. Mr. President, I would like to engage the distinguished Ranking Member of the Labor/HHS/Education Subcommittee on funding for the Centers for Disease Control (CDC) and Prevention's building and facilities project. The CDC's physical plant facilities are in dire need of expansion and renovation. The lack of adequate laboratory and research facilities is crippling one of the nation's

critical resources. Some of the infectious disease laboratories which conduct research on deadly organisms are 60-year old temporary wooden structures. This raises serious concerns regarding safety for employees and the public. The existing CDC's buildings and facilities threatens the United States' position as the world's last line of defense for protecting the health of the public.

Mr. SPECTER. Mr. President. I concur with Senator CLELAND's concerns and share in his support of the CDC and its vital role in research and public safety. The Senate Labor/HHS/Education Appropriations Subcommittee had one of its most challenging years developing the FY 2000 budget. The Subcommittee recommended a total of $60 million for CDC, $40 million in regular line item building and facilities construction and an additional $20 million in emergency funding. This represents a significant portion of the funding needed by the CDC.

Mr. CLELAND. I commend the Chairman and Ranking Member and the Labor/HHS/Education Appropriations Subcommittee for the FY 2000 appropriations bill. Under the circumstances, The Subcommittee has done a more than adequate job than others in addressing CDC's needs. The Administration's FY 2000 budget request was $39.8 million for all of CDC's buildings and facilities activities, including the repair and improvement of existing structures. The House Labor/HHS/Education Subcommittee mark was for $40 million for buildings and facilities. The Ranking Member is correct in stating that the Senate Subcommittee exceeded the Administration and marks by $20 million. I want to state for the record that, given the need, the initial funding request was set far too low. The CDC needs $141 million or an additional $81 million to modernize the substandard existing buildings and laboratories. I would request that Senate conferees examine all possible sources to obtain additional funding for CDC, and at the very least, hold firm behind the Senate's funding level in conference.

Mr. HARKIN. I thank you Senator CLELAND for clarifying the funding needs for the CDC building infrastructure. We will continue to seek ways to provide funding to adequately bring the CDC physical plant to not only meet standard safety levels, but to exceed those levels. We have an obligation to maintain this world renowned institution and to facilitate its ability to attract highly skilled scientists, provide a safe environment for the research of highly pathogenic organisms and to fulfill its intended objectives.

Mr. CLELAND. I thank the Senator. One last point: does the Chairman and Ranking Member believe that it would be appropriate for the Administration to submit a more adequate proposal for CDC buildings and facilities in its FY 2001 budget?

Mr. SPECTER. The Senator is correct. I would hope that the FY 2001 Administration budget will appropriately address CDC's need for facilities expansion and renovation.

Mr. HARKIN. I too agree that the FY 2001 budget will address this issue.

VOCATIONAL EDUCATION

Mr. DORGAN. I am concerned about the funding level in the Senate bill for vocational education. While the Senate bill generally increases our investment in education, unfortunately funding for vocational education basic state grants would remain at the President's request of $1,030,650,000.

Funding for vocational education basic state grants has been virtually frozen over the last several years by both the Congress and the President. Consequently funding for vocational, career, and technical programs has not kept pace either with inflation or with funding for other education programs. In fact, if vocational education funding had simply kept pace with inflation over the last eight years, it would be $220 million greater than is being proposed for FY2000. I would suggest an additional $100 million in funding for basic state grants, which represents about a 10 percent increase, but realistically, I believe $50 million would represent a reasonable step in the correct direction.

Mr. DEWINE. I share the concerns of the Senator from North Dakota about the proposed funding level for vocational education. As the Chairman of the Senate Subcommittee that had the responsibility for reauthorizing the Perkins Act, I can assure my colleagues that the reauthorization of this law, which Congress enacted last year with strong bipartisan support updated the Perkins programs. The authorized funding level for the Perkins Act was increased by $10 million from $1.14 billion to $1.15 billion. Now that this work is done, now is the appropriate time to increase funding for vocational education.

Mr. DORGAN. I appreciate the Senator from Ohio's leadership on this issue and the Senator from Alaska's comments in support of vocational education funding at the Appropriations Committee mark-up. I wonder if the Senator from Alaska would give his assurance that he will work to secure additional funding for vocational education as the Labor-HHS-Education appropriations bill moves forward?

Mr. STEVENS. I share the concerns that the Senators are raising and join in their support of vocational education. I want to assure them that I am committed to work with the senior Senator from Pennsylvania to try to find additional funds for vocational education during Conference. I also want to encourage the Administration to request an increase in funds for vocational education in its FY2001 budget submission.

Mr. HARKIN. I want to add my support to the comments that have been made here. I, too, feel strongly that additional funding for vocational education is urgently warranted, and I will do what I can as the ranking member on the Labor-HHS-Education Appropriations Subcommittee to direct more resources to basic state grants in this area. Will the Chairman of the Subcommittee also join me in this effort?

Mr. SPECTER. I recognize that funding for vocational education has not kept up with inflation or with funding for other education programs. I will work with Chairman STEVENS, Senator DORGAN, Senator DEWINE, and Senator HARKIN to try to obtain additional funding for vocational education.

THE UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY'S CHILD HEALTH INSTITUTE

Mr. TORRICELLI. Mr. President, I rise to ask the distinguished managers of the bill if they would consider a request I have concerning the conference. Knowing the great difficulty they faced in reporting a bill that would not exceed this year's stringent budget restrictions, I understand why they were not able to provide funding for the University of Medicine and Dentistry of New Jersey's (UMDNJ) Child Health Institute. However, I hope that funding for the Children's Health Institute can be found in conference.

The increased attention to childhood disease clusters in various communities throughout New Jersey and other states require molecular studies for an explanation and solution. In that regard, UMDNJ of the Robert Wood Johnson Medical School developed the Child Health Institute of New Jersey as a comprehensive biomedical research center focused on the development, growth and maturation of children.

The mission of the Institute is to improve child health and quality of life by fostering scientific research that will produce new discoveries about the causes of many childhood diseases and new treatments for these diseases. Researchers will direct their efforts toward the prevention and cure of environmental, genetic and cellular diseases of infants and children. The Institute will work closely with both the Cancer Institute of New Jersey and the Environmental and Occupational Health Science Institute—two NIH-designated centers of excellence. Organizations which also played a part in developing the Child Health Institute.

The Institute is seeking funds to develop three components: a program in Molecular Genetics and Development; (2) a program in Development and Behavior; and (3) a program in Environment and Development. These programs will study human development and its disorders, noting the changing environmental conditions which alter gene function during development, maturation and aging. Institute scientists will also study human growth and development and the emergence of cognition, motion, consciousness and individuality.

The hospitals in central New Jersey birth nearly 20,000 babies each year. The founding of the Child Health Institute has created an extraordinary

health care resource for those hospitals and the patients they serve. The new Children's Hospital at Robert Wood Johnson University Hospital is scheduled to open in 2000 and the Child Health Institute in 2001. Together these institutions will provide state of the art clinical and scientific research and treatment complex to serve children and their families, not only in New Jersey, but throughout the nation with cutting edge care and the latest scientific developments.

Mr. LAUTENBERG. Indeed, New Jersey is poised to become a regional and national resource for research into the genetic and environmental influences on child development and childhood disease. Working in close partnership with the pharmaceutical and biotechnology industries, the Child Health Institute of New Jersey will become a force for healthy children nationwide. I thank my fellow Senator from the State of New Jersey and join him in giving my highest recommendation for this project.

Mr. TORRICELLI. I thank the Senator from New Jersey for his efforts on this project. I believe that the work of the Institute is an appropriate focus for the committee because the research focus will be of enormous value for the nation as a whole. Indeed, the Child Health Institute will be one of the world's only research centers to examine not only the biological and chemical effects on childhood, but also the effects of behavioral and societal influences as well.

The Child Health Institute's request is for $10 million in one time funding from the federal government for the construction of the Institute building. Total building costs are estimated at $27 million. The Institute has already raised more than $13 million from private sources including $5.5 million from the Robert Wood Johnson Foundation and $5.5 million from Johnson and Johnson. Also, the Robert Wood Johnson University Hospital has made a $2 million in-kind contribution of the land on which the Institute will be built. At maturity, the Child Health is expected to attract $7 to $9 million in new research funding annually, as well as provide $52 million in revenue for the local economy.

Mr. President, funding for the Child Health Institute in this bill would be entirely appropriate under Health Resources and Services Administration (HRSA) account. Indeed, it would be money well spent.

Senator LAUTENBERG and I simply ask that when the bill goes to conference the managers remember this request for funding the UMDNJ Child Health Institute.

Mr. SPECTER. We have received numerous requests for funding of health facilities. In the past, we have faced difficult choices in making a determination of funding priorities and this year promises to be no exception. We are aware of the request by the Child Health Institute and commend its efforts toward enhancing its research and service capacity. In conference, we will keep in mind its request as well as those with similar meritorious characteristics and goals.

Mr. HARKIN. I, too, am aware of the Child Health Institute request for assistance and share Senator SPECTER's views on this matter.

Mr. TORRICELLI. I thank both my distinguished colleagues for their assistance with this matter.

Mr. LAUTENBERG. I also would like to thank my colleagues for their help.

MEDICARE INTEGRITY PROGRAM

Mr. HARKIN. I am very concerned about the proposed $70 million funding cut to the Medicare Integrity Program (MIP) approved by the House Appropriations Committee. The Senate has recommended that MIP be funded at $630 million, the amount authorized in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In 1998, Medicare contractors saved the Medicare Trust Fund nearly $9 billion in inappropriate payments—about $17 for every dollar invested. Any funding cut to MIP is tantamount to the government throwing money out the window. In fact, I believe, because of the tremendous need to reduce an estimated $13 billion in Medicare waste, we should increase MIP funding. Therefore, I will work hard to ensure that the Senate funding level for this important program is not compromised.

Mr. ROTH. I've long been committed to the effective and efficient management of the Medicare program, specifically the detection of fraud and abuse. I supported the creation of the MIP program, established under HIPAA, to provide a stable and increasing funding source for fraud and abuse detection efforts. Prior to MIP, Medicare contractor funding for anti-fraud and abuse activities was often reduced because of other spending priorities in the annual appropriations process. MIP was created to prevent that from happening again. The House Appropriations Committee recommendation is in clear disregard of congressional intent.

Mr. SPECTER. I understand the importance of the MIP program to the integrity of the Medicare Trust Fund, and I will work to ensure that MIP is funded at the Senate recommended level of $630 million.

PREVENTION AND TREATMENT OF FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECTS

Mr. DASCHLE. Mr. President, I have worked closely with my colleagues Senator STEVENS, Senator SPECTER and Senator HARKIN to make treatment and prevention of fetal alcohol syndrome (FAS) and fetal alcohol effect (FAE) more of a federal priority and to place language in the report accompanying the Fiscal Year 2000 Labor, Health and Human Services and Education Appropriations bill to underscore this commitment. I appreciate their efforts to support programs that will prevent and address this important public health problem and their commitment to continuing those efforts as they serve on the conference committee.

There is a dramatic need for an additional infusion of resources to address alcohol-related birth defects, which are the leading known cause of mental retardation. These funds are needed for the development of public awareness and education programs, health and human service provider training, standardized diagnostic criteria and other strategies called for in the competitive grant program authorized under the Fetal Alcohol Syndrome and Fetal Alcohol Effect Prevention and Services Act. These resources will complement the excellent work that has been started by grass-roots organizations like the National Organization for Fetal Alcohol Syndrome and the Family Resource Institute.

I look forward to working with Senator STEVENS, Senator SPECTER and Senator HARKIN to promote treatment and prevention of FAS and FAE. It should be a priority for the Fiscal Year 2000 conference committee to fund these much-needed programs, and I am hopeful that the conferees will be able to find additional resources for this purpose. I believe it is critical that we provide line item funding for the competitive program that this Congress authorized last year. I look forward to working with the Administration and my colleagues in the Senate toward that end as they begin to draft the Fiscal Year 2001 Labor, Health and Human Services, and Education Appropriations bill.

Mr. STEVENS. Mr. President, I share the sentiments expressed by my colleague from South Dakota. I have witnessed first hand the devastating effects of FAS and FAE in Alaska, which has the highest rate of FAS/FAE in the nation. Our Alaska Native people are especially at risk for these entirely preventable conditions. It has been estimated that the lifetime cost of treating and providing necessary services for a single victim of FAS/FAE is in excess of $1 million. I am pleased that the bill before us contains language encouraging the Department of Health and Human Services to provide necessary resources to fund comprehensive FAS/FAE prevention, education and treatment programs for Alaska and for a four-state region including South Dakota and will work with the conference committee to ensure that funds are available for these programs. I also support language in the report mandating development of a nationwide, comprehensive FAS/FAE research, prevention and treatment plan. I know that federal support can make a difference. In Alaska, federal assistance has allowed two residential treatment programs for pregnant women and their children—the Dena A Coy program in Anchorage and the Lifegivers program in Fairbanks—to make a positive difference in the lives of numerous Alaska Native women and their children. I look forward to working with my colleague to find real solutions to

the problems of alcohol-related birth defects.

Mr. SPECTER. Mr. President, I have worked closely with my colleagues to find creative ways to address FAS and FAE at the federal level while drafting the Fiscal Year 2000 Labor, Health and Human Services and Education Appropriations bill. I agree that it is critical to continue that effort during the conference with members from the House of Representatives in order to further improve the federal commitment to individuals with FAS and FAE and their families.

Mr. HARKIN. Mr. President, I would like to add my voice in support of the comments expressed by my colleagues from South Dakota, Alaska and Pennsylvania. FAS and FAE are 100 percent preventable. Our country should be doing everything it can to put an end to alcohol-related birth defects and help individuals and families trying to copy with the disease.

IDEA FUNDING AT NIH

Mr. NICKLES. I would like to address a question to my friend from Pennsylvania regarding the Institutional Development Awards (IDeA) Program funding within the National Institutes of Health (NIH) budget. I am joined by my colleagues Senators LOTT, DASCHLE, and REID in support of the House level of funding for IDeA in the Labor, Health and Human Services, and Education, and related agencies Appropriations bill. It is my understanding that the Senate level is $20,000,000 while the House level is $40,000,000.

Mr. LOTT. It is my understanding that movement to the House level is not an increase in the NIH budget, is that correct? As I understand it, this would reallocate money within the NIH budget and that this would not be additional funding. This would set aside a portion of NIH research money for those states, Mississippi included, to more fully exploit the opportunities to develop a competitive biomedical research base.

Mr. NICKLES. The distinguished Majority Leader is correct. The point of this inquiry is to ask the chairman if he would reserve some resources for those IDeA states that receive the least among of research money.

Mr. DASCHLE. I agree with my colleagues that this program is of tremendous benefit to rural states and to our nation's ability to produce top quality research. In recent years, five states have received 48 percent of the NIH research money. We need to broaden this distribution. In my state of South Dakota, universities have benefitted from this program in the past, but we need to continue this investment so that they may compete for research monies on an equal footing. Increasing IDeA funding would help to meet this goal.

Mr. REID. I would also like to point out that according to the NIH's own figures, an average IDeA state, such as Nevada, receives $67 per person in research money while the other states receive, on average, $258 per person. This program helps to disburse this vital research money to those states who traditionally do not fair well but can perform this research for much lower overhead and indirect costs.

Mr. NICKLES. I would also add that Oklahoma only receives, an average, $45 per person of research money.

Mr. SPECTER. Mr. President, I would agree with Senators LOTT, DASCHLE, and REID on the value of the IDeA program. As Senator NICKLES mentioned before, we did increase this allocation from fiscal year 1999 in order to broaden the geographic distribution of NIH funding of biomedical research by enhancing the competitiveness of biomedical and behavioral research institutions which historically have had low rates of success in obtaining funding. With their concern in mind, I would therefore like to assure my fellow Senators that when we conference, we will take a very close look at the House funding level of $40,000,000 for IDeA.

Mr. NICKLES. I would like to thank the Chairman for his assistance.

Ms. MIKULSKI. Mr. President, I rise to speak on the Fiscal Year 2000 Appropriations bill funding the Departments of Labor, Health and Human Services and Education. I would like to thank Senator SPECTER and Senator HARKIN for the tremendous job they and their staffs have done on an extremely large, complex, and vitally important appropriations bill. This bill is important because it meets the day-to-day needs of Americans as well as the long-range needs of our country.

However, I am concerned that the Senate has had to resort to gimmicks and tricks such as ''forward funding'' and ''emergency spending.'' When Congress resorts to these tricks, it means we're not doing our job right. The GM worker in Baltimore can't ''forward fund'' or declare his next trip to the grocery store ''emergency spending.'' If a mother can't pay for her children's health care using such devices, then Congress should not be able to resort to them to pay for our children's education, health care for the underserved, or job training.

I am pleased with a number of funding levels in this bill. I know that Senators SPECTER and HARKIN had a difficult task in funding so many programs that meet compelling human needs. As the Senator for and from the National Institutes of Health, I am very glad to see the $2 billion increase in NIH funding, which keeps us on pace to double NIH's budget over five years. I am particularly pleased with the $680.3 million for the National Institute on Aging (NIA). This is an increase of more than $80 million over last year. As we double NIH's budget, I believe that it is especially important to double NIA's budget. Our population is aging; by 2030 there will be about 70 million Americans age 65 and older, more than twice their number in 1997. This is clearly an investment in the future health of our nation.

Many of the day-to-day needs of our nation's seniors are met by the Older Americans Act (OAA). It is heartening to see the $35 million increase in funding for home delivered meals because it is greatly needed. We are seeing an increased demand for home delivered meals which assist more older persons in remaining in their homes and communities. The Committee has also provided a $1 million increase for the ombudsman program and an $8 million increase to $26 million for state and local innovations/projects of national significance (Title IV).

I am disappointed that other programs under the Older Americans Act did not see needed increases in funding. OAA programs have been level funded and losing ground for too long. I am also deeply concerned that there is no provision to fund the National Family Caregiver Support Program. This program would offer valuable services to assist our nation's caregivers by providing respite care, counseling, information, and assistance among other services. This program has strong bipartisan support. I would urge that we look at ways to provide the necessary resources for this program in Fiscal Year 2000 so that it can be funded once it is authorized. As the Ranking Member of the Subcommittee on Aging, I will continue to work with my colleagues on the HELP Committee to reauthorize the OAA during Fiscal Year 2000.

In addition, I was distressed by the drastic cut of almost $860 million to the Social Services Block Grant. However, I'm pleased that the Senate has restored these funds. The Social Services Block Grant provides help to those who practice self help. In Maryland, this program funds adoption, case management, day care, foster care, home based services, information and referral, prevention and protective services to more than 200,000 people.

I must also mention the importance of funding for the Centers for Disease Control and Prevention (CDC). I am very aware of the funding constraints the we have been operating under and believe that the $30 million increase for CDC is a step in the right direction. However, it is below the President's budget request and does not go far enough. While I am appreciative of the efforts to increase funding to modernize CDC's facilities and improve public health infrastructure, CDC has been revenue starved for too long. Improving public health in our country requires investments in NIH, CDC, and FDA. I am thrilled with our support of NIH, but I believe that if we do not provide sufficient resources to CDC and FDA we are only doing part of the job. I would urge that we consider this as we move to conference on this bill and when we look at funding for these agencies next year.

I am also pleased at the funding levels of many of our national education programs and this bill is certainly better than the one that passed the House.

I am very concerned that the funding level for the bill overall has been reduced to pay for other programs. The spending caps put us in a tough position. And it is education that always suffers the most.

Like I said, even though the Senate funding levels are much better than the House, there are at least two major problems with the Senate bill. There is no funding in this bill for school construction and there is no funding in this bill for lowering class size and hiring 100,000 new teachers. Last year, we passed a bipartisan bill, and we all agreed to lower class size. We agreed that this is one of the most important things we can do for our kids and our classrooms. Yet this bill contains no money for class size.

There is also no funding for school construction. What happened to our commitment to make sure our kids are not attending classes in crumbling schools? I see there is $1.2 billion in the bill for something called ''Teacher Assistance Initiative.'' As far as I know, no one knows what this means exactly. Like Senator MURRAY said on the floor of the Senate last week, it clearly isn't class size reduction.

I have serious reservations about this bill. It does not live up to the commitment we made here in the Senate to reduce class size and hire 100,000 teachers. It does nothing to fix our broken down schools. And the House bill is even worse.

The House bill cuts $2.8 billion out of the President's education agenda to improve public schools. It denies 42,000 additional children the opportunity to participate in Head Start. It repeals last year's bipartisan agreement to fund 100,000 new teachers to create smaller classes. It combines Class Size Reduction, Eisenhower Teacher Training and Goals 2000 into a block grant funded at $200 million less than the authorized level and $396 million less than the President's request for comparable programs.

Given our recent tragedies in our schools, it is a shame that the House bill denies after school services to an additional 850,000 ''latch key'' children in 3,300 communities during the critical 2–6 p.m. hours when children are most likely to get into trouble. The bill also freezes federal funding to help schools to create safer learning environments and denies funding for an additional 400 drug and school violence coordinators serving 2,000 middle schools.

We need to work hard in conference. We are going to have to fight to keep our stand behind our kids. We cannot allow the House to gut these important programs. We cannot let the Senate ignore class size and school construction. I look forward to working with my colleagues to make sure we increase the Federal investment in education.

Mrs. MURRAY. Mr. President, this evening we will vote on what is arguably the most important of our 13 appropriations bills, the Labor, Health and Human Services and Education Appropriations Act. When it comes to funding for education, the Congress has fundamentally ignored the messages of the American people. In this bill, education spending remains in the neighborhood of 1.6 percent of overall federal spending, a very poor neighborhood indeed. The American people cannot understand why, if education is their first priority, it is the last bill passed and the lowest funding priority of their Congress. They cannot fathom why, in a year when school districts across the country are hiring highly-qualified teachers to reduce class size, the Congress is walking away from its commitment.

The House, regrettably, has done far worse by education than any of us could have imagined. The drastic cuts to education that would take effect under the House bill would send America back into the 19th century, not forward into the 21st. The House bill would cause 142,000 fewer children to be served in Head Start, would keep 50,000 students out of after-school programs, and would deprive 2.1 million children in high-poverty communities of extra help in mastering the basics of reading and math.

The Senate has done better by our schools, but only through smoke-and-mirrors budgeteering that should give our school communities no long-term confidence. Advance funding is not without effect on the local school budget, which demands consistency and predictability.

The numbers in the Senate bill are a better level from which to negotiate in the conference committee, but even these funding levels ignore the grim reality that our schools face a fundamentally tougher job than they did even five years ago, with skyrocketing enrollment, of students who are more expensive to educate, and who have less support at home and in the community.

Despite all this, at least the Senate provides current funding for most educational services, makes some effort toward meeting the higher needs in others, and does a good job of providing new investments in a few areas. Funding for the Individuals with Disabilities in Education Act is increased by more than $900 million, a good start toward meeting our national commitment to fund forty percent of a local school district's costs of educating a disabled child.

The $200 per student increase for Pell grants is a good investment, but only about half of what is needed this year. I'm particularly proud that we were able to increase funding for adult and family literacy, by increasing the adult basic education program by more than $100 million. This means that thousands more adults and their families will be able to take the first steps toward increased viability in our changing economy.

The failures in this bill are many, however. As an example, let's look at funding for vocational and technical education. Current funding or freezes in funding are not sufficient in a world where the economy changes as rapidly as ours is changing. Young people need the skills not only to survive but to thrive. All young people need access to applied skills as well as theoretical ones, in order for them to succeed in the workplace, the classroom, and in life. And yet, we do not make the significant investments needed.

The largest failure of all, of course, is the backward step the majority is taking on class size reduction. Reducing class size by helping school districts hire 100,000 high-quality teachers nationwide is an investment in our schools that is paying dividends right now. The first 30,000 teachers are in the classroom, and what a classroom it is. To walk from a class with 25 or 28 first graders into one of the smaller classes I've been visiting this fall is a stark contrast. Improved achievement, increased time on task, more individual attention, and a lack of discipline problems are obvious in the smaller class. The teacher in the larger class looks as if he is running to catch up, and the student must keep her hand in the air for too long a time. This is a very real, tangible investment we have made in our schools. The Senate and the House, on a completely partisan basis, are reneging on the most common-sense investment in school improvement made in recent history. The reason that the Republicans are so afraid of these 30,000 teachers is that this program is actually working.

Pili Wolfe, Principal at Lyon Elementary School in Tacoma, Washington, where federal class size funds are being used to dramatically reduce class size in first grade, and to provide high-quality professional development for teachers through a program called Great Start, says: ''Children in our first-grade Great Start classrooms have shown more growth within the first month of school than any previous first-grade class.''

Andrea Holzapfel, a first-grade teacher at Lyon, says: ''Smaller numbers allow me to spend significantly more time in individual and small-group instruction. Having fewer children allows more participation by the kids in discussion and classroom activities.''

The program works. The one-page, on-line application form means no paperwork, no bureaucracy. Two-hundred and sixty-one of Washington state's two-hundred and ninety-six school districts have already put class size reduction and teacher professional development into effect in their schools. The accountability is to the local community, through a school report card describing how many teachers were hired and in which grades. Improved student achievement will be the ultimate measure of the success of this year's investment.

But the investment cannot stop here.

The President has said that this bill is headed for a veto, because of the

lack of continued investment in class size reduction, and other key education efforts.

One such effort is GEAR UP, which enables low-income schools and their neighboring colleges to form partnerships to get mentors to help students study hard, stay in school, and go on to college. Funding for this program is only $180 million, not the $240 necessary to get this important investment to the communities where it is needed most.

Increased funding for after-school programs was given short shrift, despite what the research shows about the link between young people having no positive pursuits in the afternoon and evening, and the related increase in crime.

Education technology has been cut by the House, and the Senate numbers are not sufficient to meet the growing need in an area where the federal government is the primary funding source in most schools and communities, far beyond the investments made by states and localities.

When it comes to education, this Congress has not stepped up to the very challenge we are asking the educators, students, families and communities across America to meet. When the expectations on Congress increased, the level of commitment and vision decreased.

I am voting for this bill to move the process along. If class size funding and other key investments are not restored, the conference report will be vetoed. If it is vetoed, I and many of my colleagues will vote to sustain that veto. This bill in its current form is only a vehicle through which we may negotiate higher numbers in conference.

The American people have a stake in this battle. We need to hear their voices now.

This has been a difficult vote for me. While the bill does provide a significant investment in public health and safety, it does so on the backs of our children and retreating from our commitment to improve class size. This bill cannot survive in its current form.

I do want to point out what I believe are positive aspects of this bill. I applaud the efforts of Chairman SPECTER and Senator HARKIN in preparing an appropriations bill that meets important public health priorities. I know how difficult this appropriations process has been and know their job was not easy. As a member of the Labor, Health & Human Services & Education Subcommittee, I am pleased that our product does maintain our commitment and investment in public health.

The additional $2 billion investment for NIH alone will bring us that much closer to finding a cure for diseases like cancer, Parkinson's, cardiovascular, Alzheimer's, MS and AIDS. Every dollar invested in NIH reaps greater savings in health care dollars as well as greater savings in human lives. This additional investment will ensure that we remain on a course to double NIH funding. I know how important this funding is and am proud to represent outstanding research institutions like the University of Washington and the Fred Hutchinson Cancer Research Center who receive significant research funding from NIH.

I am also pleased that we have provided funding for trauma care planning and development for the states. This is an essential program that assists the states in efforts to effectively develop trauma care strategies. We have neglected trauma care and we have lost ground in life saving delivery of critical care. I was pleased that the Subcommittee recognized the importance of trauma care planning.

As many of my colleagues know, I have been pushing for federal funding to establish a national poison control plan. My allegiance to ''Mr. Yuk'' is well known within this chamber, as well as within the HELP Committee. It was only two years ago that I offered an amendment during FDA reform to protect voluntary poison control labeling like Mr. Yuk from possible elimination. I have used my position on the Appropriations Committee to push for funding for poison control centers and for a national 1–800 hotline. I am pleased that this legislation includes $3 million for poison control efforts. This line-item within HRSA is a major victory for children and their parents. We have taken a huge step forward in developing a national poison control plan that builds on successful efforts in all of the states, like those made in Washington state.

As one of the most vocal women's health care advocates in the Senate, I am pleased that the Committee report to accompany this Appropriations bill addresses several women's health issues and enhances programs to eliminate gender bias or discrimination. I want to thank the Chairman for his support of funding for the CDC Breast and Cervical Cancer Screening Program for low income women. This continued commitment will save lives and improve survival rates for women who often have little or no access to cancer screening. We know that early dedication offers the greatest hope of survival.

I am pleased that we have been able to provide additional funding to expand the WISE WOMEN program to screen for cardiovascular disease as well as breast and cervical cancer. Cardiovascular disease is the number one killer of American women. Twice as many women die from cardiovascular disease than breast and cervical cancers combined. I was disappointed that we could not find additional monies to expand this program in all 50 states, and will continue to work to secure additional funding for FY2000.

There are many reasons why I consider the Labor, HHS Appropriations bill one of the most important appropriations bills and the one piece of legislation that truly effects all Americans and offers hope to the most vulnerable. But, perhaps one of the most critical programs funded in this appropriations bill is funding for battered women's shelters. This funding does save lives. This funding is the life line for battered and abused women and children. I am proud to have worked with the Chairman of the Subcommittee to increase our investment in battered women's shelters. I am working for the day when we need no more battered women's shelters. Unfortunately, we have a long way to go. But, by increasing the funds available by $13.5 million for FY2000, we have offered communities more resources to assist victims of domestic violence find a vital, life-saving safe shelter.

I am hopeful that these important public health investments will survive what will likely be a difficult conference with the House.

Mrs. FEINSTEIN. Mr. President, I am pleased today to support the FY 2000 Labor-HHS-Education Appropriations bill, H. R. 1650, because it addresses important priorities of the American people.

Among other increases, this bill increases funding for the National Institutes of Health (NIH) by $2 billion, including a $384 million increase for the National Cancer Institute. This will continue us on the path of doubling the funding of NIH over five years. The President requested only a 2.1 percent increase over FY 1999, which does not keep pace with medical research inflation, projected to be 3.5 percent next year.

The National Institutes of Health—often called the ''crown jewel'' of the federal government—offers hope to millions of Americans who suffer from diseases like diabetes, arthritis, Alzheimers, Tourette's Syndrome, Parkinson's and on and on. Sadly, NIH can now only fund 31 percent of applications. Under the Presidents's FY 2000 proposal, it could have fallen to 28 percent, a 10 percent drop. This is the wrong direction, especially at a time when research is opening many new scientific doors.

Federal support for curing diseases and finding new treatments is not a partisan issue. Federal spending on health research is only 1 percent of the federal budget. Sixty eight percent of Americans support doubling medical research over five years; 61 percent of Americans support spending part of the surplus on medical research. Fifty five percent of Californians said they would pay more in taxes for more medical research, in a Research America poll.

NIH is especially important to my state where some of the nation's leading research is conducted. The University of California received $1.7 billion in NIH funds in 1998. The federal government supports over 55 percent of UC's research.

I am pleased that the bill includes $ 3.28 billion for the National Cancer Institute. This is an increase of $384 million or 13 percent over last year. With

this, NCI will be able to fund at least 10 percent more grants. If we had gone along with the President proposed 2 percent increase for cancer research, NCI would have been able to fund 10 percent fewer grants. That is the wrong direction, at a time when cancer incidence and deaths are about to explode.

Today, one in every four deaths is due to cancer. Cancer costs over $100 billion a year. Because of the aging of the population, the incidence of cancer will explode by 2010, with a 29 percent increase in incidence and a 25 percent increase in deaths, at a cost of over $200 billion per year. The cancer burden will hit America the hardest in the next 10 to 25 years as the country's demographics change. (These are the findings of the September 1999 Cancer March Research Task Force.) Cancer deaths can be reduced from 25 to 40 percent over the next 20 year period, saving 150,000 to 225,000 lives each year if we do the right thing.

I want to thank the chairman of the subcommittee for including in the committee report language indicating that we need to increase cancer research funding consistent with the recommendations of the Research Task Force of the Cancer March. The Cancer March called for increasing the National Cancer Institute budget by 20 percent each year for four years, to get to $10 billion by 2005. This bill with its 12 to 13% increase in funds is a step on the way.

The National Cancer Dialogue, a national group representing leaders of the entire cancer community and over 120 cancer organizations, recommended that NCI be funded at $5 billion in FY 2000 and CDC cancer activities at $516 million.

What can be accomplished with $5 billion for research?

More drugs: NCI could bring 40 new cancer drugs from the laboratory to clinical trials. In NIH's entire history, only 70 drugs have been approved for treating cancer.

Cancer Genetics: Continuing to identify genes involved in cancer. Improving our understanding of the interaction between genes and environmental exposures.

Imaging: Finding new ways to detect cancers earlier when they are small, not invasive and more easily treated.

Clinical Trials: Increase participation from 2 percent currently. Medicare beneficiaries account for more than 50 percent of all cancer diagnoses and 60 percent of all cancer death.

Prevention: 70 percent of all cancers are preventable says the American Cancer Society. By expanding the CDC's efforts to provide cancer screening, cancer registries and other measures to help people prevent cancer screening, cancer registries and other measures to help people prevent cancer. For example, tobacco-related deaths are the single most preventable cause of death and disability and account for 30 percent of all US cancer death.

I am also pleased to see an increase of $200 million over last year and $100 million over the President's request for Ryan White AIDS, as well as a 12 percent increase for AIDS research at NIH.

California has the second highest incidence of HIV/AIDS in the US. While the AIDS death rate has declined it is still too high. Over 40,000 new infections develop each year. In California, 100,000 people are living with HIV/AIDS. Half of all HIV-infected people do not receive regular medical care according to the Rand study, December 1998.

We face serious challenges. We must find a cure. We must find new treatments. HIV lingers in cells so long that the ''virus cannot be eradicated at all with current treatments * * * it remains tucked away longer than though,'' according to the New England Journal of Medicine, May 1999.

This funding bill also includes important funding for education at all levels. There is hardly a more important function of government than providing a solid education for our youngsters.

The bill raises education by $2 billion over last year. This is important in light of the decline in the federal share of total education funding from 14 percent in 1980 to six percent in 1998, according to the Office of Management and Budget.

No doubt we need to do more. Our nation's schools face unprecedented challenges. My state is fraught with problems: California has 6 million students, more students than 36 states have in total population and one of the highest projected enrollments in the country, California will need 210,000 new teachers by 2008. We have about 30,000 teachers on emergency credentials. We have the most diverse student body in the county. In some schools, over 50 languages are spoken. While this diversity is one of my state's great strengths, in the classroom, it places huge responsibilities on teachers.

Buildings: We need to build 6 new classrooms per day, $809 million per year. Some elementary schools have over 5,000 students. Our schools are too big.

In higher education, California is preparing for ''Tidal Wave II,'' the demographic bulge created by children of the baby boomers which will inundate our colleges and universities between 2000 and 2010.

And so our needs are huge. Our challenges are great.

I am disappointed that the Senate did not adopt the Murray amendment that would have ensured that $1.4 billion be used to hire teachers and reduce class size. By adding $200 million and raising the allocation from $1.2 billion to $1.4 billion and specifying that it be used to hire teachers and reduce class sizes, California could have hired 1,100 new teachers, on top of the 3,322 that will provide funding for last year. I hope the conference will see the importance of this.

One area of this bill that I have given my attention to is ESEA Title I, the program that provides over $8 billion for educating poor children. Unfortunately, despite my efforts in the Appropriations Committee, I was unable to delete what is known as the ''hold harmless'' provisions. Also, the committee would not accept my amendment to clarify and insure that any new or additional funds, over last year, go to states that are hurt by the hold harmless provision.

The Title I hold harmless provisions (there are two in the bill, for basic grants and for concentration grants) hold states and districts ''harmless.'' They say in essence that no state or district will receive less than it did the previous year despite changes in the number of poor children. In the bill, these apply to the Title I basic grants and the concentration grants. These provisions freeze funding in place despite the number of poor children, despite their eligibility.

I tried to delete these provisions in the committee, but because, frankly, there are more low-growth states than high-growth states like mine, in the Senate, did not have the votes to completely eliminate them.

Here is why the hold harmless provisions are wrong: One, they violate the purpose of the program since 1965, to target funds on poor children, two, they contravene the census update requirement. The authorizing law requires the Department to update child poverty data every year so that each state will receive funds according to the number of poor children. The hold harmless renders that requirement virtually meaningless.

Secretary Riley wrote, April 29, 1999: ''I do share your concern that the 100 percent hold-harmless provision undermines the apparent statutory intent that allocations for Title I and other programs be based on the most recent census data.''

Three, a poor child is a poor child. Congress recognized that poor children need extra help, wherever that child may be. A poor child in California is as worthy as a poor child in Mississippi and should not be deprived of funding.

A July 1999 study found that students in poor school districts (West Fresno, Mendota, Farmersville) ranked at or near the bottom of California's achievement tests. ''Most of the lowest-scoring school districts * * * are in rural areas with high unemployment and poverty and have many children from migrant farm worker families who speak little English and have little education.'' (Fresno Bee, 7/25/99)

Four, hold harmless provisions disproportionately hurt states with high growth rates in poor children, states like California, Arizona, New Mexico, Texas, Hawaii, South Carolina, Maryland, Nevada, Virginia, Georgia, Florida, New York, North Carolina, Oklahoma.

Here are some examples of losses of Title I Funds under FY 1999 hold harmless: California $36 million; Florida $32

million; New Mexico $4.5 million; New York $48 million; North Carolina $8 million; Texas $32 million.

Last year, under the bill's Title I hold harmless, California lost $32 million. California has 14 percent of all Title I children and gets 11 percent of Title I funds. (US Dept of Education). California has a 22 percent poverty rate for children; The US rate is 18.7 percent. (9 states exceed California's). California's number of poor students grew 53 percent from 1990 to 1995; nationally, it grew 22 percent. In total federal dollars, California pays 12.5 percent of federal taxes but gets back only 11.2 percent.

California receives $656 in Title I funds per poor child. The national average is $745. Some states receive as much as $1,289, according to the US Department of Education. California has almost 40 percent of the nation's immigrants. The poverty rate for immigrants grew by 123 percent from 1979 to 1997. (Center for Immigration Studies, 9/2/99). Income inequality is growing in California faster than the rest of the country (Public Policy Institute of California, 2/9/99)

Five, the hold harmlesses freeze in the status quo, even for those not eligible. The hold harmless provision gives funds to states and districts that may not even be eligible for funds, merely because they got funds in the past. What good are eligibility rules if we ignore them, override them willy-nilly. We either have eligibility rules or we don't.

If Congress believes the formula is not properly structured or targeted, Congress should change it in the authorizing statute. Congress will have that opportunity next year when ESEA is reauthorized.

I am grateful that the committee agreed, at my request, to modify the bill so that the Title I hold harmless will not apply in FY 2000 to the eight federal programs have funding formulas based in whole or in part on the Title I formula. Those programs are: Safe and Drug-free Schools; Even Start Family Literacy; Comprehensive School Reform; Eisenhower Professional Development (Teacher training); Technology Literacy; Class Size Reduction; Goals 2000, Title III; and McKinney Homeless Education.

This amendment was needed because, in FY 1998 and 1999, the Department of Education applied the 100 percent hold harmless to 8 other education programs, thus compounding the harm of the Title I hold harmless provision and the cuts that result from it.

I believe in the current bill, Congress is giving the Department clear guidance that the Title I hold harmless provision should not be applied to other programs.

Because last year the Department applied the hold harmless to other programs, my state lost funds under the following programs: Teacher Training $40,000; School Reform $700,000; Technology Literacy $5.4 million; Goals 2000 $3 million; EvenStart/Literacy $1 million.

I thank the committee for remedying this inequity.

I am disappointed that the Committee did not provide funding for the President's English Language and Civics Education Initiative, under the Adult Education program. This is an effort to help states and local communities provide instruction to adults who want to learn English as a Second Language (ESL) programs, as well as instruction in civics and life skills. If adequately funded, this initiative would help ensure that those who seek to become American citizens learn not only the words of the citizenship oath, but also the broader language of our civic life. Simply put, this initiative would help our nation's newcomers become full participants in American life.

In 1990, there were about 25.5 million U.S. adults age 18 and older who spoke a language other than English at home. Many of these non-English speakers were new immigrants. Some immigrants have lived here for many years. Still, other non-English speakers were born in the United States but grew up without mastering the English language. Many of these adults reported that they have difficulty speaking English, but were highly motivated to learn the language, especially to obtain jobs and gain access to educational opportunities.

As the number of non-English speaking residents has increased, so has the demand for placement in English-as-a Second-Language (ESL) classes. In the last five years, enrollment for ESL classes has jumped from 1.2 million in 1994 to nearly 2 million in 1998. In the state of California, more than 1.2 million adult students enrolled in these classes in 1998, accounting for 38.2 percent of the adult education students in the state.

The increased demand for ESL classes have resulted in long waiting lists for ESL classes in many parts of the country. For example, Los Angeles has a waiting list of 50,000 people for ESL classes. Chicago's ESL programs are filled to capacity as soon as they open their doors. And, New York State has resorted to a lottery system to select individuals who wish to learn English.

I have visited several immigrant communities throughout California and have been impressed by the high work force participation rates, the strong sense of family, and a tireless commitment to their community. However, during these visits and in letters from my constituents, I have been often told about the lack of opportunities to participate in adult English education courses. This is particularly troublesome, given the large number of people in my state seeking to become American citizens, and to otherwise more fully participate in our civic life.

More support for programs like English Language and Civics Education Initiative would help states and communities throughout California and the rest of the nation that are struggling to keep up with this demand. Providing $70 million requested by the Administration would not merely be an expenditure, but an investment in our nation's future.

While this bill cannot address all the health and education needs of our nation or even those that are a federal responsibility, allocations are good—$2 billion more for education and $3 billion more for health (for the discretionary programs). It does not do all I wish it would do. For example, it does not adequately fund afterschool programs, health professions training, or educational technology as much as I would like, but it does address many important needs and I will vote for it.

I urge my colleagues to give it their strong support.

Mr. SPECTER. Mr. President, we are under very heavy time constraints because some of our Members are about to depart. On two personal notes, I had said earlier that I had recused myself from consideration of the funding for the National Constitution Center because my wife is the director of development there. I want to repeat that and include, again, a copy of a letter to Senator COCHRAN who took over on that issue as the next senior ranking Republican.

I have one other item on a personal note. Senator INOUYE for some time has urged the naming of a building for me, which I had resisted. After my wife heard about it and the grandchildren, I have succumbed to the majority vote on the naming of the building the National Library of Medicine.

In conclusion, I hope we will have a very strong vote in favor of this bill. This bill stretches about as far as it can and is about as low cost as it can be with the chance of getting the President's signature. This is only one step along the way toward conference, and we need a very strong vote in favor of this bill if we are to take care of the important funding, especially for not only worker safety but health and education.

I yield to my colleague.

Mr. REID. Will the Senator yield to this Senator?

Mr. HARKIN. Are we in our 10 minutes of time on which we had a unanimous consent agreement?

Mr. SPECTER. That time might have already been used. Why don't we proceed with Senator HARKIN's closing statement until Senators, who have planes to catch, arrive.

Mr. HARKIN. I yield such time as he may want to the majority whip.

Mr. REID. Mr. President, I state for the Record that the issue of class size reduction is of vital importance to everyone on this side of the aisle, as the case has been made very clear. There are going to be enough votes to pass this bill by virtue of the Democrats voting in favor of it, but we want to at this time alert the conferees that if they fail to adequately address this

matter, it will be extremely difficult to support this Labor-HHS conference report.

Further, the two managers of this bill have worked very hard. They have shown compassion, courage, and expertise in getting the bill to this point, and I congratulate and commend both of them for their diligent work.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, I thank Senator REID for all of his support and his help and great work in moving this bill along. We appreciate it very much.

We have had a good debate, a long debate, a good exchange of amendments on this bill. We have had amendments that have been approved and rejected on both sides of the aisle.

I thank and commend my chairman, Senator SPECTER, for his leadership, his skill, and his persistence, his dogged persistence in managing this bill and getting it through. Senator SPECTER had tried time and time again during the long, hot, dog days of summer and coming into this fall, never giving up, always pushing us to get this bill up and get it through. Again, I commend him and thank him for his leadership and also thank Senator SPECTER and his staff for always working closely with us. I can honestly say that at no time were we ever surprised about anything. We have had a very good working relationship. We may not have always agreed on everything—that is the nature of things around here—but we always had a good, open, fair, and thoughtful relationship. I appreciate that very much on the part of my chairman.

This is always the toughest appropriations bill to get through. It was tough when I was chairman and Senator SPECTER was ranking member. Things have not changed a bit. This year was a greater challenge than ever. But I say to my colleagues on this side of the aisle, we have produced a very good bill—not just a good bill, a very good bill. It is not perfect. Maybe there are some things I would like to have seen different. Perhaps we can improve it a little bit in conference. But it is a very good bill.

Let me just give a few of the highlights of what we were able to accomplish in this bill:

First of all, an overall increase of $4 billion over last year; a $2.2 billion increase for education programs. That is $500 million more than the President asked for. So if anyone says we did not take care of education, they do not know what they are talking about, and I say that in all candor; $500 million more than what the President asked for.

A $2 billion increase for the National Institutes of Health—$2 billion last year, $2 billion this year, keeping our promised goal of doubling NIH funding in 5 years.

We have had a very important increase for community health centers, a $100 million increase for community health centers. Community health centers in rural areas and in some of our poorer areas of this country are the health care system for a lot of poor people in our country, and they are doing a great job. This bill has a $100 million increase for community health centers.

We maintain the funding for all the job training and worker protection provisions in the Department of Labor. We have over a $600 million increase for Head Start. Maybe I would like to see a little bit more, but it is good progress. We are moving in the right direction towards getting all 4-year-olds covered in Head Start programs.

The Dodd amendment almost doubles the child care development block grant to $2 billion for child care. That is very important.

We double the funding for afterschool programs. Again, I know how strongly Senator SPECTER feels about this. He authored a bill, the youth antiviolence bill, of which I am a cosponsor, taking care of these kids after school. We doubled from $200 million to $400 million the afterschool programs.

We raised the maximum Pell grant from $3,150 to $3,325, the highest it has ever been.

Let me cut to the quick. I know many of my colleagues on this side of the aisle have signed a letter expressing their concern over the lack of authorization of reducing class size. We have the money in there for it, but we do not have the authorization.

As I have said repeatedly, reducing class size is critical. I am personally disappointed that Senator MURRAY's amendment was not adopted. But I want to be very clear, though, that there is absolutely no inconsistency with signing that letter and voting for passage of this bill.

We vote to send bills with problematic issues to conference all the time around here. Maybe there is one little thing we do not agree with, but overall we agree with the major thrust of the bill, and we send it to conference.

Do not let the perfect be the enemy of the good. This is a good bill. We should send it to conference. If you are concerned about class size, the best and quickest way to have those concerns resolved is to vote the bill out and send it to conference. We will have a chance there to make improvements. If you still have problems after that, you can vote against the conference report.

But this bill is too important to the health, the well-being, and the education of the American people to kill it on the Senate floor. Everyone who votes for this bill can be proud of their vote, proud of the investments that we have made in the human infrastructure of this country.

Lastly, people have said there are a lot of gimmicks in this bill. There are no gimmicks in this bill. We advance funds because of the unique way that education is funded in this country. We do not pay it out until the next year anyway. So there are no gimmicks in this bill. This is straightforward. This is a sound bill. I strongly urge my colleagues to vote for this bill.

Again, I thank Senator SPECTER, his staff: Bettilou Taylor, Jim Sourwine, Mary Dietrich, Kevin Johnson, Mark Laisch, Jack Chow, and Aura Dunn for all of their hard work. I also thank my minority staff: Ellen Murray and Jane Daye; also my personal staff: Bev Schroeder on education; Chani Wiggins on labor; Sabrina Corlette on health; Katie Corrigan on disabilities; Rosemary Gutierrez on child labor; and, of course, my outstanding leader, legislative director, Peter Reinecke, for all of his hard work.

So again I urge my colleagues on this side of the aisle to give this bill their ''yes'' vote and send it to conference resoundingly because it is a good bill, and it is good for America.

I ask unanimous consent that several letters in support of passage of this bill be printed in the RECORD.

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

NATIONAL ASSOCIATION OF CHILD CARE RESOURCE AND REFERRAL AGENCIES,
Washington, DC, October 7, 1999.

Hon. TOM HARKIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR HARKIN: On behalf of the Board of Directors and the more than 700 members of the National Association of Child Care Resource and Referral Agencies (NACCRRA), this letter urges the U.S. Senate to pass the FY2000 budget bill. NACCRRA appreciates the inclusion of a set-aside for child care resource and referral and school-age child care in the Child Care and Development Block Grant (CCDBG), even though we sought an increase in the CCDBG to provide more and improved services to children and families throughout the country.

NACCRRA especially thanks the Senate for including language for the Child Care Aware service in the budget bill. Child Care Aware is the only national hot-line for parents, families and community persons interested and involved in child care and early education to get connected to the CCR&R in their community. We continue to request inclusion of a funding amount for CCA: $500,000.

Thank you once again.

Sincerely,

YASMINA VINCI,
Executive Director.
EDNA RANCK,
Director of Public Policy and Research.

STUDENT AID ALLIANCE,
Washington, DC, October 7, 1999.

Hon. TOM HARKIN,
Ranking Member, Labor, Health and Human Services Subcommittee, Washington, DC.

DEAR SENATOR HARKIN: We write on behalf of the Student Aid Alliance—a coalition of 60 organizations representing colleges and universities, students, and parents—to thank you for your leadership in crafting a Labor-HHS-Education appropriations bill for FY 2000 that recognizes the need for increased investment in student aid programs.

Despite the constraints of a woefully inadequate 302(b) allocation and stringent budget caps, your bill will help maintain access to postsecondary education for low-income students. It clearly recognizes the need for sustained federal investment in proven student

aid programs. We appreciate the central role you have played in bringing about increases for student aid programs in FY 2000.

At the outset of this year's appropriations process, the Student Aid Alliance set important goals for student aid funding. As you will recall, we have advocated for a $400 increase in the maximum Pell Grant, substantial increases in campus-based aid (SEOG, Perkins Loans, and Work-Study), LEAP, TRIO, and graduate education programs. Your bill takes a step in the right direction toward achieving our funding goals.

During the final weeks of the Congressional session, we will continue to seek additional opportunities to help achieve the funding recommendations of the Student Aid Alliance. We hope that by working together we can build upon your good work to make even more funding available for your subcommittee's priorities.

Again, thank you for your work on behalf of all college students. We look forward to working with you as the appropriations process continues.

Sincerely,

STANLEY O. IKENBERRY,
Co-Chair.
DAVID L. WARREN,
Co-Chair.

MEMBERS OF THE STUDENT AID ALLIANCE

American Association for Higher Education
American Association of Colleges for Teacher Education
American Association of Colleges of Nursing
American Association of Colleges of Pharmacy
American Association of Collegiate Registrars and Admissions Officers
American Association of Community Colleges
American Association of Dental Schools
American Association of State Colleges and Universities
American Association of University Professors
American College Personnel Association
American College Testing
American Council on Education
American Psychological Association
American Society for Engineering Education
American Student Association of Community Colleges
APPA: The Association of Higher Education Facilities Officers
Association of Academic Health Centers
Association of Advanced Rabbinical and Talmudic Schools
Association of American Colleges and Universities
Association of American Law Schools
Association of American Medical Colleges
Association of American Universities
Association of Catholic Colleges and Universities
Association of Community College Trustees
Association of Governing Boards of Universities and Colleges
Association of Jesuit Colleges and Universities
Career College Association
Council for Christian Colleges and Universities
Coalition of Higher Education Assistance Organizations
College and University Personnel Association
College Board
College Fund/UNCF
College Parents of America
Council for Advancement and Support of Education
Council for Higher Education Accreditation
Council of Graduate Schools
Council of Independent Colleges
Educational Testing Service
Hispanic Association of Colleges and Universities
Lutheran Educational Conference of North America
NAFSA: Association of International Educators
National Association for Equal Opportunity in Higher Education
National Association for College Admission Counseling
National Association of College and University Attorneys
National Association of College and University Business Officers
National Association of Graduate-Professional Students
National Association of Independent Colleges and Universities
National Association of State Universities and Land-Grant Colleges
National Association of Student Financial Aid Administrators
National Association of Student Personnel Administrators
National Collegiate Athletic Association
National Council of University Research Administrators
NAWE: Advancing Women in Higher Education
National Education Association
The Council on Government Relations
The Council for Opportunity in Education
United States Public Interest Research Group
United States Student Association
University Continuing Education Association
Women's College Coalition

NATIONAL COALITION FOR CANCER RESEARCH,
Washington, DC, October 7, 1999.

Hon. TOM HARKIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR HARKIN: On behalf of the National Coalition for Cancer Research, a coalition of 25 national organizations of cancer researchers, patients, and research advocates dedicated to eradicating cancer through a vigorous publicly and privately-supported research effort; I want to thank you and your colleagues on the Labor-HHS Appropriations Committee for your strong support of the National Institutes of Health (NIH) with regard to the FY 2000 appropriations.

It is very important that the Senate make a strong statement regarding the continued commitment to double the budget of the NIH in order to sustain the momentum of this historic initiative. It is vitally important that the Senate pass this legislation in order to provide the necessary leverage to maintain the Senate's position in conference negotiations and to move this important legislation to the next process. Thank you for your strong support and consideration of this important issue.

Sincerely,

CAROLYN R. ALDIGE,
President.

NATIONAL ALLIANCE FOR EYE AND VISION RESEARCH,
Washington, DC, October 7, 1999.

Hon. TOM HARKIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR HARKIN: Thank you for your continued strong commitment to biomedical research demonstrated by the $2 billion increase provided for the NIH in the Fiscal Year 2000 spending bill moving through the Senate.

On behalf of the National Alliance for Eye and Vision Research (NAEVR), I urge you and your colleagues to hold firm to your commitment through the conclusion of the budget process in order to stay on track towards doubling the NIH budget by 2003. Your efforts have given renewed hope to millions of Americans afflicted with disease and disabling conditions that improved treatments and cures may be close at hand.

It is critical that the Senate pass the Labor-HHS-Education spending bill in order that the nation's commitment to biomedical research is not weakened in the negotiations to determine the final funding outcome for NIH.

Once again, thank you for your strong support and for your consideration of this important issue.

Sincerely,

STEPHEN J. RYAN, MD,
President.

Mr. LOTT addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. LOTT. I will be brief because I know we need to go to final passage.

I must say that, amazingly, in a moment we are going to be voting on final passage of the Labor-HHS appropriations bill. I think this is the first time in 3 years that we have done that. I know we did not have one last year. I cannot recall for sure about 1997. I know we did in 1996. Regardless, this is the 13th and last of the appropriations bills. We are going to get to final passage. I hope it will pass.

I have to extend my congratulations to the chairman of the subcommittee, the Senator from Pennsylvania, and the Senator from Iowa. A lot of people thought we could not get it done, but here we are. I want to say a special thanks to PAUL COVERDELL, who acted as one of my assistants on this matter, working with the whip on our side, and HARRY REID, who did a great job. In fact, I had asked Senator COVERDELL if he would do this every week, and he has respectfully declined.

Having said that, following this bill—the last appropriations bill—there will be no further votes this evening, and no votes will occur on Friday of this week. In addition, the Senate will not be in session on Monday, in light of the Columbus Day holiday.

On Friday, the Senate will begin consideration of the Comprehensive Test Ban Treaty at 9:30 a.m. Obviously, this is a very important treaty, a very important matter, so I urge my colleagues to participate in the debate tomorrow. I think we have somewhere between 10 and 20 speakers who are going to speak on this tomorrow. I hope the Senators will watch it from their offices or review the debate that occurs on Friday.

This evening, the Senate will shortly begin the Agriculture appropriations conference report. Additional debate on that issue will occur this evening. Several votes will occur on Tuesday, October 12, beginning at 5:30. There could be one vote or more. I think it is very possible there could be a couple votes at that time on Tuesday dealing with the Agriculture appropriations conference report and possibly with the Comprehensive Test Ban Treaty.

So I thank all my colleagues for their cooperation. We have had a very successful week. We passed the FAA reauthorization, confirmed two judicial nominations, passed the foreign operations conference report. Now we are hopefully fixed to pass the Labor-HHS appropriations bill, and we will file cloture tonight, since it seems it is necessary, on the Agriculture appropriations conference report.

The bottom line: No further votes tonight; the next vote, 5:30 on Tuesday.

I yield the floor.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. I have a good bit to say, but since colleagues want to get to the airport, I shall say it after the final vote takes place.

I yield the floor.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mr. COVERDELL. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The bill having been read the third time, the question is, Shall it pass? The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from New York (Mr. SCHUMER) is necessarily absent.

I also announce that the Senator from Connecticut (Mr. DODD) is absent because of family illness.

The PRESIDING OFFICER (Mr. SESSIONS). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 73, nays 25, as follows:

[Rollcall Vote No. 321 Leg.]

YEAS—73

Abraham	Gorton	Mikulski
Akaka	Grassley	Moynihan
Baucus	Gregg	Murkowski
Bennett	Harkin	Murray
Biden	Hatch	Reed
Bingaman	Hollings	Reid
Bond	Hutchinson	Robb
Boxer	Hutchison	Roberts
Breaux	Inouye	Rockefeller
Bryan	Jeffords	Roth
Burns	Johnson	Santorum
Byrd	Kennedy	Sarbanes
Campbell	Kerrey	Shelby
Chafee	Kerry	Smith (OR)
Cleland	Kohl	Snowe
Cochran	Landrieu	Specter
Collins	Lautenberg	Stevens
Coverdell	Leahy	Thompson
Daschle	Levin	Thurmond
DeWine	Lieberman	Torricelli
Domenici	Lincoln	Warner
Dorgan	Lott	Wellstone
Durbin	Lugar	Wyden
Feinstein	Mack	
Frist	McConnell	

NAYS—25

Allard	Brownback	Craig
Ashcroft	Bunning	Crapo
Bayh	Conrad	Edwards
Enzi	Hagel	Sessions
Feingold	Helms	Smith (NH)
Fitzgerald	Inhofe	Thomas
Graham	Kyl	Voinovich
Gramm	McCain	
Grams	Nickles	

NOT VOTING—2

Dodd Schumer

The bill (S. 1650), as amended, was passed.

The text of the bill will be printed in a future edition of the RECORD.

Mr. SPECTER. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. SPECTER. Mr. President, I thank my colleagues on both sides of the aisle.

I ask unanimous consent when the Senate completes all action on S. 1650, it not be engrossed and be held at the desk.

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

Mr. SPECTER. Mr. President, I thank my colleagues on both sides of the aisle for the very strong vote in support of this bill. I thank my distinguished colleague, Senator HARKIN, ranking member, for his cooperation, for his leadership, and for his extraordinary diligence. We have had an extraordinary process in moving through this bill.

It is very difficult to structure funding for the Department of Education, the Department of Health and Human Services, and the Department of Labor which can get concurrence on both sides of this aisle. The bill came in at $91.7 billion. There have been some additions. It is hard to have enough spending for some, and it is hard not to have too much spending for others. I think in its total we have a reasonably good bill to go to conference.

The metaphor that I think is most apt is running through the raindrops in a hurricane. We are only partway through. We are now headed, hopefully, for conference. I urge our colleagues in the House of Representatives to complete action on the counterpart bill so we may go to conference.

We have already started discussions with the executive branch. I had a brief conversation with the President about the bill. He said his priorities were not recognized to the extent he wanted. I remind Senators that the Constitution gives extensive authority to the Congress on the appropriations process. We have to have the President's signature, but we have the constitutional primacy upon establishing the appropriations process at least to work our priorities. I am hopeful we can come to an accommodation with the President.

We have had extraordinarily diligent work done by the staff: Bettilou Taylor, to whom I refer as ''Senator Taylor,'' has done an extraordinary job in shepherding this bill through and taking thousands of letters of requests from Senators; Jim Sourwine has been at her side and at my side; I acknowledge the tremendous help of Dr. Jack Chow, as well as Mary Dietrich, Kevin Johnson, Mark Laisch, and Aura Dunn. On the minority staff, Ellen Murray has been tremendous, as has Jane Daye.

There is a lot more that could be said, but there is a great deal of additional business for the Senate to transact. I thank my colleagues for passing this bill.

AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2000—CONFERENCE REPORT

Mr. LOTT. Mr. President, I ask consent that the Senate proceed to the conference report to accompany the Agriculture appropriations bill, the conference report be considered as read, and immediately following the reporting by the clerk and granting of this consent, Senator JEFFORDS be recognized.

Mr. JEFFORDS. I object.

Mr. LOTT. In light of the objection, I now move to proceed to the conference report of the committee of conference on the bill (H.R. 1906) an act making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies for the fiscal year ending September 30, 2000, and for other purposes.

The PRESIDING OFFICER. The report will be stated.

The clerk read as follows:

The committee on conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 1906), have agreed to recommend and do recommend to their respective Houses this report, signed by a majority of the conferees.

The PRESIDING OFFICER. The question is on agreeing to the motion.

The motion was agreed to.

(The conference report is printed in the House proceedings of the RECORD on September, 30, 1999.)

Mr. LOTT. Mr. President, I ask consent following my remarks, Senator JEFFORDS be recognized.

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

Mr. LOTT. I say to the membership, if an agreement cannot be reached for a total time limitation that is reasonable, I will file a motion for cloture on the Agriculture conference report, and that a cloture vote will occur on Tuesday of next week at 5:30 unless a consent can be worked out to conduct the vote at an earlier time or unless something can be worked out to just have the vote on final passage.

I ask the Senator from Vermont if he is in a position to agree to a time limitation for debate at this time on the pending Agriculture conference report?

Mr. JEFFORDS. I believe I can't make that agreement at this time.

Mr. LOTT. I thank my colleague for his frankness. I understand his feeling about it. I know there are Senators on both sides of the aisle who have some

reservations about going forward with this bill. I know they can understand the need to move this very important bill on through the conference process and to the President for his signature.

CLOTURE MOTION

I send now a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the conference report to accompany H.R. 1906, the Agriculture appropriations bill.

Trent Lott, Thad Cochran, Tim Hutchinson, Conrad Burns, Christopher S. Bond, Ben Nighthorse Campbell, Robert F. Bennett, Craig Thomas, Pat Roberts, Paul Coverdell, Larry E. Craig, Michael B. Enzi, Mike Crapo, Frank H. Murkowski, Don Nickles, and Pete Domenici.

Mr. LOTT. I ask consent that the mandatory quorum under rule XXII be waived.

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

Mr. LOTT. I ask consent that the cloture vote occur at 5:30 p.m. on Tuesday.

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

Mr. LOTT. I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont is now recognized.

Mr. JEFFORDS. Mr. President, it is with great disappointment and reluctance that I stand before the Senate to express my reasoning for opposing the fiscal year 2000 Agriculture appropriations bill. This bill provides funding for agricultural programs, research, and services for American agriculture. In addition, it provides billions of dollars of aid for farmers and ranchers throughout America who have endured natural and market disasters.

However, and most unfortunately, it neglects our Nation's dairy farmers. I understand the importance of funding these programs and the need to provide for farmers. However, dairy farmers throughout the country, drought-stricken farmers in the Northeast, have been ignored in this bill. Congress is willing to provide billions of dollars in assistance to needy farmers across the country. Dairy farmers in States are not asking for Federal dollars but for a fair price structure for how their products are priced.

Vermonters are generally men and women of few words. Given that the State's heritage is so intertwined with agriculture and the farmer's work ethic, whether fighting the rocky soil or the harsh elements, Vermonters have developed a thick skin. If Vermonters want advice, they will ask it. Until then, it is best to keep one's mouth shut.

Indeed, a Vermonter will rarely meet a problem with a lot of discussion but, rather, with a wry grin and perhaps a shrug. If there is a blizzard and the temperature is below zero, the Vermonter will most likely put on his boots and grab a shovel. Talking isn't going to make the snow melt, but hard work will clear a path so the mailman can get to the door.

A Vermonter will always speak his or her mind with the fewest words possible. President Calvin Coolidge was a native Vermonter to the core. A woman told Calvin Coolidge, that taciturn 30th President who hailed from Vermont, she bet she could get him to say more than two words. Coolidge thought a moment and then replied, ''You lose.''

Vermonters know I must speak my mind about the importance of protecting the farm families in our State. They expect me to be generous with my thoughts and expressions on just how critical the Northeast Dairy Compact is to Vermont. I will not let them down. The clock is ticking on the dairy compact and Federal order reform. Every moment is valuable.

As Governor Aiken, a true Vermonter, said:

People ask what's the best time of the year for pruning apple trees. I say, when the saw is sharp.

In other words, procrastination has no place in a Vermonter's mindset. Assuming every Vermonter owns a sharp saw, the best time to get to work pruning an apple tree is right about now.

America's dairy farmers need our help. Now is the time to help them. Congress has the tools and the means, so let us not procrastinate on protecting the future of one of our most important resources. The farmers in New England have a program that works. It is called the Northeast Dairy Compact. Because the dairy pilot program has worked so well, no fewer than 25 States have approved compacts and are now asking Congress for approval.

Unlike other commodities such as wheat, cotton, or soybeans, milk cannot be stored to leverage a better price from the market. Milk must be bottled and shipped to the grocery store as soon as it is taken from the cow. Because of the unique situation milk is in compared to other commodities and ensuring there is a fresh local supply of milk in every region of the country, Congress established a pricing structure to protect farmers and consumers. There have been several modifications of the 1937 Agricultural Marketing Adjustment Act over the years to comply with changes at the marketplace, but the structure of the Federal milk marketing orders is as solid and important both to farmers and consumers today as in 1937.

The Federal milk marketing orders have assisted dairy farmers in surviving the economy and weathering prices. The Federal milk marketing orders over the last 60 years have been, and continue to be, supplying the Nation with sufficient supplies of a wholesome product and at very reasonable prices. You ought to compare the prices over time with other things such as soft drinks and things such as that and you will realize what a deal you have. To those who say they do not understand them, who make fun of their seeming complexity, I can only reply: They work. Because they work, dairy is not looking for a bailout in the form of disaster relief; no.

But dairy farmers do need relief of a different kind. There is no need for the expenditure of money. The compact we need to have does not cost the Government money; it saves the Government money. It also brings about a calm structure to the pricing aspects. It protects the producers, protects also the manufacturers, and has worked out especially well for consumers, giving them an average price for their milk which is lower than the average in the country. Where commodity farmers are asking their Government for relief from natural and market disasters, dairy farmers are asking for relief from the promised Government disaster in the form of a fair pricing structure from the Secretary of Agriculture.

This chart, which I will have here in a moment, will demonstrate so those who can see it will understand better what I am talking about. What we are here about today is that, basically, we have a very reasonable request for the continuation of a compact which has worked for many years now, and is so good that, first of all, it has 25 States that have passed laws to have another compact. But, most importantly, it also, unfortunately I should say at the same time, is keeping farmers in business. For some reason or other, those up in the Midwest, who have this compulsion to believe they can provide the milk for the whole Nation if they just had the chance, they don't like it. Why? It is keeping the farmers in business and they want them out of business so they can take away their markets.

Second, you have people who do not like it—although those in the area who are using it like it very much—but others outside the area are very concerned about it; that is, those who buy the milk are concerned because they no longer have a monopoly or they are at the mercy of the market. Because when dairy sits there, it spoils, so you have to get it right away. If nobody takes it, it is not worth much. So the processors do not like this because they do not set the price. They do not have a monopoly.

How does it work? We put together a system for the dairy farmer up in northeastern Vermont. They worked out this arrangement. That is why Massachusetts, which has very few farms, and Rhode Island, agreed to join together, because they found out it would work out for their processors, it would work out for the consumers, and it would work out for the farmers. But dairy farmers do need relief of a different kind.

There is no need for an expenditure of money where commodity farmers

are asking for relief from natural and market forces. They are asking for relief in the form of a fair pricing structure from the Secretary of Agriculture. This chart says it all. I hope my colleagues remember, I had this chart before this body some time ago. It helps us get the necessary votes to show a majority understood. From this chart, which is the revenue loss resulting from the Federal USDA order proposed—that is 1–B—you can see why we are having such conflict and why we are having a difficult time getting the dairy bill through.

On this chart, those States in red are the ones that will lose under 1–B. The States in green are the ones that will gain. Guess where those are that will gain. They are in the upper Midwest. Everybody else in the country, with a few exceptions, loses. So what does the Secretary do? He sets up this scam way of approving the order by saying it is 1–B or disaster. How would you vote? Would you vote for 1–B or would you vote for disaster? Guess what. 1–B won, but was that the preference of the farmers? No. We have gone to court on that and the court agreed and said that was a farce. So there is a restraining order to stop the imposition of 1–B. But remember that chart because it shows why and what this is all about.

Unless relief is granted by correcting the Secretary's final rule and extending the Northeast Dairy Compact, dairy farmers in every single State will sustain substantial losses, not because of Mother Nature or poor market conditions but because of the Clinton administration and the few in Congress who have prevented this Nation's dairy farmers from receiving a fair deal.

Unfortunately, Secretary Glickman's informal rulemaking process developed pricing formulas that are fatally flawed and contrary to the will of Congress. The Nation's dairy farmers are counting on this Congress to prevent the dairy industry from being placed at risk, and to instead secure a sound future.

Secretary Glickman's final pricing order, known as option 1–B, which I just talked about, was scheduled to be implemented on October 1 of this year. However, the U.S. district court has prevented the flawed pricing system from being implemented by issuing a 30-day temporary restraining order on the Secretary's final rule. That will expire at the end of this month. Hopefully, it will be extended.

The court found the Secretary's final order and decision violates Congress' mandate under the Agriculture Marketing Agreement Act of 1937, and the plaintiffs who represent the dairy farmers would suffer immediate and irreparable injury from implementation of the Secretary's final decision.

The court finds the plaintiffs have a likelihood of success in their claim that the Secretary's final order and decision violates the AMAA by failing adequately to consider economic factors regarding the marketing of milk in the regional orders across the country.

Again, this chart shows why the court said we had better take another look at this. If this is what is going to happen with this order by the Secretary of Agriculture, that does not seem to be consistent with talking about the regions, making sure the regions are handled fairly.

The temporary restraining order issued by the U.S. district court has given Congress valuable additional time to correct Secretary Glickman's rule. We must act now. With the help of the court, Congress can now bring fairness to America's dairy farmers and consumers. Instead of costing dairy farmers millions of dollars in lost income, Congress should take immediate action by extending the dairy compact and choosing option 1–A for the Secretary.

The Agriculture appropriations bill, which includes billions of dollars in disaster aid, seems to be a logical place to include provisions that would help one of this country's most important agricultural resources without any cost to the Federal Government. Again, I repeat that over and over again—without any cost to the Federal Government. Giving farmers and consumers a reliable pricing structure and giving the States the right to work together, at no cost to the Federal Government—again, at no cost to the Federal Government—to maintain a fresh supply of local milk is a novel idea.

If you learn about agricultural problems in this country, you will realize much of the aid in this bill does not go for disasters of the kind of weather or whatever. It is low prices. So what is going to happen? The Federal Government is going to put up billions of dollars because the farmers did not get the price that they thought was fair. That is fine, but why in the world could you, then, deny the area of New England an order which helps them to keep their farmers in business and doesn't cost any money to the Federal Government?

That sounds like a convoluted way of running a system, but we may be getting used to it.

It is an idea towards which Congress should be working. Instead, a few Members in both the House and Senate continue to block the progress and the interest of both consumers and dairy farmers.

The October 1, 1999, deadline for the implementation of the Secretary's rule has come and gone, but with the help of a U.S. Federal district court, Congress still has time to act. We must seize this opportunity to correct the Secretary of Agriculture's flawed pricing rules and at the same time maintain the ability of the States to help protect their farmers without additional costs to the Federal Government.

Federal dairy policy is difficult to explain at best. I have been here 24, 25 years. When I was in the House, I was fortunate enough, or unfortunate as you might say, to be the ranking member on a subcommittee dealing with dairy. I point back to that time because that was the Watergate years. The reason I got that job was because there were not many Republicans left, and all of us received ranking jobs of some sort.

At that time, we had problems, and we have had problems every year I have been here. We finally have come across a program that works that will prevent the travesties we have witnessed over the years. I have seen it for 24, 25 years now, and I finally see there are programs that will work, programs that will keep us out of disasters, programs that will make us proud of agriculture and protect the consumers' costs and protect all the others who work with it. Why do we want to do away with it?

Federal dairy policy is difficult to explain at best. As a Member who has served many years, and during my years in the House, I worked very closely with dairy programs that impacted dairy farmers and consumers. The Federal Milk Marketing Program may be difficult to explain, but its intent is simple. The Federal milk marketing orders, which are administered by USDA, were instituted in the 1930s to promote orderly regional marketing conditions by, among other things, establishing a regional system of uniform classified pricing throughout the country's milk markets. Milk marketing policy is defined by the fact that milk is a unique commodity. It is not something such as grain which is put in a storage bin or put in a freeze locker or canned. When you want it, you want it fresh and you want to be able to drink it.

Fluid milk is perishable and must be worked quickly through the marketing chain and reach consumers within days of its production. That is why if a farmer goes to the person from whom he normally purchases milk and he says we don't want it, they are at their mercy: ''Well, we'll take it up $2, $3 less a hundredweight if you really want to get rid of it.''

Unlike other commodities, this means that dairy farmers are in a poor bargaining position with respect to the price they can obtain from milk handlers. In addition, persistent price instability, particularly when prices are depressed, serves to drive producers from the market and damage the market's ability to provide a dependable supply of quality milk to consumers.

We get this up and down. If there is too much, farmers go out of business; if there is too little, then farmers either come back or they put more cows out. The interesting thing is, if you look at the charts—consumers should be very interested in this—you will see a ratchet effect. Every time the price to the farmer goes down, the retail price stays up there because the processors keep it up there. The farmers lose and the consumers lose. That price should

go down if the demand goes down, but that does not happen. That is another reason why this compact has worked so well because it takes that ratchet situation out of the system.

Based on the Agriculture Marketing Agreement Act of 1937, the major objectives of the Federal milk marketing orders are as follows: to promote orderly marketing conditions for dairy farmers; to equalize the market power of dairy farmers and processors within a market and thereby obtain reasonable competition; to assure consumers of adequate and dependable supplies of pure and wholesome fluid milk products from the least costly sources; and to complement the efforts of cooperative associations of dairy farmers, processors, and consumers; and to provide maximum freedom of trade with proper protection of established dairy farmers against loss of the market.

For dairy farmers increasing production to adjust to market conditions is not a matter of sowing more seeds. Price stability is a key to dairy farmers' success. That makes sense to me and should make sense to anyone who values having a local supply of fresh milk available at their local market at reasonable prices.

Yet while the market order system is basically sound, it still needs improvement. It is for this reason that the Congress in the 1996 farm bill directed the Secretary of Agriculture to revise the pricing system.

This Congress has made its intention abundantly clear with regard to what is needed for the new dairy pricing rules. Sixty-one Senators and more than 240 House Members signed letters to Secretary Glickman last year supporting what is known as option 1–A for the pricing of fluid milk.

On August 4 of this year, you will recall the Senate could not end a filibuster from the Members of the upper Midwest but did get 53 votes, showing a majority of the Senate supports option 1–A and keeping the Northeast Dairy Compact operating. Most recently, the House passed their version of option 1–A by a vote of 285–140.

The House and Senate have given a majority vote on this issue. Thus, I was very hopeful that its inclusion would have been secured in the Agriculture appropriations bill.

This unified statement of congressional intent reflected the fact that the majority of the country and the dairy industry support option 1–A. It has a broad support of Governors, State departments of agriculture, the American Farm Bureau, and dairy cooperatives and coalitions from throughout the country. Even the Land-O-Lakes Cooperative in the upper Midwest supports option 1–A and the compacts.

You can imagine the surprise and disappointment of so many of my colleagues and dairy farmers around the country when Secretary Glickman instead chose option 1–B for the pricing structure for fluid milk. Simply stated, if this option is allowed to be implemented, it will put the future of this country's dairy industry at severe risk.

The pricing provisions of the Secretary's final rule will result in lower producer prices by as much as a $1/2 million a day and will unnecessarily force farmers out of business. Adequate local supplies of fresh milk in our region will then be threatened and consumers will pay higher prices for fresh milk which is transported great distances from other areas of our country.

I see my good friend from New Jersey is here. I am ready to go on at length. I expect he wants to express himself.

Mr. President, I yield the floor at this time.

Mr. TORRICELLI. Mr. President, I thank the Senator from Vermont for yielding. I thank him in behalf of the dairy farmers in New Jersey and agricultural interests in our State and region for his extraordinary leadership in what is a defining moment for those of us in the Senate as to whether or not we will stand with agriculture in the Northeast or the dairy farmers and the farmers who remain in our region of the country are simply to dwindle and die as did so many who came before them.

I could not feel more strongly about this issue at this moment in the Senate. As the Senator from Vermont, year after year I have come to this well—or in my service in the House of Representatives—as an American feeling the need and the pain of others who suffered from hurricanes in Florida, earthquakes in California, tornadoes in the Midwest, floods in the upper Northwest to get assistance to people in need.

Through the years, I voted for agricultural appropriation after agricultural appropriation because I understood the hard work of American farmers in our heartland and the difficulties they face in flood or in diseases to crops, whatever the problem might be.

You can imagine my surprise to find, when the State of New Jersey, New England, and the Mideastern States have suffered the worst drought in generations, that our farmers are not receiving the same consideration.

From June through August, in a normal year, the State of New Jersey would receive 8 inches of rain. This year, New Jersey received 2 inches of rain. Our reservoirs were severely drained. The crops of many fruit and vegetable growers were devastated with losses of 30 to 100 percent.

Yesterday, Senator SANTORUM noted that this legislation deals with the falling prices of crops in the Midwest and offers relief. He appropriately said: We wish we had falling prices at which to sell our crops.

The crops of New Jersey farmers are destroyed. Yet this legislation, which offers $8.7 billion in relief, goes largely for low crop prices in the South and to a lesser degree in the Midwest. Only 10 percent is for natural disaster assistance for the entire Nation.

Not only is it not adequate, it is an insult to the hard-working farmers in New Jersey and New England who have been devastated by the drought. In my State, 400,000 acres of farmland, on 7,000 farms, have sustained what is estimated to be up to $100 million worth of damage.

Secretary Glickman has estimated there could be $2 billion worth of damage in the entire Northeast. The Governors of our States, including Governor Whitman in my own State, have estimated it could be $2.5 billion. That was before Hurricane Floyd brought its own damage to North Carolina and New Jersey and other agricultural interests. This legislation offers but 10 percent—less than half, probably less than a third—of what the need really is at the moment.

It will surprise some around our country to understand why a Senator from New Jersey would take this stand attempting to block the entire agricultural appropriations for the whole Nation because of farmers in New Jersey.

New Jersey has not been identified as the Garden State by chance. Agriculture in New Jersey is a $56 billion industry. It is the third largest industry in the entire State. It matters. The nursery industry alone is a $250 million annual business. The sale of vegetables, such as tomatoes, peppers, and cucumbers, is a $166 million industry. And the sale of fruits, such as cranberries, peaches, and blueberries, is a $110 million business. Our field crops, such as corn, winter wheat, and soybeans, generate $66 million in sales while our dairy industry is a $41 million business.

This is not some ancillary problem in the State of New Jersey. It is the economic life of whole counties, entire communities, and thousands of people. At $8,300 for an average acre of land in New Jersey, our farmland is the most valuable in the Nation, growing 100 different kinds of fruits and vegetables for local and national consumption.

I take a stand against this legislation because I have no choice. I join with the Senator from Vermont because of the devastation of our agriculture industry but also because I share the Senator's deep concern for the future of dairy. The dairy industry was once one of the largest and most important in the State of New Jersey. There are now no more than 180 dairy farms left, with hard-working people in Salem, Warren, Sussex, and Hunterdon Counties.

I know if the Senator from Vermont does not get consideration for his dairy farmers, his dairy industry will become tomorrow what the dairy industry has come to be today—prices that do not sustain a quality of life and do not allow people to keep the land. Those dairy farms will be destroyed.

In the last decade alone, 42 percent of the dairy farms in New Jersey have been destroyed—beautiful lands that sustained families and communities and are now parking lots and shopping centers or simply vacant, idle land. The fact is, a dairy farmer today in New Jersey cannot get a price to sustain the costs of his business. Without

the compact that the Senator from Vermont is advocating, they never will. New Jersey dairy farms have experienced a 37-percent drop in the price of their product. It is not sustainable.

So I thank the Senator from Vermont for yielding the time. I pledge to return to this floor with him to fight for disaster assistance for New Jersey farmers who have lost their crops and need help—not a loan, because they cannot sustain a loan; they cannot pay interest on a loan. These are small family farms that simply need a Federal grant, a fraction of the kind of expenditures that will go to the South and the Midwest—a fraction—so they can plant their crops again in the spring and have a new crop next year to feed their families and feed our communities. For this dairy compact, we need to make sure these few remaining dairy farmers are not lost and the 20 percent of the fresh milk that goes to New Jersey families can continue to come from our own farms.

For those people who live in the urban areas of New Jersey and in suburban communities, who think they are far away from these dairy and agricultural needs, this remaining agricultural land in New Jersey must not be destroyed, because with every dairy farmer who goes out of business, every family farmer who has to sell their land, that open space is lost to suburban sprawl, and it affects the quality of life of every family in our State.

So I thank the Senator from Vermont for yielding the time. I pledge to return again and again with him to try to fight this legislation and, if by chance we should fail, to urge the President to veto it. I thank the Senator for yielding the time.

I yield the floor.

Mr. JEFFORDS addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I commend the Senator from New Jersey for his very realistic look at this bill. I would like to emphasize that there is so much more than the ordinary disaster in here. It has nothing to do with hurricanes and the drought. And the billions of dollars for the Northeast, which had the drought and problems and all, have nothing to do with farmers. Not only that, the program they have—which costs no money and which has given security to the farmers and helped the consumers—will not go forward. They rejected our attempts to put it in there.

The Senator from Oregon, I believe, desires to speak on another matter. I would like to finish up with a few more remarks, and then I would be happy to yield. We may have one other Member coming over to speak on dairy. But I know he also supports this effort, and I appreciate that very much.

Let me remind my colleagues that unlike years ago, the Federal pricing program has essentially no Federal cost and no Federal subsidy. So here we are arguing for something to protect our farmers, to protect consumers, to protect the processors with a reasonable price, and we cannot get it approved, when billions of dollars are being spent in the disaster bill for nondisasters—except a lower price. That is a disaster, but it is not the kind of disaster we look to for protection by the Federal Government.

The overall loss to dairy farmers caused by the overall final rule is even more startling. We are back on 1–B, the one the Secretary of Agriculture jammed down the farmers' throats. Fortunately, the courts have put a stop to that.

The Secretary's final rule will drop the price paid for cheese by as much as 40 cents per hundredweight of milk. That is the way we look at how we reward the farmers for each hundredweight of milk. Dairy economists estimate that U.S. dairy farm annual income will fall in total by at least $400 million or more under the Secretary's final decision.

Who benefits from that? Do the consumers? No. There is no evidence whatsoever that they will benefit. Who will benefit? The processors, the ones that buy the milk. Their profits will go up. The farmers' profits will go down. And the consumer prices will go up. What we are trying to set up is a system where that does not occur. The Northeast is projected to lose $80 million to $120 million per year under 1–B. The Southeast loses $40 to $60 million. The upper Midwest will lose upwards of $70 million, even though, as the chart in red shows, they lose a lot less. In fact, they gain. On the other hand, most areas of the country will be better off under option 1–A, including the upper Midwest. Marginally increasing producer income in most regions of the country, option 1–A is based on solid economic analysis, benefiting both farmers and consumers. It takes into account transportation costs for moving fluid milk, regional supply and demand needs, the cost of producing and marketing milk, and the need to attract milk to regions that occasionally face production deficits.

In early August, dairy farmers were given the opportunity to vote for option 1–B or reject the Federal Milk Marketing Order Program. That is right. There were two choices given to dairy farmers: Either approve option 1–B or have no Federal order program. Which is it? It is not a surprise that the farmers overwhelmingly chose the lesser of two evils.

There was no sense to this. There was no reason to allow it to occur. Correcting the Secretary's final rule, as part of the Agriculture appropriations bill, would have prevented dairy farmers across the Nation from losing millions of dollars in income.

Let me also explain briefly, before I turn to my friend from Oregon, the votes were in the conference committee to put in what we are trying to do. They were there. However, what happened? Just as we were about to have that vote, people from processors and others came in, and the leaders who were behind this move were able to convince those Members not to vote for what we want here, which is basically real help to farmers and consumers.

With that, Mr. President, I yield the floor, at least until my good friend from Oregon has finished.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, I want to take a few minutes tonight—Senator GRAHAM of Florida will be joining me, and Senator GORDON SMITH of my home State, my friend and colleague, will be joining me as well tonight—the three of us want to take a few minutes to talk about the important amendment we were able to have added to the HHS appropriations bill during the course of the last week.

In the beginning, we especially express our appreciation to Senator SPECTER and Senator HARKIN. They worked with the three of us and our staffs over the last week on this particular issue.

What our agricultural labor amendment does is require the Department of Labor to report to the Congress on how the Department plans to promote a legal, domestic workforce—specifically, to improve compensation, working conditions, and other benefits for agricultural workers in the United States.

Today's agricultural labor program is a disaster for both farm workers and for farmers. We have a system that is completely broken. Estimates are that well over half of the farm workers in this country are illegal. As a result of their status, they can have no power at all. They can't even vote. They are subjected to the worst possible conditions imaginable, horrendous housing, and, in many instances, thrown into the back of pickup trucks and moved by people called coyotes, who, for a profit, bring them from other countries. The conditions to which our agricultural workers are subjected in so many instances are nothing short of immoral.

At the same time, the growers, who have a dependable supply of workers to pick their crops, are also in a completely untenable situation, the growers who want to do the right thing. Senator SMITH and I represent a great many of those growers and farmers in our home State of Oregon, who don't know where to turn to find legal workers.

The General Accounting Office did a report a couple of years ago on the farm worker situation in our country. They said there really are enough farm workers, but they came to that conclusion only by counting the illegal farm workers in our country. Well over half of the farm workers in the United States are illegal. It is a situation that essentially turns those farmers, when they want to do the right thing, into people who have to make a choice as to whether or not they want to be felons

and not comply with the law or simply another individual in the bankruptcy line in our country.

To give you an idea how absolutely unacceptable this situation is, just this week I had berry farmers from my home State in Oregon telling me they had recently had meetings with the Department of Justice and the Immigration and Naturalization Service. They were told, in effect, how to work the system, but they weren't given any hope that what they were doing was within the law. In effect, the administration was telling the berry farmers in my State, with a wink and a nod, they should tolerate this system that is based on workers who can have no power and farmers who lack a system that is dependable and reliable so they can find legal workers.

In the last session of Congress, Senator GRAHAM, Senator SMITH, and I put together a bipartisan proposal to change this wholly unacceptable situation and produce a new system for dealing with agricultural labor that would be in the interest of both the farm worker and the farmer. Under our proposal, workers who were legal would get a significant increase in their benefits. Just how significant was documented in a report done for us by the Library of Congress, October 21, 1998. At page 2 of that report, it states specifically that the Library of Congress found that under our proposal—it received 67 votes in the Senate—the legal farm worker would get significantly higher wages, under what the Senate voted for. In addition, there would be benefits for housing, transportation, a variety of benefits that are so critical to the farm workers.

But after 67 Members of the Senate voted for our proposal, the administration said: It is unacceptable. We are going to veto it. It is not good enough. We have other ideas.

At that time, Senator SMITH, Senator GRAHAM, and I entered into a series of discussions with the Clinton administration asking them for their plan on how to produce this system that would address the legitimate concerns of both the farm workers and the growers. We have been at that for more than a year.

I see our good friend Senator GRAHAM coming to the floor, and I will yield to him in just a moment.

Senator GRAHAM, Senator SMITH, and I have been at the task of trying to get from the administration their plan to deal with agricultural labor for more than a year. We told them, if they don't like our proposal—67 votes in the Senate; the Library of Congress said it will produce higher benefits, wages, improved transportation, and improved housing for so many legal workers—since it wasn't good enough for the Clinton administration, we would like to see their proposal. We decided we would, in the spirit of comity and a desire to get an agreement with the executive branch, wait for their proposal.

We are still waiting to this day. The administration remains on the sideline to this day, unwilling to come forward with any specific ideas that would be in the interests of both the workers and the growers. Just this week, they told the berry farmers in my home State—and we do a lot of things in Oregon well; frankly, what we do best is grow things; our farmers are very important to our State—the administration basically told them, just wink and nod at the rules that are out there today.

In December of 1998, Alexis Herman, Secretary of Labor, sat in a meeting in Senator GRAHAM's office with Senator GRAHAM, Senator SMITH, and myself. Alexis Herman told us, three Members of the Senate, that the administration would give us a specific proposal for dealing with this agricultural labor situation by the end of February 1999.

No such proposal has ever been delivered. In a moment, I am going to yield to my friend from Florida because he has essentially laid out a timeline that demonstrates how many times we have tried to get the administration off the sidelines and to join us in a bipartisan effort to produce a system that would work for the farm worker and for the grower.

By its inaction, the administration is perpetuating a system that is a disaster for both the farm worker and the farmer. It is a system that is totally broken—a system that has condemned the vast majority of farm workers to some of the most terrible and immoral conditions imaginable. It is a system that has made it impossible for the farmers who want to do the right thing to know where to turn.

In the last Congress, Senator GRAHAM, Senator SMITH, and myself brought a legislative proposal that would change that, which the Library of Congress said would produce a significant amount of additional benefits for the legal farm worker. The Clinton administration said that wasn't good enough, and we have waited and waited for their ideas.

Well, tonight, as a result of the action taken in the Labor-HHS bill, we are calling, as a matter of law, on the Clinton administration to give us their plan as to how to produce a legal domestic workforce, which would have improved compensation, improved working conditions, and improved benefits that those farm workers are entitled to as a matter of simple justice.

So I am hopeful that we will get the administration off the sidelines soon. I am hopeful that they will do what they promised to do well over a year ago.

If the Senator from Vermont is willing, I would like to break my remarks off at this point and allow the Senator from Florida to speak for a few minutes. We want to be courteous to our colleague from Vermont because he is dealing with an issue of great importance to him. We will be brief.

I ask unanimous consent that a memorandum be printed in the RECORD.

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

CONGRESSIONAL RESEARCH SERVICE,
LIBRARY OF CONGRESS,
Washington, DC, October 21, 1998.

[Memorandum]

To: The Honorable Ron Wyden; Attention: David Blan.
From: American Law Division.
Subject: Agricultural Labor Proposal.

In your letter of October 15, 1998, you asked for a memorandum comparing the basic federal protections available to farm workers with the protections that would have been extended to farm workers under the proposed conference agreement to the Commerce State Justice bill/H2A provision. The letter stated that you are ''especially interested in whether the agricultural labor proposal before the Appropriations Conference Committee would have offered farm workers, and particularly the more than 99.5% of U.S. farm workers who work on non-H-2A farms new or expanded benefits compared to current law.''

The proposal would have required the Secretary of Labor to establish state and regional registries containing a database of eligible United States workers seeking temporary or seasonal agricultural jobs, in order to inform those workers of available agricultural jobs and to grant them the right of first refusal for available jobs. Basically, farmers would have to apply to the registry for U.S. workers, and hire all referred U.S. workers, before they could seek nonimmigrant alien temporary agricultural workers under the immigration program known as ''H-2A.'' Agricultural employers could not import any workers unless the registry failed to refer a sufficient number of registered workers to fill all of the employer's job opportunities. Therefore, the employer could only acquire as many imported workers as would be needed in addition to those U.S. workers referred.

The proposal would have had an impact on domestic farm workers in addition to its effect on alien workers. The general legislative scheme was to condition the right of an agricultural employer to request and hire temporary alien workers on the employer's requirement, first, to seek domestic workers from the registries maintained by the Labor Department, and, then, to extend the protections granted to H-2A aliens under the proposal to all workers in the same occupation on the same farm. Under the proposal, agricultural employers seeking domestic and foreign workers through the registries were required to assure that they would not refuse to employ qualified individuals, and would not terminate them unless there were ''lawful job-related reasons, including lack of work.'' Employers were also required to comply with the following specific assurances.

WAGES

Under current law, agricultural employers, unless they are exempt as small farmers, must pay the applicable minimum wage and overtime rates under the federal Fair Labor Standards Act (FLSA) or 1938, as amended. 29 U.S.C. §§201–19. Under that law, farm workers must receive the greater of the applicable federal or state minimum wage.

Under the conference agreement, the employer must pay the greater of the prevailing wage in the occupation or the adverse effect wage rate to the workers. The employer using the registry must provide assurances that the wages and benefits promised to the workers hired from the registry would be provided ''to all workers employed in job opportunities for which the employer has applied [from the registry] and to all other workers in the same occupation at the place of employment.''

MIGRANT WORKER PROTECTION

Under current law, agricultural employers who hire migrant and seasonal workers must

comply with the provisions of the Migrant and Seasonal Agricultural Worker Protection Act (MSWPA). 29 U.S.C. §§1801–72. The MSWPA, however, does not cover any temporary nonimmigrant alien authorized to work in agriculture employment under the H–2A program. See 29 U.S.C. §1802(8)(B)(ii).

Under the proposal agricultural employers were required to comply with all applicable federal, state, and local labor laws, including laws affecting migrant and seasonal agricultural workers, for all United States workers as well as all alien workers on the farm.

HOUSING

Under current law, employers have no responsibility to provide housing or housing assistance to their workers. Under the Migrant and Seasonal Agricultural Worker Protection Act (MASWPA), any person who owns or controls housing must comply with substantive federal and state safety and health standards applicable to that housing. 29 U.S.C. §1823.

Under the conference proposal, employers are required to provide housing at no cost to all workers in jobs for which the employer has applied to the registry, and to all other workers in the same occupation as the place of employment, if the workers' permanent place of employment is beyond normal commuting distance. The employer may provide a housing allowance as an alternative.

WORKERS COMPENSATION

Under current law, workers compensation coverage is exclusively a subject of state law, which may not cover all agricultural employees, especially those considered casual or temporary.

Under the proposal, the employer was required to provide insurance coverage providing benefits equivalent to those under state law, at no expense to the worker, for any job that was not covered by the state workers compensation law.

HEAD START

Under current law, migrant employees find barriers to participation in Head Start programs.

Under the proposal, the Migrant and Seasonal Head Start Program would have been established, removing barriers to participation by the children of migrant farmworkers.

TRANSPORTATION

Under current law, employers are not obliged to provide transportation to workers. If transportation is furnished, the employer and any farm labor contractor must comply with the motor vehicle safety requirements of the MSWPA. 29 U.S.C. §1841.

Under the conference proposal, a worker who completed 50 percent of the period of employment would be reimbursed for transportation expenses to the job, and a worker who completed the period of employment would be reimbursed for the cost of transportation back to the worker's permanent place of residence.

ENFORCEMENT OF LABOR LAWS

Under current law, labor laws are enforced primarily by the U.S. Department of Labor and by the responsible state labor enforcement agencies.

Under the proposal, the Secretary of Labor was required to establish an expedited complaint process, including a written determination of whether a violation has been committed within 10 days of the receipt of a complaint.

Workers on farms where the employer did not seek workers through the Labor Department registry would not have been affected by the proposal. Agricultural employers who hire migrant and seasonal workers must comply with the provisions of the Migrant and Seasonal Agricultural Worker protection Act (MSWPA). 29 U.S.C. §§1801–72.

In conclusion, the proposed agricultural registry program would have required farmers to extend the protections of the federal migrant and seasonal worker law to all workers in the same occupation on the site. The proposed agricultural employment bill could well have expanded employment protections for U.S. workers beyond current law. If an agricultural employer applied to a registry and found enough U.S. workers for some or all of the available job opportunities, then those U.S. workers would have been entitled to the enhanced wage, housing, transportation, and other benefits and protections made applicable to all employees in the same work on the same site.

Mr. WYDEN. I am going to yield the floor at this time.

Mr. JEFFORDS. Mr. President, the Senator from Maine has a brief statement to make on the bill that we are talking about. I know the Senator from Florida has a brief statement, and I have no objection to the Senator from Florida leading. I also thank my friend from Oregon for his remarks about a very serious topic.

I yield to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. GRAHAM. Mr. President, I thank my colleagues from Vermont and Maine for their always courteous generosity, and my colleague from Oregon, with whom I have been working so closely for approximately 2 years-plus now on this important issue.

There is one thing I believe we can agree on, and that is that the status quo of agricultural farm workers in America is unacceptable. It is unacceptable to have somewhere between 35 and 50 percent of all of our migratory farm work done by people who are here illegally. It is unfair to the individuals involved because it puts them in the shadows of our society.

If I may, I will state a personal experience. Immediately after Hurricane Andrew, which hit south Florida in August of 1992, there was great concern about communicable diseases such as cholera; therefore the Public Health Service wanted to inoculate the whole population against the potential of these diseases. There is a substantial migrant farm worker population that lives in the southern part of our State, and many of those people refused to come forward to be inoculated, nor would they allow their children to be protected against communicable diseases because they live in such a dark shadow because of their undocumented status. They were fearful that if they came forward, even with firm promises and commitments by the Public Health Service that they would not be reported for any other purpose, they were still not willing to take the risk. So they put themselves, their families, and the entire community at risk. That is one anecdote of the degree to which, by our acceptance of the status quo, we have placed hundreds of thousands of people into a status of servitude and in the dark closet of our society.

We also have placed honest farmers in an extremely difficult situation. They are frequently presented with documents that appear to be credible. They hire people to do necessary work during the brief period that is available to harvest the crops, and then they find out later that these people had fraudulent documents, were undocumented, and that they might be subject to various sanctions.

We also know that because of the current system, we have farm workers—both those who are legal citizens or residents of the United States, as well as those who are undocumented—living in horrendous circumstances of housing, being transported in vehicles that don't meet basic safety standards, being placed in a position where their salaries are held each week in order to pay off previous debts, and they live in conditions that are reminiscent not of the 21st century but of the 17th or 18th century. These people are doing extremely difficult work, work that is vital to our Nation and vital to our Nation's economy. They deserve better from us, the policymakers of America, than we have done for them in the past.

One thing we also know, in addition to the fact that the status quo is unacceptable, is the status quo will continue until we decide that this issue is important enough to engage in a serious debate in which we can analyze what the problems are with the status quo, and what the range of solutions to those problems are, and which of those solutions appear to be most appropriate. And it is regarding that which the Senator from Oregon has mentioned that we have had a series of efforts to try to elicit from the administration their plan.

Now, why have we focused so much on the administration? Well, first, they happen to have a unique perspective on the problem, since they are responsible to the Department of Labor, and, secondarily, the Department of Agriculture, for the implementation of the status quo. Therefore, they should be in a specially advantaged position to analyze and recommend alteration to the status quo.

We also know in this form of government we have that while the legislature's responsibility is to enact law, the President, because of his role and because of his constitutional veto authority, plays a key position in terms of legislation and the law.

So beginning in June of 1997, we have been meeting with representatives of the administration, heads of departments, as well as representatives of the White House. Senator WYDEN and myself, sometimes accompanied by others, have met face-to-face, occasionally by conference telephone call, and occasionally by correspondence with the administration on 12 separate occasions between June of 1997 and May of 1999.

Each one of those had a common theme: What is your proposal? What is your diagnosis of the problem? What is your prescription against this problem?

As of today, in early October of 1999, we have yet to receive a credible response to that question.

Thus, the amendment that was accepted to the bill we have just adopted directs the administration to submit to the Congress such a plan. It is my hope that the administration will do so with a sense of expedition. I hope within a period of 60 or 90 days we receive its recommendations so that, if not at their first session of the 106th Congress, then at the earliest point in the second session of the 106th Congress, we would be in a position to have the administration's views as to how this very vexatious problem could be resolved.

I might say that the fact we have made this request, and have made it now for the better part of 30 months, is not an indication that we are going to desist until we have heard the administration's plan. While we would like to have their guidance and suggestions, we consider it to be our ultimate responsibility, as we did in 1998 when we presented to the Senate and the Senate adopted by a margin of well over 2 to 1, the proposal that we submitted. We will continue to take effective action to keep this issue on America's agenda because we cannot tolerate a continuation of the status quo which places hundreds of thousands of human beings into a position of servitude and which places hundreds of thousands of legitimate farmers in a position in which they must operate at the fringe of the law when what they want to do is to be law-abiding citizens.

Before this 106th Congress concludes, I hope we will have had the wisdom to reject the status quo and to have adopted humane, effective public policy which will erase the stain of the status quo of American farm workers, which will have lifted this cloud of illegality from American farmers, which will assure standards of treatment that we as fellow human beings would consider to be dignified and respectful for other human beings, and that we can move forward with a new era in America agriculture.

I appreciate the work of my colleague from Oregon. I also commend our other colleague from Oregon, Senator GORDON SMITH. It is an outstanding example of the people of Oregon who have sent to us these two Members of the Senate, who happen to be from different parties but understand their ultimate commitment is to America and to what is best for this great Nation. They are giving us, in this case, as in other areas, an example of what bipartisanship means and what bipartisanship can accomplish. For that, as well as for their friendship, I extend my gratitude.

The PRESIDING OFFICER. The Senator from Maine.

Mr. JEFFORDS. Mr. President, I know my good friend from Maine is desirous to speak, and I certainly appreciate that.

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. SNOWE. I thank the Senator.

Mr. President, I rise today in opposition to the Agriculture conference report. I rise in strong opposition to the conference report.

First, I wish to commend my colleague from Vermont, Senator JEFFORDS, for his leadership, for his perseverance, for his hard work and determination on behalf of all the small dairy farmers, not only in his State of Vermont but in the State of Maine and throughout New England. I thank him. I commend him for the extraordinary effort he has displayed and exhibited throughout this process.

It is only regrettable that those members of the conference committee in resolving the differences between the House and the Senate on the Agriculture conference report did not recognize the position that has been held by all of us who represent the New England States for the Northeast Dairy Compact. That is why I rise in strong opposition to the Agriculture appropriations conference report because it does not extend a reauthorization of the Northeast Dairy Compact.

This issue is a States rights issue more than anything else. Quite simply, it addresses the needs of the States in the Northeast, and most specifically those in New England, that have organized in a way that we can allow fair prices for locally produced supplies of fresh milk.

All the legislatures have approved the compact in New England, and in the Northeast, and all that is required is the sanction of Congress to reauthorize this compact. The compact has protected New England farmers against the loss of their small family dairy farms and consumers against the decrease in the fresh supply of local milk. The compact has proven to be an effective approach to address farm insecurity. The compact has stabilized the dairy industry in this entire region and has protected farmers and consumers against volatile price swings.

As I say, we are talking about small dairy farmers. In my State of Maine, the farmer has an average of 50 cows on their farm. They are trying to preserve a way of life, a way of life that has been there for families for generations. We are trying to protect them through this dairy compact.

All we are asking from this Congress is a reauthorization so we can extend this way of life to small dairy farmers—not agribusiness, not big business, not co-ops, just small dairy farmers who want to produce milk so they can sell it to the consumers in my State of Maine, to Senator JEFFORDS' State of Vermont, and within the New England region.

Over 97 percent of the fluid milk market in New England is self-contained. Fluid milk markets are local due to the demand for freshness and high transportation cost. So any complaints raised from other parts of the country about unfair competition is quite disingenuous.

All we are asking for is a continuation of the Northeast Dairy Compact, the existence of which does not threaten or financially harm any other dairy farmer in the country—not any other dairy farmer in the country. It is to help our dairy farmers within New England, to help the consumers, to help a way of life. The Northeast Dairy Compact currently encompasses the New England States and only applies to fluid milk sold on grocery store shelves in the Northeast.

Only the consumers and the processors in the New England region pay to support the minimum price to protect a fair return to the areas' family dairy farmers and to protect a way of life important to the people of Northeast.

All six of the New England States have supported this through the acts of the legislature, and through all of their Governors, because each Governor has signed a resolution supporting the Northeast Dairy Compact.

Let me repeat. Every Governor and every State legislature in New England have supported the dairy compact. Republicans, Democrats, and Independents support the dairy compact through acts of the legislatures because they recognize how important this compact is to the small dairy farmers in the Northeast.

Under the compact, New England retail milk prices have been among the lowest and the most stable in the country. The opposition—again, we have heard it day in and day out—has manufactured arguments against the compact, saying that increased milk prices.

Let's look at dairy prices over the past few months around the country for a gallon of fresh milk. The price in Augusta, ME, ranged from $2.89 to $2.99 per gallon from February to April of 1999; in Boston, MA, the market price stayed perfectly stable at $2.89 from February to April of 1999; the price in Seattle ranged from $3.39 to $3.56 over the same time period. Washington State is not in the compact. Yet their milk was approximately 50 cents higher per gallon than in the State of Maine. The range in Los Angeles was from $3.19 to $3.29; in San Diego, the range was from $3.10 to $3.62. California is not in the compact. Las Vegas prices were $2.99 all the way up to $3.62 in that time period; not much price stability there. And then Nevada is not in the compact. In Philadelphia the range was $2.78 to $3.01 per gallon, not as wide a shift as Nevada but a much wider price shift than the Northeast Compact States.

That is why Pennsylvania dairy farmers want to join us. That is why Pennsylvania supports joining the compact.

Denver, CO, on the other hand, is not in the compact. A gallon of milk in Denver has cost consumers anywhere from $3.45 to $3.59 over the past few months, over one half a dollar more than in New England.

The Northeast Dairy Compact has not resulted in higher milk prices in

New England in spite of what the opposition has said, but milk prices are among the lowest in the country and are among the most stable.

Opponents also say consumers are getting a raw deal having to spend more on milk. Obviously, based on what I have said thus far in terms of prices around the country, this claim is inaccurate, as prices are among the lowest in the Northeast Compact area and reflect greater price stability.

Also, where is the consumer outrage from the compact States for spending a few extra pennies for fresh fluid milk so as to ensure a safety net for dairy farmers so they can continue in an important way of life. Where is that consumer outrage? It isn't in New England. I have not heard of consumer complaints in my State over the last 3 years as a result of this dairy compact, even in instances where milk prices might have gone up a few pennies because consumers support our dairy farmers. They realize that this pilot program is very important to a way of life, to the kind of milk they want in their region, and they are willing to support it. They recognize this dairy compact has been a huge success.

The Compact Commission sent out over $4 million in checks to Northeast dairy farmers this past month. That averages to over $1,000 for each dairy farmer—enough to help keep small family farmers in business and continue a historical way of life that is so important.

The Northeast Interstate Dairy Compact has provided the very safety net that we have hoped for when the compact passed as part of the Freedom to Farm Act, the omnibus farm bill of 1996. The dairy compact has helped farmers maintain the stable price for fluid milk during times of volatile swings in farm milk prices.

In the spring and summer months of 1997 and 1998, for instance, when milk prices throughout most of the country dropped at least 20 cents a gallon while consumers' prices remained constant, the payments to the Northeast Interstate Compact dairy farmers remained above the Federal milk marketing prices for class 1 fluid milk because of the dairy compact and I might add, at no expense to the Federal Government. The costs to operate the dairy compact are borne entirely by the farmers and the processes of a compact region.

Also, consider what has happened to the number of dairy farmers staying in business since the formation of the dairy compact. Another goal of the compact is to preserve a way of life of the small dairy farmer. It is now known throughout New England there has been a decline in dairy farmers going out of business. This is a clear demonstration that with the dairy compact, the dairy producers were provided a safety net, which is what we had hoped for. The results have been just that.

In addition, the compact requires the Compact Commission to take such action as necessary to ensure that a minimum price set by the commission for the region does not create an incentive for producers to generate additional supplies of milk. There has been no rush to increase milk production in the Northeast, as has been stated. Oh, we heard time and time again by the opposition that it would increase milk production.

We inserted in the compact legislation back in 1996 compensation producers that have been implemented by the New England Dairy Commission specifically to protect against increased production of fresh milk. That legislation in the 1996 farm bill required the commission to reimburse the USDA for any portion of the Government's cost of purchasing surplus dairy products that could be attributed to an increase in milk production in the Northeast in excess of the projected national average. This provision was included in the farm bill in response to critics' concern that the compact price would lead to overproduction of milk in the Northeast and thus cause Government purchases of surplus milk under the dairy support program to rise.

Between March and September of 1998, the commission placed $2 million in escrow in anticipation of a potential liability to USDA for surplus purchases. The commission ended up paying $1.76 million to the USDA toward the end of the fiscal year and returned unused escrow funds of $400,000 to the Northeast producers who did not increase milk production during fiscal year 1998.

I welcome anybody in this Chamber to cite any other commodity farm program that actually paid back the Federal Government money, that didn't cost the Government any money. I daresay there is no other instance of any other commodity farm program that actually reimbursed the Federal Government, that didn't cost the Government one dime—other than the New England Dairy Compact.

How can other regions of the country feel threatened by a Northeast Dairy Compact for fluid milk produced and sold mainly at home in our region of the country? This compact did what it said it would do: Preserve its way of life, create price stability; it didn't cost the Government money; it didn't increase production, and if it did in any small way, we reimbursed the Government so it wouldn't cost any money.

Despite what has been stated by the opposition, again there has been no additional cost to the Federal nutrition programs, no adverse price impact in the WIC Program—the Women's, Infants and Children Program—or the Federal school lunch and breakfast program. In fact, the advocates of the programs support the compact and serve on its commission.

It should be noted that in the farm bill conference in 1996, the Secretary of Agriculture was required to review the dairy compact legislation before implementation to determine if there was compelling public interest for the compact within the compact region. In August 9, 1996, and only after a public comment period, Secretary Glickman authorized the implementation of the dairy compact, finding that it was, indeed, in the compelling public interest to do so.

In addition, another mechanism for guaranteeing that this was in their interest, that it wasn't going to cost money to the Federal Government, the Agricultural Appropriations Act of 1998 directed the Office of Management and Budget to study the economic effects of the compact and especially its effect in the Federal food and nutrition programs. Key findings of the OMB study released in February 1998 showed that, for the first 6 months of the compact, the New England retail milk prices were 5 cents per gallon lower than retail milk prices nationally.

Also, a GAO study stated that the compact economically benefited the dairy producers, increasing their income from milk sales by about 6 percent, with no adverse effects to dairy farmers outside the compact region.

These were independent studies. We had OMB, GAO, we had every safety mechanism and precaution in this legislation, and it has demonstrated time and time again it is in the best interests of our small dairy farmers, not costing the Government money—in fact, to the contrary.

The consumers in the Northeast Compact area are showing their willingness to support this compact, to pay a little more for milk if the additional money is going directly to the dairy farmer. Because we are not talking about big corporate farms, we are talking about the small dairy farmer whose family has been in business 100 years, 150 years—generational. That is what they want to do—to maintain their families, to maintain a way of life, and to sell their milk to their local consumers.

Environmental organizations have supported dairy compacting as the compact helps to preserve dwindling agricultural land and open spaces that help combat urban sprawl.

I will ask unanimous consent to have printed in the RECORD a joint resolution from the Legislature of the State of Maine that was passed last spring. I have it here on this board. It shows strong support, on a bipartisan basis, in the Maine State Legislature, and how enormously important this compact is to the near 500 dairy farmers in Maine who produce annually over more than $100 million in the State of Maine, and how it is in the best interests of Maine's consumers and businesses that this compact be reauthorized. It is that important.

So we have Republicans and Democrats in the State legislatures, we have an independent Governor who supports it, we have everybody across the political spectrum who supports this dairy compact because they understand the value of it.

I also will ask unanimous consent to have printed in the RECORD a July 15, 1999, letter from Maine's Commissioner of Agriculture, who wrote:

I am writing to urge your continued support of Maine's dairy farmers. As you know there is legislation pending before Congress relating to the reauthorization of the Northeast Dairy Compact Commission, and reorganization of the Federal Milk Marketing Orders. These issues are of the utmost importance to Maine dairy farmers and the dairy industry and the infrastructure in this State as a whole.

We need only look at the recent volatility of milk prices to see the Northeast Dairy Compact has been a great success.

He goes on to say:

I cannot stress enough the importance of this issue to the Maine dairy industry.

I also will ask unanimous consent to have printed in the RECORD a September 29, 1999, letter from the Council of State Governments, Eastern Regional Conference, signed by Senators and Representatives and heads of the departments of agriculture of Maine, Connecticut, Delaware, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island, and Vermont.

These State elected officials from States all over the Northeast wrote:

The Northeast Interstate Dairy Compact, in setting minimum regional prices for milk, has been an essential stabilizing force with respect to the price that the northeast dairy farmers receive for the milk they produce. Because of its regional focus, it has been extremely successful in promoting adequate local milk production to meet the needs of consumers for fresh milk at an affordable price.

I am also submitting for the RECORD the Council of State Governments' resolution of August 11, 1999, in support of the reauthorization of the compact.

Last, I will ask consent to have printed in the RECORD a September 30 editorial from the Bangor Daily News in my State of Maine, which states:

The compact helps keep local farmers in business, not only through price support but also by keeping enough other farmers at work. That means a dairy infrastructure of grain dealers, truck drivers, and farm machinery salespeople will remain. And that means jobs where they are needed most, in the smallest towns whose residents cannot simply turn to alternative industries. This is not mere nostalgia for the bucolic past, but an immediate dollars and cents issue.

The editorial goes on to say:

Certainly there would be less support for the compact as it stood alone as the sole agricultural support states enjoyed. But the sheer number and variety of Federal programs for crops or for not growing crops, for research and marketing, for electricity, grazing water, etc., makes singling out this relatively small program seem more than a little short-sighted.

That raises an important point. We do not get any support. We do not get the kinds of subsidies that other parts of the country, other commodity programs, have received. Our dairy farmers work hard. They work hard for the sole interest of producing a small amount, so they can sell to their local consumers, to their neighbors, to their community, to their State. That is all they ever want.

This editorial goes on to say:

None of the Midwestern representatives so angry about the compact have suggested, for instance, that Congress end the millions of dollars spent on local farm research or cut the power lines at the Hoover dam.

Yet the dairy compact is in no sense different than these programs—or it is different only in the sense it helps farmers in this region rather than the usual pattern of helping farmers in the Midwest. Unless Congress has some hidden reason to single out punishment for New England dairy farmers, it should support the compact as a sensible part of our Nation's agricultural policies.

That is an important final point. As one who served 16 years in the House of Representatives, and now in my fifth year in the Senate, I have seen a huge disparity in our farm programs between the policies and programs providing support for the big, the very big, farmers, and the lack of support for the small family farmer, who is so indicative and characteristic of my State and I know the State of Vermont that my colleague, Senator JEFFORDS, represents. It is the small family farmer who just wants to survive, wants to go about doing his business each and every day. Yet we are not going to allow them to do that and to continue a way of life.

The pattern I have seen in these agricultural programs that are supported here in this conference report, time and time again over my 20 years, has been to the exclusion of the small family farmer and to the benefit of the big agribusiness in America. I say that is a travesty of justice. I say it is unfair. I say it is not right.

That is why this dairy compact is so important. Indeed, it is shortsighted on the part of the conferees who did not support the reauthorization in this conference report. It is shortsighted of those who are unwilling to give it their support once again, raising the most bogus of arguments, which we have dispelled. We have refuted all of their arguments, not just based on our hearsay alone, but we have had OMB studies, we have had GAO studies—by everybody's reckoning. We even have legislatures in all the New England States and in the Northeast that support this dairy compact, and the Governors. Can they be all wrong? Could they be misrepresenting their constituency? I say not.

I hope we can defeat this conference report. It simply is not right. It is simply not fair. I ask you to support the small farmers and the way of life they want to embrace, that they cherish, and that they want to sustain. We owe them that much.

Again, I thank my colleague from Vermont, Senator JEFFORDS, for doing yeoman's work on behalf of these small dairy farmers in his State and my State, throughout New England and the other States that want to join because they have seen the success of this compact over the last 3 years. It was a very effective and successful pilot program, and it deserves to be continued.

Mr. President, I now ask consent that the material I referred to be printed in the RECORD, and I yield the floor.

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

STATE OF MAINE JOINT RESOLUTION

Whereas, Maine has nearly 500 dairy farms producing milk valued annually at over $100,000,000; and

Whereas, maintaining a sufficient supply of Maine-produced milk and milk products is in the best interest of Maine consumers and businesses; and

Whereas, Maine is a member of the Northeast Interstate Dairy Compact; and

Whereas, the Northeast Interstate Dairy Compact will terminate at the end of October 1999 unless action is taken by the Congress to reauthorize it; and

Whereas, the Northeast Interstate Dairy Compact's mission is to ensure the continued viability of dairy farming in the Northeast and to ensure consumers of an adequate, local supply of pure and wholesome milk; and

Whereas, the Northeast Interstate Dairy Compact has established a minimum price to be paid to dairy farmers for their milk, which has helped to stabilize their incomes; and

Whereas, in certain months the compact's minimum price has resulted in dairy farmers receiving nearly 10% more for their milk than the farmers would have otherwise received; and

Whereas, actions taken by the compact have directly benefited Maine dairy farmers and consumers; now, therefore, be it

Resolved: That We, your Memorialists, respectfully urge and request that the United States Congress reauthorize the Northeast Interstate Dairy Compact; and be it further

Resolved: That suitable copies of the Memorial, duly authenticated by the Secretary of State, be transmitted to the Honorable William J. Clinton, President of the United States, the President of the Senate and the Speaker of the House of Representatives of the Congress of the United States, each member of the United States Congress who sits as chair on the United States House of Representatives Committee on Agriculture or the United States Senate Committee on Agriculture, Nutrition and Forestry, the United States Secretary of Agriculture and each Member of the Maine Congressional Delegation.

STATE OF MAINE, MAINE DEPARTMENT OF AGRICULTURE, FOOD & RURAL RESOURCES

Augusta, ME, July 15, 1999.

Sen. OLYMPIA J. SNOWE,
Washington, DC.

DEAR SENATOR SNOWE: I am writing to urge your continued support of Maine dairy farmers. As you know, there is legislation pending before Congress relating to reauthorization of the Northeast Dairy Compact Commission and reorganization of the Federal Milk Marketing Orders. These issues are the utmost importance to Maine dairy farmers and the dairy industry and infrastructure in this state as a whole.

We need only look at the recent volatility in milk prices to see that the Northeast Dairy Compact has been a great success. The Compact was designed to provide dairy farmers with a safety net against huge drops in prices. While much of the rest of the country saw recent reductions in prices by up to one third, the blow to dairy farmers of the northeast, while substantial, was cushioned by the

floor price established through the Compact. The Compact worked! For many Maine dairy farmers, the Compact has been the difference between existence and extinction.

There is no question that the Federal Milk Marketing Orders needed reform. Consolidation of orders and updating of standards and definitions was long overdue. However, adoption of the pricing changes to the different classes of milk as proposed by USDA will have enormous impacts for Maine dairy farmers. Even by the most conservative estimates produced by USDA, farm income in the northeast will decrease $84 million dollars per year under the new proposed pricing system. Most estimates indicate the loss to farmers will be in excess of $100 million dollars.

Pending legislation would reauthorize the Northeast Compact (along with authorization of a Southern Compact), require USDA to adopt the so called 1–A option of pricing class I milk and require USDA to hold rulemaking hearing on pricing of class III milk. I urge your continued support and hope you will encourage uncommitted colleagues to support the Jeffords/Leahy amendment legislation. I can not stress enough the importance of this issue to the Maine dairy industry.

Please contact me with any concerns or questions you have regarding these important matters.

Sincerely,

ROBERT W. SPEAR,
Commissioner.

COUNCIL OF GOVERNMENTS,
Septembver 29, 1999.

Re: Northeast Interstate Dairy Compact.

The Northeast Interstate Dairy Compact, in setting minimum regional prices for milk, has been an essential stabilizing force with respect to the price that northeast dairy farmers receive for the milk they produce. Because of its regional focus, it has been extremely successful in promoting adequate local milk production to meet the needs of consumers for fresh milk at an affordable price.

As you know, the Dairy Compact is due to expire on October 1, 1999. Twenty five states, including all of those in the Northeast, have adopted the Dairy Compact. If it is not reauthorized, the resulting volatility in milk prices will cause regional dairy farmers to suffer devastating financial consequences. Therefore, we urge you to promote the extension of the Northeast Dairy Compact, as well as ratification of the Southern Dairy Compact, by Congress in an effort to secure the financial future of our region's dairy farmers.

In summary, we believe prompt action is necessary on both of these matters that are so critical to maintaining he viability of the region's agriculture industry and, thereby, our overall economy and quality of life. The financial losses endured by our farmers are substantial and immediate. We respectfully request that you and your Congressional colleagues from the Northeast support the measures we are proposing and promote regional solidarity to assist the struggling northeast farmers.

Please feel encouraged to contact any of the signatories below or our staff in the Council of State Governments' Eastern office with responses to this letter and any recommendations for immediate follow-up action.

Sincerely,

Representative Jessie G. Stratton, Co-Chairwoman, Joint Environment Committee, CT.
John F. Tarburton, Secretary, Department of Agriculture, DE.
Representative V. George Carey, Chairman, Environment & Natural Resources Committee, DE.
Senator John M. Nutting, Co-Chairman, Joint Agriculture, Conservation & Forestry Committee, ME.
Jonathan Healy, Secretary, Department of Agriculture, MA.
Stephen Taylor, Commissioner, Department of Agriculture, Markets & Food, NH.
Assemblyman William Magee, Chairman, Assembly Agriculture Committee, NY.
Representative Italo Cappabianco, Minority Chairman, Agriculture & Rural Affairs Committee, PA.
Ken Ayars, Chief, Division of Agriculture & Marketing, Department of Environmental Management, RI.
Representative Douglas W. Petersen, Co-Chairman, Joint Natural Resources & Agriculture Committee, MA.
Assemblywoman Connie Myers, Vice-Chair, Agriculture & Natural Resources Committee, NJ.
Representative Thomas E. Armstrong, Member, House Agriculture & Rural Affairs Committee, PA.
Senator William Slocum, Minority Chairman, Senate Agriculture & Rural Affairs Committee, PA.
Leon C. Graves, Commissioner, Department of Agriculture, VT.

COUNCIL OF STATE GOVERNMENTS,
EASTERN REGIONAL CONFERENCE,
Burlington, VT, August 11, 1999.

REAUTHORIZATION OF THE NORTHEAST INTERSTATE DAIRY COMPACT AND THE RATIFICATION OF A SOUTHERN COMPACT

Whereas, the Northeast Interstate Dairy Compact has maintained a successful track record of stabilizing the price dairy farmers receive for the milk they produce and has created a beneficial partnership between consumers and dairy farmers; and

Whereas, it is in the best interest of the general public to perpetuate our existing dairy industry and insure the continuance of local production to adequately meet the demand of all consumers for fresh milk at an affordable price; and

Whereas, dairy compacts have received the support of diverse coalitions, representing state and local governments, consumers, environmentalists, land conservation interests, financial institutions, equipment and feed dealers, veterinarians, the tourism industry, and agricultural organizations; and

Whereas, compacts are complimentary to the Federal Milk Marketing Order System, which provides the basis for orderly milk marketing through a uniform federal minimum pricing structure; and compacts take into account regional differences in the cost of producing fluid milk, and therefore permit a more localized determination of milk prices, allowing the compact to work in concert with the Federal Order System; and

Whereas, there has recently been a drop in the Basic Formula Price of $6 cwt, emphasizing the volatility that exists within the dairy industry; and

Whereas, the Constitution of the United States expressly authorizes the states to enter into interstate compacts with the approval of Congress and twenty-five states have passed legislation seeking authority to enter into an interstate dairy compact; and

Now, therefore be it *Resolved,* That, we request that the 106th Congress of the United States take immediate action to reauthorize the Northeast Interstate Dairy Compact and ratify a Southern Compact.

[From the Bangor Daily News, Sept. 30, 1999]

MILK AND MONEY

As a strict measure of its faithfulness to letting the market choose winners and losers, the Northeast Interstate Dairy Compact fails entirely. As policy for promoting economic diversity, food safety and open space, however, it is an important program for the region.

The compact helps dairy farmers by guaranteeing a minimum price for milk. Though it has cost consumers approximately 15 cents per gallon since 1996, it returns to them at least that much value through other means. As members of Congress debate the future of the compact—which was set to end tomorrow but has been postponed by a judge's ruling Tuesday—they should keep in mind that their decision affects far more than a few small farmers.

The compact helps keep local farms in business not only through the price support but also by keeping enough other farmers at work. That means a dairy infrastructure of grain dealers, truck drivers and farm machinery salespeople will remain. And that means jobs where they are needed most, in the smallest towns whose residents cannot simply turn to alternative industries. This is not mere nostalgia for the bucolic past, but an immediate dollars and cents issue.

Having a healthy dairy industry is far more useful and considerably less expensive to Maine taxpayers than sitting by and watching these farms go under, then setting loose its retraining programs and hoping for the best. On a national level, the compact prevents an overdependence on a few large Midwestern sources for this important and highly perishable food. And it gives New England states more local say on controversial issues such as bovine growth hormone.

Certainly, there would be less support for the compact if it stood alone as the sole agricultural support states enjoyed. But the sheer number and variety of federal programs for crops or for not growing crops, for research and marketing, for electricity, grazing and water, etc., makes singling out this relatively small program seem more than a little short-sighted. None of the Midwestern representatives so angry about the compact have suggested, for instance, that Congress end the millions of dollars spent on local farm research or cut the power lines at the Hoover Dam.

Yet the dairy compact is in no sense different than these programs—or it is different only in the sense that it helps farmers in this region rather than the usual pattern of helping farmers in the Midwest. Unless Congress has some hidden reason to single out for punishment New England dairy farmers, it should support the compact as a sensible part of the nation's agricultural policies.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. Mr. President, I will be finishing quickly. I would like to point out—exactly where the Senator from Maine left off—why we are here. It may be a little confusing why we are involved in a conference report, but it was pointed out in the farm bill of 1996, we got agreement that we should run a pilot program in New England of a very exciting idea, of a compact where the States would get together and handle the problems of their dairy farmers by having an organized marketing system.

We would show this kind of a system where people from the States would sit down on a commission and make sure the price of milk was held at a level which would guarantee a supply of

fresh fluid milk, which is a basic part of agricultural law, and that the demonstration program would be reviewed when the milk orders were to be implemented.

What happened? Did the program work? That was the problem, it did. That is why we are here tonight because the program did work.

As the Senator from Maine pointed out, the opponents of this, in the Midwest in particular, were so confident it was going to fail, they went out and got the OMB, who they figured would be most friendly to them being of the administration, many Democrats—whatever, that is beside the point—but so certain were they that it would be a failure, they got OMB to do a study.

Lo and behold, what happened? The study came back, and the GAO later came back and said it worked great, it is a wonderful program. That is why 25 States now have said that ought to be a program in which they can get involved. Half the States in the country have already said it is a success. OMB said it is a success.

What is the problem now? Why? Because of the desire of those in the Midwest to take over and supply these areas with milk themselves and not the local dairy farmers, which helps make sure we have that fresh quality milk available, they decided they will put them out of business.

They cannot put them out of business because it is working. The processors, who have been used to setting the price themselves—in many cases there are one or two; there are not many processors, so when there is a good supply of milk, they can go to zero. That has stopped. It is working well.

The Department of Agriculture was not going to do the pilot program. We had to get it extended.

That is where we are. We wanted to extend it, and when we had one, at least we thought we had one in the conference committee that we would have approved because the majority in the House and Senate agreed it was a good program and ought to be extended, what happened? Forces came in and put pressure on Members and we ended up without a majority in the committee. Therefore, we got thrown out into the cold.

We are here to make sure this bill, which belonged on that conference report, that everyone seemed to agree to, goes forward. That is why we are now trying to hold up this bill to get action. We are not going to try to hold up the bill for the disaster payments. We will get into a further discussion of this whole bill and the stuff in it.

The one part that worked so well that does not cost any money and prevents disasters, we cannot get it put into law. That is why we are here. We are going to continue. We are going to fight as long as we possibly can to make sure the dairy farmers in our States, the family farms, the small, beautiful hillsides that have their nice wonderful cows will be there for people to look at, and we will have a fresh supply of milk from our local farms.

Hopefully, since it was such a successful program, the 25 States that have already passed laws through their legislatures to participate in the compact will have the wonderful opportunities that have been so successful in New England.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

MORNING BUSINESS

Mr. SMITH of New Hampshire Mr. President, I ask unanimous consent that the Senate now proceed to a period for morning business, with Senators permitted to speak for up to 10 minutes each.

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

CONFERENCE REPORT ON FOREIGN OPERATIONS APPROPRIATIONS

Mr. MCCAIN. Mr. President, I supported passage of the Conference Report on H.R.2606, the Foreign Operations Appropriations bill for Fiscal Year 2000.

Foreign aid programs, which constitute a mere one percent of federal spending, are an important and underappreciated component of United States foreign and national security policy. Passage of the annual appropriations bill for foreign operations is, consequently, an imperative. It is for this reason that I voted for its passage, and anticipate its being signed into law by the President.

Despite my support for passage of the Conference Report, this legislation is not without its flaws. While it includes essential economic and military assistance for Israel and Egypt, it contains none of the funding associated with implementation of the Wye River accords involving Israel, Jordan, and the Palestinian Authority. It is anticipated that such funding will be included in a supplemental appropriations bill at some point in the not-too-distant future, but I question the fiscal and political wisdom of budgeting in this manner. Smoke and mirrors rarely provide for sound budgeting practices or a coherent foreign policy.

I am also concerned about the continued inclusion in this legislation of unrequested earmarks and adds. While the Conference Report represents a vast improvement over the bill passed by the Senate in June, it still represents the legislature's continued refusal to desist from earmarking in spending bills. Such earmarks in the bill include $500,000 for what by any other name remains the Mitch McConnell Conservation Fund, $15 million for American universities in Lebanon, and a requirement to establish a $200 million maritime fund using United States commercial maritime expertise. The bill essentially mandates the establishment of an International Law Enforcement Academy in Roswell, New Mexico, thereby demonstrating yet again that fiscal prudence and operational necessity remain alien concepts to members of this body.

There are more examples, but I think I have made my point. As I have stated in the past, there is undoubtedly considerable merit to some of the programs for which funding is earmarked at the request of members of Congress. My concern is for the integrity of the process by which the federal budget is put together. Merit-based competitive processes ensure that the interests of the American taxpayer are protected, and that the most cost-effective approach is employed. Absent such procedures, I will continue to have no choice but to highlight the practice of adding and earmarking funds for programs and activities not requested by the respective federal agencies.

Finally, I must register my strong opposition to language in the bill prohibiting any direct assistance to Cambodia and requiring U.S. opposition to loans from international lending institutions for that impoverished country. Cambodia's election was not perfect; in fact, the months leading up to the vote were characterized by numerous efforts on the part of the Cambodian People's Party to intimidate its political opposition. Cambodia, however, is experiencing its first period of relative peace and stability in many years, and it is regrettable that some in the Senate remain committed to isolating the government in Phnom Penh during a time when we should be working within that country to strengthen democratic institutions while facilitating economic growth. Section 573 of the Conference Report, consequently, represents a significant impediment to our ability to help Cambodia move forward from an enormously painful past.

Despite these flaws, Mr. President, I reiterate my support for passage of the bill and request the accompanying list, be printed in the RECORD.

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

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2000, AND FOR OTHER PURPOSES—DIRECTIVE LANGUAGE AND EARMARKS

BILL LANGUAGE PROVISIONS

Not less than $500,000 should be made available for support of the United States Telecommunications Training Institute;

$19.6 million shall be available for the International Fund for Ireland;

$10 million shall be available for the Russian Leadership Program;

$1 million shall be available for the Robert F. Kennedy Memorial Center for Human Rights;

Sense of Congress that the Overseas Private Investment Corporation shall create a maritime fund with total capitalization of up to $200 million. The fund shall leverage U.S. commercial maritime expertise;

REPORT LANGUAGE PROVISIONS

The Agency for International Development is ''encouraged'' to provide assistance for the

Morehouse School of Medicine to establish an International Center for Health and Development;

$250,000 shall be made available to the International Law Institute;

AID is directed to restore biodiversity funding, which benefits the agricultural and pharmaceutical industries;

$700,000 is earmarked for Historically Black Colleges and Universities for implementation of a distance learning program;

AID is directed to ''uphold its commitment'' to American Schools and Hospitals Abroad by providing at least $15 million for fiscal year 2000, with the money allocated to institutions operating in Lebanon;

The bill directs that $500,000 shall be provided for research, training and related activities in the Galapagos Islands. Usually referred to as the Mitch McConnell Conservation Fund, the money will likely be allocated for the Charles Darwin Research Station and the Charles Darwin Foundation;

$861,000 is earmarked for the Seeds of Peace program;

$5 million is earmarked for the Irish Peace Process Cultural and Training Program.

$19 million is earmarked for the International Fund for Ireland;

$10 million is earmarked for the Russian Leadership Program;

$3 million is earmarked for Carelift International to support social transition initiatives in Central Europe and the new independent states;

The Department of State is directed to take measures ensuring the establishment of the International Law Enforcement Academy of the Western Hemisphere at the deBremmond Training Center in Roswell, New Mexico;

$35.8 million is earmarked for the Global Environment Facility.

Total: $321 million.

RESEARCH AND EXPERIMENTATION TAX CREDIT

Mrs. FEINSTEIN. Mr. President, I rise to note that since June 30 of this year, the Research and Experimentation Tax Credit has, once again, been allowed to lapse. As this body considers whether to enact a so-called ''extenders'' package, I want to urge my colleagues to include and pass a permanent extension of the Research and Experimentation tax credit.

The research and experimentation tax credit provides business an incentive to fund development of the technologies of tomorrow by providing a tax credit for investments in research.

The research and experimentation tax credit is an important element in the creation of strong economic growth and rising productivity. Industry leaders have credited it with spawning private enterprise investments. It is especially important to the high-tech and emerging growth industries that are driving the California economy. And, because it creates jobs and spurs economic activity, the research and experimentation tax credit helps to increase the tax base, paying back the benefit of the credit.

Yet, despite its many benefits, for 18 years the research and experimentation tax credit remains, inexplicably, a temporary tax provision requiring regular renewal.

In fact, since 1981, when it was first enacted, the Research and Experimentation Tax Credit has been extended nine times. In four instances the research credit had expired before being renewed retroactively and, in one instance, it was renewed for a mere six months.

This is not a process which is conducive to encouraging business investment in the innovative industries—high technology, electronics, computers, software, and biotechnology, among others—which will provide future strength and growth for the U.S. economy.

Earlier in this decade California was faced with its severest economic downturn since the Great Depression. Today, the California economy is healthy and vibrant, and it is so in no small part because of the critical role played by innovative research and development efforts in nurturing new ''high tech'' industries.

Today the 150 largest Silicon Valley companies are valued at well-over $500 billion, $500 billion which did not exist two decades ago. Much of this growth is a result of ability of companies to undertake long-range and sustained research in cutting-edge technologies. Scores of California companies—and companies across the country—owe much of their success and growth to the incentive provided by the research and experimentation tax credit.

Research and experimentation is the lifeblood of high technology development, and if we want to continue to replicate the successful growth that has characterized the U.S. economy during this past decade it is crucial that we create a permanent research and experimentation tax credit.

For example, Pericom Semiconductor, located in San Jose, has expanded from a start-up company in 1990 to a company with over $50 million in revenue and 175 employees by the end of last year and is ranked by Deloitte Touche as one of the fastest growing companies in Silicon Valley. According to a letter I received from Pericom, utilization of the research and experimentation tax credit has been key to their success, enabling them to add engineers, conduct research, and expand their technology base.

Indeed, according to a 1998 study conducted by the national accounting firm Coopers & Lybrand, a permanent credit will increase GDP by nearly $58 billion (in 1998 dollars) over the next decade. The productivity gains from a permanent extension will allow workers throughout the Nation to earn higher wages, and the additional tax revenue created by these new jobs will help pay back the benefit of the credit.

Whether it is advances in health care, information technology, or environmental design, research and development are critical ingredients for fueling the process of economic growth.

Moreover, aggressive research and experimentation is essential for U.S. industries fighting to be competitive in the world marketplace. For example, American biotechnology is the world leader in developing effective treatments and biotech is considered one of the critical technologies for the 21st century. With other countries heavily-subsidizing research and development, it is critical that U.S. companies also receive incentive to invest the necessary resources to stay on top of breakthrough developments.

I recently received a letter from the CEO of Genentech, for example, in which he wrote:

The R&D tax credit is especially important to Genentech and our patients. Our newest therapy, Herceptin, which is used to treat metastatic breast cancer, is a prime example. The early clinical trials for Herceptin showed that it was a somewhat effective treatment for metastatic breast cancer, but the results were not particularly robust. It was a classic case of a research project being ''on the bubble'' in terms of deciding whether to go forward into the most expensive phase of human clinical trials. However, because the value of the tax credit to Genentech directly means that we are able to move one additional drug candidate each year into clinical trials, we were able to move forward with the Phase III Herceptin clinical trial in late 1994. I dare say that without the R&D credit, Herceptin might well not have become a reality. Today, thousands of patients are receiving this important treatment.

I ask unanimous consent that the full text of the September 30, 1999 letter from Genentech Chairman Arthur Levinson be printed in the RECORD.

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

GENENTECH, INC.,
San Francisco, CA, September 30, 1999.

Hon. DIANNE FEINSTEIN,
Hon. BARBARA BOXER,
U.S. Senate, Hart Senate Office Building, Washington, DC.

DEAR SENATOR FEINSTEIN AND SENATOR BOXER. On behalf of Genentech, I would like to thank you both for your long-standing leadership and support for the Research and Experimentation Tax Credit, more commonly known as the R&D tax credit. Once again, however, we find ourselves in the perilous position of the Congressional session quickly coming to an end without providing an extension of the credit, which expired on June 30, 1999. As you are well aware, the credit is critical to California's economy, as the high technology and biotechnology sectors count on the value of the credit to continue the economic expansion our sectors have enjoyed for the past few years.

The R&D tax credit is especially important to Genentech and our patients. Our newest therapy, Herceptin, which is used to treat metastatic breast cancer, is a prime example. The early clinical trials for Herceptin showed that it was a somewhat effective treatment for metastatic breast cancer, but the results were not particularly robust. It was a classic case of a research project being ''on the bubble'' in terms of deciding whether to go forward into the most expensive phase of human clinical trials. However, because the value of the tax credit to Genentech directly means that we are able to move one additional drug candidate each year into clinical trials, we were able to move forward with the Phase III Herceptin clinical trial in late 1994. I dare say that without the R&D credit, Herceptin might well not have become a reality. Today, thousands of patients are receiving this important therapy.

Clearly, Genentech is among the most research intensive companies in the world. In

1996, we invested $471 million, or 49% of our revenue, on research and development and have consistently devoted more than 30% of revenues to R&D in the subsequent years. But research is our lifeblood. It gives life to the ideas we test to treat serious, unmet medical needs. Our strong portfolio of products is a direct reflection of the ideas our scientists have brought from the lab to the patient. And, as evidenced by our exciting pipeline, I firmly believe the best of our science is yet to come.

Direct federal support for overall research has, for the most part, been declining for over a decade. While a long-term commitment to increasing funds available to the federal government for basic research is important, maximizing private industry innovation through a permanent R&D tax credit is perhaps the most cost-effective means of ensuring that high levels of private-sector investment will continue to be made.

Your leadership and commitment to the R&D tax credit, has resulted in great economic benefit for both our country and for California. I encourage you to, once again, redouble your efforts to extend the credit now so that greater economic benefits and new therapies can benefit all Americans.

I have attached a couple of op-ed pieces regarding the credit which I and others wrote, and which ran in the San Jose Mercury over the last two years. I look forward to continuing to work with you and your staffs in support of the R&D tax credit.

Sincerely,

ARTHUR D. LENINSON, Ph.D.,
Chairman and Chief Executive Officer.

Mrs. FEINSTEIN. Most biotech research and development efforts are long term projects spanning five to ten years, sometimes more. The uncertainty created by the temporary and sporadic extensions is incompatible with the basic needs of biotech innovation—providing companies with a stable time frame to plan, launch, and conduct research activities. In the case of a promising but financially intensive research project, such unpredictability can make the difference as to whether the project is completed or abandoned.

Anyone who has watched the growth of America's high tech sector in the past two decades—much of it in California—has seen first hand how research and development investment leads to new jobs, new businesses, and even entire new industries. And anyone who has benefitted from breakthrough products—from new treatments for genetic disorders to cleansing contaminated groundwater—has felt the effect of this tax credit.

Over the past two decades the research and experimentation tax credit has proven its worth in creating new technologies and jobs and in growing tax revenues for this country. It should not be imperilled by remaining a temporary credit, subject to termination because of the uncertainty of a given political moment. I urge my colleagues to work to make sure that any Senate tax bill contains a permanent extension for the Research and Experimentation Tax Credit.

INCREASING THE FEDERAL RESPONSE TO THE AIDS EPIDEMIC

Mr. KERRY. Mr. President, we are now entering the third decade of the AIDS epidemic and while we have made some progress in fighting this devastating disease, our federal response is still lacking.

More than 400,000 people have died of complications associated with acquired immunodeficiency syndrome since 1981. Last year, more than 54,000 new cases of AIDS were reported in this country. This trend is staggering and belies the misperception that somehow the AIDS epidemic in this country or abroad has abated. While it is true that therapeutic and treatment breakthroughs have led to longer and more productive fulfilling lives for those living with HIV, and that the death rate from AIDS has fallen in recent years, the fact remains that this epidemic has no cure and the rate of new infections has not slowed.

But these are days of great hope, Mr. President, in the fight against AIDS. During the years of inaction by the Reagan and Bush Administrations during the 1980s, we entered the second decade of the epidemic on a much different note: treatments were few, toxic and largely ineffective; training of physicians in the care of patients with HIV was incomplete, uneven and erratic; discrimination and abuse of people living with AIDS in housing, employment and medical care was rampant and abhorrent. It was difficult to have much hope as we entered the 1990s.

But this decade has seen great promise. We have made significant strides. No longer an immediate death sentence, AIDS has lost some—but certainly not all—of its social stigma. In that dark dawn of the epidemic, Mr. President, who would have believed that we would see a decade in which two Miss Americas would be AIDS activists, touring the country and speaking out on AIDS prevention and care? In the early 1980s, who would have believed that we would have an Office of AIDS Research at the National Institutes of Health, that funding for the Ryan White program would increase by 260 percent, or that funding for AIDS research would increase by 67 percent?

And yet, Mr. President, the rumbling of the epidemic has not been stilled. In the early 1980s, who would have believed that some African countries would have 25 or 35 percent infection rates, or that an entire generation of gay men in the United States would be lost? Who would have believed that infection rates would continue at staggering paces at the same time leading voices would declare the epidemic over? Have we truly become victims of our own success?

I certainly hope not, for as Tony Kushner wrote at the end of his monumental play, Angels in America, ''great work remains to be done.''

Until we have an AIDS-free day in America, I will not become complacent. As ranking member of the Housing subcommittee, I know that great work remains to be done in finding shelter for people living with AIDS. I was pleased that my colleague from Missouri, Senator BOND, and my friend from Maryland, Senator MIKULSKI, were able to answer my request positively to increase funding by $7 million for the Housing Opportunities for People With AIDS program in the VA–HUD and Independent Agencies appropriations bill for fiscal year 2000. This money is crucial as people living with AIDS have a fundamental need for adequate and safe housing. I will continue to work with all of my colleagues to keep the HOPWA program sufficiently funded.

Great work remains to be done on HIV prevention. We are lacking in our commitment to adequately fund the Centers for Disease Control in their anti-HIV efforts. Until a cure is found, we must ensure that the federal government issues information widely which is accurate, blunt and unequivocal. Prevention efforts work, Mr. President. I have seen the work of the AIDS Action Committee in Boston and I can tell you that their innovative programs are working to slow the spread of AIDS. Unlike the increase in funding which the National Institutes of Health has received, the CDC's prevention efforts have remained at roughly the same level in the past few years. It was my hope that the appropriators would have recognized the unmet needs related to HIV prevention in this country and it is my fear that the failure to keep pace with that need portends a disaster.

For example, in this legislation as in other legislation this year, we again were subjected to the perennial ill-informed debate on the issue of needle exchange. I am dismayed that the Labor-HHS-Education appropriations bill will include language which deprives the Secretary of Health and Human Services from using her discretion based on science and empirical academic study to determine if needle exchange programs reduce the transmission of HIV without encouraging illicit drug abuse. This is bad public policy, when Senators act like scientists, and it is bad health policy. It is my hope that the conferees on this bill will restore the Secretary's discretion.

Great work remains to be done in combating AIDS abroad. We are a failure in our policy toward Africa. Our international efforts need to be bolstered to assist developing countries crippled by the effects of HIV disease. My distinguished colleague and friend from Vermont, Senator LEAHY, has been stalwart in raising the funding levels to fight AIDS abroad in the Foreign Operations appropriations bill and the Congress needs to follow his guidance by continuing to increase these levels. In addition, tomorrow I will introduce the Lifesaving Vaccine Technology Act of 1999 to spur research of vaccines to combat diseases which kill more than one million people every

year, and I will have much more to say on this topic at that time.

Great work remains to be done for hemophiliacs. There is perhaps no greater neglect by the federal government in responding to the AIDS epidemic than the ignoring of our hemophiliac population. On November 11, 1998 the Ricky Ray Hemophilia Relief Act was signed into law. The bill, authored by the Senator from Ohio, Senator DEWINE, received overwhelming bipartisan support, and I was proud to be an original co-sponsor of the bill. When it passed, hemophiliacs felt their thirteen year battle to be compensated for the lapse in regulation of our nation's blood supply was over.

In the early 1980s, it became apparent that HIV was being improperly screened, and HIV-tainted blood product was being distributed to patients across the country. At the time, there were 10,000 Americans suffering with hemophilia, an illness which requires regular infusions of blood clotting agents.

According to the Institute of Medicine's report on HIV and the Blood Supply, ''meetings of the FDA's Blood Product Advisory Committee in January, February, July and December 1983 offered major opportunities to discuss, consider, and reconsider . . . and review new evidence and to reconsider earlier decisions, [yet] blood safety policies changed very little during 1983.'' In effect, the report found the FDA was at fault for not responding to clear evidence of transmission dangers. As a result, more than sixty percent of all Americans with hemophilia were infected with HIV through blood products contaminated by the AIDS virus. Currently, more than 5,000 have died and more are dying each day. In my office, I have been visited by courageous hemophiliacs and when they leave, I never know if I will ever see them again. This population has been decimated, Mr. President, and the personal tragedy is unspeakable.

We must fully fund the Ricky Ray Relief Act. The Senate version of the Labor-HHS-Education bill appropriates $50 million out of the $750 million needed to fund the Ricky Ray Trust Fund, and that is certainly better than the inadequate level of the other body, but it is a far cry from the level needed by the hemophiliac community. Members of this community never anticipated the one-time compensation from the trust fund, intended to assist with staggering medical bills and improve the quality of their lives, would turn out to be a pay-out to their estates.

You need only to speak to some of my constituents, like Therese MacNeill. She will tell you, as a mom, the hardship she has experienced in coping with the tragedy of losing one son to AIDS and caring for another who is HIV-positive. Terri MacNeill will let you know in no uncertain terms why we must fully fund Ricky Ray to help families who for years were storing HIV-infected blood product in their family refrigerators next to the lettuce and milk, and now are struggling under mountains of medical bills.

Other countries have recognized the plight of hemophiliacs who were infected by poorly screened blood. Australia, Canada, Denmark, France, Italy, and Switzerland are just some of the countries which have established compensation programs. Sixty Senators signed on as co-sponsors of the legislation authorizing the establishment of the Ricky Ray Trust Fund. Now is the time to realize our commitment to the hemophiliac population on par with other countries as well as our own actions in authorizing the bill. I hope that when the appropriations conference committee meets on this bill, the funding levels for the Ricky Ray act are raised substantially.

Mr. President, let me conclude by saying that I am heartened by the response of my friends, the distinguished Senator from Pennsylvania, Senator SPECTER, and the able Senator from Iowa, Senator HARKIN, in crafting this legislation. They have risen to an incredible challenge in the funding of programs designed for AIDS care, research and treatment, and I remain committed to work with them during this year and next to finish some of the great work that remains to be done, especially in regard to HIV prevention programs and the Ricky Ray Trust Fund.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Wednesday, October 6, 1999, the Federal debt stood at $5,654,882,997,504.81 (Five trillion, six hundred fifty-four billion, eight hundred eighty-two million, nine hundred ninety-seven thousand, five hundred four dollars and eighty-one cents).

One year ago, October 6, 1998, the Federal debt stood at $5,536,217,000,000 (Five trillion, five hundred thirty-six billion, two hundred seventeen million).

Five years ago, October 6, 1994, the Federal debt stood at $4,690,449,000,000 (Four trillion, six hundred ninety billion, four hundred forty-nine million).

Ten years ago, October 6, 1989, the Federal debt stood at $2,877,626,000,000 (Two trillion, eight hundred seventy-seven billion, six hundred twenty-six million) which reflects a doubling of the debt—an increase of almost $3 trillion—$2,777,256,997,504.81 (Two trillion, seven hundred seventy-seven billion, two hundred fifty-six million, nine hundred ninety-seven thousand, five hundred four dollars and eighty-one cents) during the past 10 years.

MOTIVES OF VOTE

Mr. SMITH of New Hampshire. Mr. President, a couple of days ago on the Senate floor, one of my colleagues, Senator LEAHY from Vermont, made some remarks regarding the possible motives of some of us who made a vote on a particular nominee, Ronnie White of Missouri to the Federal court. I want to read from the Senate manual what we all know as rule XVIIII. I want to indicate before reading that I do not believe Senator LEAHY violated that rule. That is not the purpose of bringing this up.

The rule says:

> No Senator in debate shall, directly or indirectly, by any form of words impute to another Senator or to other Senators—
>
> Plural—
>
> any conduct or motive unworthy or unbecoming of a Senator.

That rule is very clear, and it is not very often throughout the history of the Senate that rule has been violated.

I want to quote what Senator LEAHY said on October 5 on the Senate floor after the vote on Ronnie White. He said:

> Mr. President, I have to say this with my colleagues present. When the full history of Senate treatment of the nomination of Justice Ronnie White is understood, when the switches and politics that drove the Republican side of the aisle are known, the people of Missouri and the people of the United States will have to judge whether the Senate was unfair to this fine man and whether their votes served the interests of justice and the Federal courts.

Then the Senator from Vermont concluded by saying:

> I am hoping—and every Senator will have to ask himself or herself this question—the United States has not reverted to a time in its history when there was a color test on nominations.

The reason why I say rule XVIIII was not violated in that case, I believe, although the Senator from Vermont may have walked up to the line—he did not cross it—is because he said ''I am hoping.'' I, therefore, will not make any contest at this point on that.

It concerned me deeply that those comments were made. I want to say for the record, and it is interesting because I spoke to at least a dozen colleagues who voted the same way I did, in opposition to this nominee—not that it matters—who did not even know what race Mr. White was. I didn't know. I had no idea, and I had numerous conversations about this nominee over the course of several weeks and months, as his nomination was pending. I never knew what his race was nor would I care because I wouldn't want to look, frankly. What difference does it make? It doesn't make any difference to me.

This went further than the Senate floor, which is quite disturbing. In the Washington Post today is in an article, ''Deepening Rift Over Judge Vote, Minorities Confirmed At a Lower Rate.'' That was the Washington Post story. Very prominently pictured in the article is a picture of Ronnie White, and in addition, Senators ASHCROFT and BOND. There is an implication there that I don't like.

In the article, we have Governor Mel Carnahan, who happens to be the opponent of Senator ASHCROFT in the election in Missouri for the Senate, who said:

''Judge White is a highly qualified lawyer and judge and the [death penalty] figures were manipulated by Senator Ashcroft to undermine him,'' Carnahan said.

Then it got a little worse from the Chief Executive of the United States of America. I want to point out, if President Bill Clinton were Senator Bill Clinton, and he said what I am about to read, in my view, he would have violated rule XVIIII. That is why I bring it up. Here is what the President said about all of us who voted against Mr. White's nomination:

Yesterday's defeat of Ronnie White's nomination for the federal district court judgeship in Missouri was a disgraceful act of partisan politics. The Republican-controlled Senate is adding credence to the perception that they treat minority and women judicial nominees unfairly and unequally.

That basically is a direct attack on all of us and our motives, basically accusing us of being—the implication is that we are racists, that we do not treat minorities fairly, and that we discriminate against women as well.

That came from the President of the United States.

I will also quote from an article in the Washington Times today in relation to J.C. Watts, the most prominent African American Republican in the Congress of the United States, who was also deeply offended, as he should have been, by these remarks. It is interesting what Chairman Watts of the House Republican Conference said. This is J.C. Watts talking:

''It is fascinating to me that racism often is defined, not by your skin color, but by your ideology,'' said Mr. Watts, the lone black Republican in the House, in a luncheon with editors and reporters at The Washington Times.

He said further:

Unless you're a Democrat. It's OK to do it to black Republicans, black conservatives. But don't do it to a black Democrat.

Then it is racial.

It really is troublesome to me that we create these barriers between us.

President Clinton said:

[By voting down] the first African American judge to serve on the Missouri State Supreme Court, the Republican-controlled Senate is adding credence to the perceptions that they treat minority and women judicial nominees unfairly and unequally.

But anyway, it is troubling to me that these kinds of things happen. I voted against the nominee because of his views on some issues. I spoke to this on the Senate floor on the same day. I am quoting myself now:

In the case of Justice White, who now serves on the Supreme Court in Missouri, he has demonstrated that he is an activist, and has a political slant to his opinions in favor of criminal defendants and against prosecutors. It is my belief that judges should interpret the law, and not impose their own political viewpoints.

That is why I voted against Ronnie White.

Prominent law enforcement people in Missouri were also opposed to him, and said so, as Senator ASHCROFT made very clear.

It is troubling to me that this issue raises its ugly head when somebody happens to be African American. I thought really we would get beyond this. It would have been nice if the President of the United States had said: Ninety-two percent of the minority nominations that have come through this Senate have been confirmed, most of them unanimously without even a recorded vote. It would have been nice if the President said that was pretty good on the part of this Senate, instead of singling out one who had not been confirmed for, I believe, good reason.

One of the things you find out in the Senate, if you stay here long enough, is that you probably have said something somewhere along the line you would like to take back. I am going to say up front regarding my colleague from Vermont, I do not impugn his motives, but it is interesting that Senator LEAHY did not vote to confirm Clarence Thomas. He voted against Clarence Thomas, a very prominent member of the Supreme Court who happens to be African American—a man I was proud to support. I did not hear the President mention any of us who voted for Clarence Thomas, an African American. The reason is very simple: Clarence Thomas is a conservative. That is the reason.

I would never impugn my colleague's motives for voting against Clarence Thomas. I assume he voted against Clarence Thomas because he was a conservative, he did not like his politics, did not like his views on abortion and other issues. I believe that.

I say, without any hesitation, if my colleague were here on the floor now, I would look at him and say: Absolutely, I believe you, that that is your motive, and no other motive.

There was also another vote in 1989 in committee, for a gentleman by the name of William Lucas. Lucas was President Bush's pick for Assistant Attorney General for Civil Rights. He happens to be African American. Lucas's nomination never got to the Senate floor. The vote in Judiciary was 7–7. The Senator from Vermont voted no. Again, I would never use the issue of race to say that was the reason for his vote. I would not even imply it.

So I think it is important that we move beyond this, stop this divisiveness, and give people the benefit of the doubt, and particularly Senator HATCH who so many times has brought nominees whom you and I—I would say to the Senator in the Chair, I myself have often disagreed with Senator HATCH on some of the nominations he has brought, but he has brought them forth I think probably more fairly than he should have in terms of the nominations he brings forth.

So to throw that blanket over 54 individuals who voted the way they did, or even to imply it, is unfortunate.

So I say, to set the record straight, I am going to vote against a person who I think is an activist, who does not represent the views that I believe should be on the court, no matter what the color, and, most frankly, without knowing the color if I can help it because I do not think it matters. It is unfortunate in this case that we came to that.

Mr. President, I want to touch on one other issue before we close up the Senate.

THE PANAMA CANAL

Mr. SMITH of New Hampshire. A few days ago, on October 4, I indicated that there were 88 days until the Panama Canal would be turned over to the Chinese—to the Panamanians and ultimately into the hands of the Chinese Communists. That was October 4.

Today is the 7th, so we have 87, 86, 85—we are down to 85 days before the canal is closed, will be turned over to the Chinese. I have a chart here on which I will put some stickers to cross those days off. The days go fast. I point out that we are going to see this canal in the hands of a nation that does not have positive feelings toward the United States—to put it as nicely as I can. So this is the flag of Communist China. So now 3 more days have gone by.

I recently addressed this issue of Panama and the impending turnover on October 4, a few days ago. Again, 3 more days have passed. The countdown continues. On December 31, this canal leaves the control of the United States and will come into the hands of the Chinese Communists.

In his book, ''The Path Between the Seas,'' David McCullough's history of the canal reminds us of its historic importance:

The creation of the Panama Canal was far more than a vast, unprecedented feat of engineering. It was a profoundly important historic event and a sweeping human drama not unlike that of war. . . .

Great reputations were made and destroyed. For numbers of men and women, it was the venture of a lifetime. . . . Because of it, one nation, France, was rocked to its foundations. Another, Colombia, lost its most prized possession, the Isthmus of Panama. . . .The Republic of Panama was born. The United States was embarked on a role of global involvement.

So while the United States has no assurances it may remain in Panama after December 31, despite overwhelming public opinion in Panama in support of a continued U.S. presence—we are going to be leaving—the Chinese firm of Hutchison Whampoa will be there in the ports of Cristobal and Balboa on both sides of the canal, having won, through what was widely regarded as a corrupt bidding practice, the right to lease the ports for 25 years and beyond. Both sides of the canal will now be in the control of the Chinese.

After the United States withdraws from Panama, December 31, there is no doubt that a security vacuum will be

created. Who is going to fill it? We have less than 3 months, 85 days, a very short window of time to try to work out a solution that is mutually acceptable to us and to the Panamanians.

Let us look at the status of the transition. What bothers me is that this administration is doing nothing to try to renegotiate those leases or to somehow talk with the Panamanians to try to get us to remain there. To date, we have transferred to the Government of Panama 57,000 acres—remember, we spent $32 billion building that canal—57,000 acres and 3,000 buildings controlled by our military, including schools, hospitals, houses, airports, seaports, roads, and bridges. It represents about 62 percent of the total property.

As of July 1 of this year, U.S. troop strength was down from 10,000 in February 1994 to a little over 1,200, so we are just about finished. All U.S. presence on the Atlantic side was terminated on 30 June with the transfer of Fort Sherman and Pina Range. The remaining 36,000 acres and 1,900 facilities will be transferred to the Government of Panama as follows: On the 28th of July, the Empire Range for the Army and the Balboa West Range for the Air Force will go. On the 13th of August, the U.S. Army mortuary—these are what has already happened—on the 17th of August, the Curundu Middle School; on the 1st of November, Fort Kobbe, Howard Air Force base, Farfan housing and radio site will go; Curundu Laundry; Fort Clayton, West and East Corozal; Building 1501, Balboa, and Ancon Hill communications site; and on December 31, the grand enchilada, the big prize, the Panama Canal itself, gone, without a whimper.

It troubles me this issue has not even entered the Presidential debate in this country. There is no one at the State Department or in the Defense Department or in the White House talking to the Panamanians about reopening the bidding process or renegotiating leases to try to get in there ahead of the Chinese company. As if to rub it in, to rub salt in the wound even more, the actual turnover is going to take place on December 10. Perhaps they advanced the date so it wouldn't interfere with our Christmas or New Year's Eve parties or maybe they were afraid of Y2K. Maybe they were afraid we would get stuck there.

The bottom line is, on December 10 we will turn it over, which is about 21 days earlier than we should. So I want to elaborate, again, on the significance of the canal to seapower, to our Navy, and to the importance of preserving both the spirit and the letter of the neutrality treaty.

I will now discuss the background of a controversial law in Panama known as Law 5.

President Teddy Roosevelt was a reader and admirer of Alfred Thayer Mahan, a gentleman regarded by many as the father of the modern American Navy. Mahan's book, ''The Influence of Sea Power,'' had a profound impact on Theodore Roosevelt. Mahan traced the rise and decline of past maritime powers and concluded that supremacy at sea translated into national greatness and commercial success. We are essentially an island or, more specifically, a peninsula nation. The Navy is very important to us.

Roosevelt, whose first published work was ''The Naval War of 1812,'' had read Mahan's book and understood its importance. It prompted him to be a strong advocate of constructing the canal, to be sure the United States would have easy access through the isthmus of Panama and into the Pacific from the Atlantic and vice versa.

In World War II, damage to the canal could have and would have delayed the buildup of our war efforts in the Pacific big time. I can't imagine what it would be like to not have been able to use the canal. It would have delayed the flow of supplies to Great Britain, the Soviet Union, the dispatch of essential war materials from South America to the United States, and on and on.

I am concerned that some officials in Panama might be somewhat naive about the canal's security and about world history. In June, the then Panamanian Foreign Minister disagreed sharply with General Wilhelm, head of SOUTHCOM, who had testified before the Senate Foreign Relations Committee that Panamanian security forces were undermanned and ill equipped to deal with growing threats from Colombian guerrilla incursions and drug traffickers. Panama's Foreign Minister at that time, Jorge Ritter, said the general's statements were inadmissible and argued that ''never have the U.S. military forces been here to guard our borders, and they have even less to do with the security of Panama, nor do they have anything to do with the security of the canal.''

Even more surprisingly, the Foreign Minister alleged that the growth of drugs in Panama did not begin with withdrawal of U.S. troops but, instead, grew while there were military bases in Panama.

Perhaps this gentleman, with all due respect, has forgotten what happened in 1989. During questioning before the Senate Foreign Relations Committee, Adm. Thomas Moorer, former Chairman of the Joint Chiefs of Staff, was asked if the 1977 treaty had been more helpful or more harmful to U.S. interests. Moorer's immediate response was that 26 soldiers had died in Operation Just Cause in 1989. Among the reasons for the military intervention—to thwart drug trafficking, to preserve democracy in Panama, and to defend the canal—26 Americans gave their lives. To have Mr. Ritter make those kinds of statements is outrageous.

Part of the Senate Foreign Relations Committee hearing testimony includes some interesting commentary on the background of Mr. Ritter. He was the president of the Panama Canal Authority. He was also the chief Panamanian negotiator who reportedly torpedoed the base talks in Panama. He was tied by the Panamanian press and outside press to the highest levels of drug cartels and served as Panama's ambassador to Colombia during the time that Manuel Noriega was doing business with the drug cartels in Colombia. He was Noriega's point man, bottom line.

It was also reported to the press that Ritter had issued a Panamanian ID card for Jorge Escobar, which was found on him when he died in Colombia in a shoot-out with law enforcement. I am not surprised that Mr. Ritter downplayed the importance of the canal and U.S. military base rights. It doesn't surprise me at all.

Hopefully, with the recent inauguration of President Moscoso, that attitude, as expressed by the former Foreign Minister, has changed. I hope it has. I am told that the new Panamanian President was planning to visit but, for whatever reason, I am not sure, canceled her trip. I had hoped to have the opportunity to meet with her. Hopefully, we will be able to do that at some point in the future.

I have been informed that, unlike her predecessor, President Moscoso would like to do business with the United States and would like to be above board with the negotiations. I wish her much success. I hope she realizes how important her actions are. It would be nice if some in the State Department and the administration would talk with her and encourage her in the next few weeks and months.

I also hope that it is not too late for her to weigh in on the decision about the leases at Cristobal and Balboa. I realize that would take a lot of political courage for her, but I hope she will give a thorough review of the bidding process, its known irregularities, and its compliance with both the spirit and the letter of the canal and neutrality treaty.

In conclusion, this Law 5 reportedly does the following: It gives responsibility for hiring new pilots for the canal who control the ships passing through the canal. It gives Hutchison Whampoa, the Chinese company, the right to possess Rodman Naval Station when it reverts to Panama this year. It gives the authority to control the order of ships utilizing the entrance to the canal and to deny ships access to the ports and entrances of the canal, if they are deemed to be interfering with Hutchinson's business operations. Contrast this with the explicit grant of expeditious passage in the 1977 treaty, which the Panama Canal treaty gave to the U.S. Navy.

Now we are seeing the Chinese Communists—and there are thousands of Chinese now in Panama. People say: Well, it is private business. There is no private business in China. It is all controlled by the government, whatever they do. So this is government business in China. It is Chinese Communist government in Panama by the Chinese. Law 5 gives the right to transfer unilaterally its rights to a third party to

any company or any country they select. This ought to be troublesome, and yet it is not even on the radar screen in the political debates around our country today.

Certain public roads could become private in a hurry, which could impact canal access.

This Hutchison Whampoa deal includes U.S. Naval Station Rodman, as mentioned previously; U.S. Air Station Albrook; Diablo; Balboa, a Pacific U.S.-built port; Cristobal, an Atlantic U.S.-built port; the island of Telfers, strategically located adjacent to Galeto Island, a critical communications center.

Telfers Island is said to be the future home of a Chinese work in progress, an export zone, called the ''Great Wall of China'' project.

I cannot understand how we can ignore this presence into the Western Hemisphere. Monroe would turn over in his grave. The Monroe Doctrine said that foreign European nations, and other nations around the world, should stay out of the Western Hemisphere. Yet, here they are.

Law 5 is subservient to the 1977 treaty. But if we fail to notice the discrepancies and fail to act upon those discrepancies, or to point out there are potential compliance problems, then we lose the opportunity to respond.

As I said before, I don't have the easel here now, but it's 84 more days. We will come back next week, and I will come back with the chart and it will be 79 days, or whatever it happens to be. But as each day ticks off, another day goes by—another day we haven't talked to President Moscoso and we haven't tried to reopen the negotiations, and we are another day closer to turning the Panama Canal not over to the Panamanians, but to the Chinese Communists—and not a whimper from anybody in the State Department, or the President, the Defense Department, Presidential campaigns, or anywhere. So the days are getting short. I think that I have an obligation to tell the American people, on a day-to-day basis—remind them—about what is going on.

ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on October 7, 1999, he had presented to the President of the United States, the following enrolled bill:

S. 559. An act to designate the Federal building located at 300 East 8th Street in Austin, Texas, as the ''J.J. 'Jake' Pickle Federal Building.''

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–5528. A communication from the Deputy General Counsel, Federal Bureau of Investigation, Department of Justice, transmitting, pursuant to law, the report of a rule entitled ''Federal Bureau of Investigation, Criminal Justice Information Services Division Systems and Procedures'' (RIN1105–AA63), received October 4, 1999; to the Committee on the Judiciary.

EC–5529. A communication from the General Counsel, Federal Emergency Management Agency, transmitting, pursuant to law, the report of a rule entitled ''National Flood Insurance Program; Procedures and Fees for Processing Map Changes; 64 FR 51461; 09/23/99'', received September 30, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–5530. A communication from the Chairman, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the annual report for calendar year 1998; to the Committee on Banking, Housing, and Urban Affairs.

EC–5531. A communication from the Assistant General Counsel for Regulatory Law, Department of Energy, transmitting, pursuant to law, the report of a rule entitled ''Safety of Nuclear Explosive Operations'' (AL 452.2A), received October 4, 1999; to the Committee on Energy and Natural Resources.

EC–5532. A communication from the Principal Deputy Assistant Secretary for Congressional Affairs transmitting a draft of proposed legislation entitled ''Veterans Programs Improvement Act of 1999''; to the Committee on Veteran's Affairs.

EC–5533. A communication from the Director, Office of Regulations Management, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled ''Enrollment-Provision of Hospital and Outpatient Care to Veterans'' (RIN2900–AJ18), received October 4, 1999; to the Committee on Veteran's Affairs.

EC–5534. A communication from the Director, National Science Foundation, transmitting, pursuant to law, the 1998 biennial report of the Committee on Equal Opportunities in Science and Engineering; to the Committee on Health, Education, Labor, and Pensions.

EC–5535. A communication from the Commissioner of Social Security transmitting a draft of proposed legislation entitled ''Civil Monetary Penalty Extension Act of 1999''; to the Committee on Finance.

EC–5536. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Weighted Average Interest Rate Update'' (Notice 99–49), received September 27, 1999; to the Committee on Finance.

EC–5537. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Appeals Customer Service Program'' (Announcement 99–98, 1999–412 I.R.B.—, dated October 18, 1999), received October 4, 1999; to the Committee on Finance.

EC–5538. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Ethalfluralin; Reestablishment of Tolerance for Emergency Exemptions'' (FRL #6383–2), received October 4, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5539. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Tebuconazole; Extension of Tolerance for Emergency Exemptions'' (FRL #6386–4), received October 4, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5540. A communication from the Director, Office of Procurement and Property Management, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Agriculture Acquisition Regulation: Part 415 Reorganization; Contracting by Negotiation'' (RIN0599–AA07), received September 30, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5541. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Avocados Grown in South Florida and Imported Avocados; Revision of the Maturity Requirements for Fresh Avocados'' (Docket No. FV99–915–2 FR), received October 4, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5542. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Fresh Bartlett Pears Grown in Oregon and Washington; Increased Assessment Rate'' (Docket No. FV99–931–1 FR), received September 30, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5543. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Vidalia Onions Grown in Georgia; Decreased Assessment Rate'' (Docket No. FV98–955–1 FIR), received September 30, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5544. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Oranges, Grapefruit, Tangerines, and Tangelos Grown in Florida; Modification of Procedures for Limiting the Volume of Small Red Seedless Grapefruit'' (Docket No. FV99–905–4 IFR), received September 30, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5545. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Voluntary Egg, Poultry and Rabbit Grading Regulations'' (Docket No. PY–99–904), received September 30, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5546. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Interim Final Rule-Revision of Regulation for Mandatory Inspection (Flue-Cured Tobacco)'' (Docket No. TB–99–07), received September 30, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5547. A communication from the Manager, Federal Crop Insurance Corporation, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Final Rule: General Administrative Regulations; Interpretations of Statutory and Regulatory Provisions'' (RIN0563–AB74), received October 4, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5548. A communication from the Acting Inspector General, Department of Defense, transmitting, pursuant to law, a report relative to the DoD annual financial audit of the uses of the Superfund; to the Committee on Environment and Public Works.

EC–5549. A communication from the Director, Office of Regulatory Management and

Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; Indiana'' (FRL #6452–6), received September 30, 1999; to the Committee on Environment and Public Works.

EC–5550. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; California State Implementation Plan Revision, Santa Barbara County Air Pollution Control District and South Coast Air Quality Management District'' (FRL #6448–5), received October 4, 1999; to the Committee on Environment and Public Works.

EC–5551. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Final Authorization of State Hazardous Waste Management Program Revision'' (FRL #6448–5), received October 4, 1999; to the Committee on Environment and Public Works.

EC–5552. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Technical Support Document for the Evaluation of Aerobic Biological Treatment Units with Multiple Mixing Zones'', received October 4, 1999; to the Committee on Environment and Public Works.

EC–5553. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''USEPA Region 2 Draft Interim Policy on Identifying EJ Areas; June 1999; Parts I, II and III'', received October 4, 1999; to the Committee on Environment and Public Works.

EC–5554. A communication from the Director, Office of Congressional Affairs, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''Changes, Tests, and Experiments'' (RIN3150–AF94), received October 4, 1999; to the Committee on Environment and Public Works.

EC–5555. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment to Class E Airspace; Moundsville, WV; Docket No. 99–AEA–11 (9–29/10–4)'' (RIN2120–AA66) (1999–0319), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5556. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revision of Class E Airspace; Raton, NM; Direct Final Rule; Confirmation of Effective Date; Docket No. 99–ASW–11 (9–29/9–30)'' (RIN2120–AA66) (1999–0317), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5557. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revision of Class E Airspace; Perry, OK; Direct Final Rule; Confirmation of Effective Date; Docket No. 99–ASW–15 (9–29/10–4)'' (RIN2120–AA66) (1999–0321), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5558. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Class D Airspace; Bullhead City, AZ; Direct Final Rule; Confirmation of Effective Date; Docket No. 99–AWP–8 (9–20/10–4)'' (RIN2120–AA66) (1999–0320), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5559. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Burkhart Grob Luft-Und Raumfahrt GmbH and CO KG Models G103 TWIN II and G103A TWIN II ACRO Sailplanes; Request for Comments; Docket No. 99–CE–68 (9–29/10–4)'' (RIN2120–AA64) (1999–0379), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5560. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; MD Helicopters Inc. Model 369D, 369E, 369FF, 500N, and 600N Helicopters; Docket No. 98–SW–80 (9–30/10–4)'' (RIN2120–AA64) (1999–0378), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5561. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A330–301, and Model A340–211, –212, –311, and –312 Series Airplanes; Docket No. 99–NM–119 (10–1/10–4)'' (RIN2120–AA64) (1999–0377), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5562. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Short Brothers SD3–30, SD3–60, SD3–SHERPA, and SD3–60 SHERPA Series Airplanes; Docket No. 99–NM–29 (1–1/10–4)'' (RIN2120–AA64) (1999–0375), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5563. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Empressa Brasileira de Aeronautica S.A. Model EMB–145 Series Airplanes; Request for Comments; Docket No. 99–NM–198 (10–1/10–4)'' (RIN2120–AA64) (1999–0376), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5564. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Fokker Model F.28 Mark 0070 and Mark 0100 Series Airplanes; Docket No. 99–NM–346 (–28/10–4)'' (RIN2120–AA64) (1999–0373), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5565. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Allied Signal Inc. TFE731 Series Turbofan Engines; Docket No. 99–ANE–51 (9–29/10–4)'' (RIN2120–AA64) (1999–0374), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5566. A communication from the Chief Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Inseason Adjustment for the D Fishing Season Directed Pollock Fishery in Statistical Area 630 of the Gulf of Alaska, received September 30, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5567. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Atka Mackerel in the Central Aleutian District and Bering Sea Subarea of the Bering Sea and Aleutian Islands, received September 30, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5568. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Pollock by Vessels Catching Pollock for Processing by the Mothership in the Bering Sea Subarea, received September 30, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5569. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Prohibition of Directed Fishing for Pollock in Statistical Area 610 of the Gulf of Alaska'', received September 30, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5570. A communication from the Deputy Assistant Administrator for Fisheries, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries off West Coast States and in the Western Pacific; Pacific Coast Groundfish Fishery; Amendment 11'' (RIN0648–AL52), received October 4, 1999; to the Committee on Commerce, Science, and Transportation.

EC–5571. A communication from the Associate Chief, Policy and Program Planning Division, Common Carrier Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Telecommunications Carriers' Use of Customer Proprietary Network Information and Other Customer Information, Order on Reconsideration and Petitions for Forbearance'' (CC Docket No. 96–114) (FCC 99–223), received September 30, 1999; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. HATCH, from the Committee on the Judiciary, without amendment:

S. Res. 179. A resolution designating October 15, 1999, as ''National Mammography Day.''

EXECUTIVE REPORTS OF A COMMITTEE

The following executive reports of a committee were submitted:

By Mr. HATCH, for the Committee on the Judiciary:

Ellen Segal Huvelle, of the District of Columbia, to be United States District Judge for the District of Columbia.

Anna J. Brown, of Oregon, to be United States District Judge for the District of Oregon.

Charles A. Pannell, Jr., of Georgia, to be United States District Judge for the Northern District of Georgia.

Florence-Marie Cooper, of California, to be United States District Judge for the Central District of California.

Ronald M. Gould, of Washington, to be United States Circuit Judge for the Ninth Circuit.

Richard K. Eaton, of the District of Columbia, to be a Judge of the United States Court of International Trade.

(The above nominations were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. CRAIG (for himself and Mr. CRAPO):

S. 1705. A bill to direct the Secretary of the Interior to enter into land exchanges to acquire from the private owner and to convey to the State of Idaho approximately 1,240 acres of land near the City of Rocks National Reserve, Idaho, and for other purposes; to the Committee on Energy and Natural Resources.

By Mrs. HUTCHISON (for herself and Mr. GRAMM):

S. 1706. A bill to amend the Federal Water Pollution Control Act to exclude from stormwater regulation certain areas and activities, and to improve the regulation and limit the liability of local governments concerning co-permitting and the implementation of control measures; to the Committee on Environment and Public Works.

By Mr. THOMPSON (for himself and Mr. FRIST):

S. 1707. A bill to amend the Inspector General Act of 1978 (5 U.S.C. App.) to provide that certain designated Federal entities shall be establishments under such Act, and for other purposes; to the Committee on Governmental Affairs.

By Mr. MOYNIHAN (for himself, Mr. JEFFORDS, Mr. LEAHY, Mr. KERREY, Mr. ROBB, Mr. ROCKEFELLER, Mr. SARBANES, Mr. GRAMS, and Mr. LIEBERMAN):

S. 1708. A bill to amend the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to require plans which adopt amendments that significantly reduce future benefit accruals to provide participants with adequate notice of the changes made by such amendments; to the Committee on Finance.

By Mr. KYL (for himself, Mr. MCCAIN, Mrs. HUTCHISON, Mr. DOMENICI, Mr. BINGAMAN, and Mrs. FEINSTEIN):

S. 1709. A bill to provide Federal reimbursement for indirect costs relating to the incarceration of illegal aliens and for emergency health services furnished to undocumented aliens; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Ms. SNOWE (for herself, Mr. HELMS, Mr. SARBANES, Mr. BIDEN, and Mr. BYRD):

S. Res. 198. Expressing sympathy for those killed and injured in the recent earthquakes in Turkey and Greece and commending Turkey and Greece for their recent efforts in opening a national dialogue and taking steps to further bilateral relations; considered and agreed to.

By Mr. REED (for himself, Ms. COLLINS, Mr. TORRICELLI, Mr. REID, Mr. LEVIN, Mr. WELLSTONE, Mr. LIEBERMAN, Mr. KERRY, Mr. KENNEDY, Mr. SARBANES, Mr. DORGAN, Mr. SCHUMER, Mr. AKAKA, Mr. INOUYE, Mr. CHAFEE, Mrs. BOXER, Ms. MIKULSKI, Mr. DODD, Mr. WYDEN, Mr. CONRAD, Mr. GRAHAM, Mr. DURBIN, Mr. DEWINE, Ms. LANDRIEU, Mr. JOHNSON, Mr. JEFFORDS, Mr. SMITH of Oregon, Mr. ROBB, and Mr. FRIST):

S. Res. 199. A resolution designating the week of October 24, 1999, through October 30, 1999, and the week of October 22, 2000, through October 28, 2000, as ''National Childhood Lead Poisoning Prevention Week''; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CRAIG (for himself and Mr. CRAPO):

S. 1705. A bill to direct the Secretary of the Interior to enter into land exchanges to acquire from the private owner and to convey to the State of Idaho approximately 1,240 acres of land near the City of Rocks National Reserve, Idaho, and for other purposes; to the Committee on Energy and Natural Resources.

CASTLE ROCK RANCH/HAGERMAN FOSSIL BEDS LAND EXCHANGE

● Mr. CRAIG. Mr. President, I rise today to introduce a bill to authorize the Castle Rocks Ranch/Hagerman Fossil Beds Land Exchange in my home state of Idaho.

Mr. President, in Idaho we have one of the foremost rock climbing destination sites in the world. It is called the City of Rocks National Reserve and is located in South Central Idaho. Most of the Reserve is owned by the National Park Service with parts of it being owned by the State of Idaho, the Forest Service, the Bureau of Land Management, and private landowners. The State of Idaho runs the Reserve with a cooperative agreement with the National Park Service.

The Reserve has unique geologic features—essentially, large rock formations jut out of the ground. I can't give it justice with my description—it is really something that must be seen, so I invite everyone to come to Idaho and visit the City of Rocks. Besides the rock formations, many of which are used extensively and known internationally for rock climbing, the site has unique historic significance. The California Trail, one of the major trails for Westward expansion during the 19th Century, passes through the Reserve. One of the Reserve's major attractions, Twin Sisters, was a landmark for this trail and is currently being protected for historic significance. Additionally, wagon trains often stopped in the area to maintain their wagons. During these stops, pioneers wrote their names on the rocks with wagon grease. Many of these names are still visible on the rocks today and serve as a record of our ancestors who passed through the area.

Near the Reserve exists the Castle Rock Ranch, an approximately 1,240 acre ranch containing similar rock formations, which are ideal for fork climbing. Additionally, the Ranch contains irrigated pasture land. The Ranch was recently purchased by The Conservation Fund and other conservation groups in order to put it into the public domain for recreation. It is currently being operated as a working ranch. However, the State of Idaho would like to acquire this Ranch to make it into a state park. They would open up the rock formations for rock climbing, provide for camping and hiking, and, where irrigated pasture land exists, trade that irrigated land for dry land inholdings within the Reserve. This would help local ranchers acquire irrigated land, which is more valuable than gold in Southern Idaho, and allow the state to consolidate inholdings within the Reserve.

A couple of counties to the West and across the mighty Snake River exists the Hagerman Fossil Beds National Monument. This National Monument contains the Hagerman Fossil Beds, which is important because it contains the world's most important fossil deposits from a time period known as the late Pliocene epoch, 3.5 million years ago. They represent the last glimpse of time before the Ice Age. Additionally, the beds contain the largest concentration of Hagerman Horse fossils in North America. While the State of Idaho owns the actual fossil beds, the National Park Service runs and maintains the facility.

The State of Idaho wants to divest its interest in the fossil beds and acquire the Castle Rock Ranch. Additionally, the National Park Service wants to acquire the Fossil Beds. This would make it easier for everyone to work to protect the resources we have and open up opportunities for recreation. Consequently, I am introducing this legislation.

In brief, the legislation would authorize the National Park Service to acquire the Castle Rock Ranch, exchange the Ranch with the State of Idaho for the Hagerman Fossil Beds, and mandate that the State exchange land within the Ranch for inholdings within the City of Rocks. In the end, the National Park Service would run and own the Hagerman Fossil Beds, the State of Idaho would own and run a state park in part of the Castle Rock Ranch, and voluntary inholders in the

City of Rocks would be able to trade their inholdings for irrigated land on the Castle Rock Ranch.

The only concern I have is the existence of an easement on the Hagerman Fossil Beds for the local irrigation company. This is the only way for farmers in the local area to get water to their farms—a necessity in that region. Section 4(e) of this legislation was included to ensure that this easement will continue to exist. It is vital to the existence of family farms in the area, and, for the record, it is not my intent to harm—and I will do all in my power to prevent this legislation from harming—this easement or the irrigation in the local area.

Mr. President, this is a unique proposal that makes fiscal sense for taxpayers and has garnered the support of the National Park Service, the State of Idaho, The Conservation Fund, The Access Fund (a national climbing group), other conservation groups, local legislators, and many local residents. I hope that my colleagues will recognize the importance of this legislation and work for its enactment.●

By Mr. MOYNIHAN (for himself, Mr. JEFFORDS, Mr. LEAHY, Mr. KERREY, Mr. ROBB, Mr. ROCKEFELLER, Mr. SARBANES, Mr. GRAMS, and Mr. LIEBERMAN):

S. 1708. A bill to amend the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to require plans which adopt amendments that significantly reduce future benefit accruals to provide participants with adequate notice of the changes made by such amendments; to the Committee on Finance.

THE PENSION REDUCTION DISCLOSURE ACT OF 1999

Mr. MOYNIHAN. Mr. President, I rise today, joined by Senators JEFFORDS, LEAHY, GRAMS, KERREY, ROBB, ROCKEFELLER, and SARBANES, to introduce legislation to provide greater disclosure of the impact of pension plan conversions.

This is the second bill I have sponsored this session aimed at achieving transparency of the effects of traditional pension plan conversions to ''cash balance'' plans, which have become extremely controversial in recent months. At least 300 large U.S. companies have converted to cash balance plans in the last few years.

Cash balance plans combine certain features of ''defined benefit'' and ''defined contribution'' plans. Like defined contribution plans, cash balance plans provide each employee with an individual account representing a lump-sum benefit. Like traditional defined benefit plans, cash balance plan contributions are made primarily by the employer and are insured by the Pension Benefit Guaranty Corporation.

The calculation of benefits under cash balance plans, however, differs from other defined benefit plans. Whereas a traditional defined benefit plan grows slowly in the early years and more rapidly as one approaches retirement, cash balance plans de-accelerate this later-year growth and increase the early-year growth. Consequently, younger employees tend to do better under cash balance plans than under traditional plans, while older employees typically do worse. In some cases, an older worker's starting account balance may remain static for years—typically referred to as the ''wear away'' period.

The controversy over cash balance plans arises in part because present disclosure requirements are inadequate. Under present law, when an employer amends a defined benefit pension plan in a manner which significantly reduces the rate of future benefit accrual, the employer must provide participants with an advance written notice of the amendment. The law does not, however, require employers to disclose the effect the amendment will have on participants. In fact, it does not even require employers to disclose that benefits will be reduced. All that present law requires is that employers provide participants with a summary or copy of the plan amendment. Consequently, current law can be satisfied with a summary buried in an obscure document. In some cases, workers have complained that their employers purposefully obscured benefit reductions. As a result, employee anger over cash balance plans has grown, resulting in several class action lawsuits being filed in just the last three years.

The Pension Reduction Disclosure Act will strengthen existing law by requiring disclosure of information which will enable employees to determine the effects of benefit reductions. Specifically, before the plan is changed, each adversely-affected employee must receive illustrative examples showing the effects of the change on various employee groups. Moreover, each employee must have the opportunity to receive the benefit formulas for the old and new versions of the plan so that he or she can make specific comparisons of both plans. Then, 90 days after the plan is changed, each adversely-affected employee must have, upon request, the opportunity to receive an individual benefit comparison prepared by the employer. This information will provide employees with the knowledge they need regarding pension benefit reductions, while imposing minimal burden on employers.

The Pension Reduction Disclosure Act, is a modified version of legislation I introduced in March entitled The Pension Right to Know Act (S. 659). The new measure attempts to address concerns raised by employers concerning S. 659. For example, the new measure requires disclosure only for adversely-affected employees, not all employees, in order to meet employer concerns that S. 659 was too broad in its reach. Moreover, the new bill addresses employer concerns that it would be difficult to provide individual benefit comparisons before the amendment effective date due to a lack of individual data. Under the bill introduced today, individual benefit comparisons would be required no earlier than 90 days after the effective date, and then only upon request. (To enable employees to compare the old and new plans before the effective date, this bill provides illustrative examples and, upon request, the benefit formulas for the old and new plans.) Another change is that the new bill allows the Secretary of Treasury to develop alternative and simplified compliance methods where appropriate, as in cases where there is no fundamental change in the manner in which benefits are determined. Moreover, the Secretary may reduce the advance notice period from 45 days to 15 days in cases in which the 45-day requirement would be unduly burdensome because the amendment is contingent on a merger, acquisition, disposition or other similar transaction.

I believe that such disclosure not only is in the best interest of employees, but also of the employer. Several class action lawsuits have been filed in the last three years challenging conversions to cash balance plans. These suits will likely cost millions of dollars in attorneys' fees, but with proper disclosure they might not have occurred.

I want to acknowledge the work of the Clinton Administration in helping to craft this measure. The bill largely follows the outline of a proposal suggested by the Administration in July which was developed in collaboration with my staff. The Departments of Treasury and Labor have provided great insight and creativity in developing this bill, and I thank them for their assistance. Two of our distinguished House colleagues, Congressman ROBERT MATSUI of California and Congressman JERRY WELLER of Illinois, are introducing this legislation in the other chamber, so hopefully it will become law this year.

In closing, let me repeat what I have said in the past. I take no position on the underlying merit of cash balance plans. Ours is a voluntary pension system, and companies must do what is right for them and their employees. But I feel strongly that companies must fully and comprehensibly inform their employees regarding whatever pension benefits the company offers. Companies have no right to misrepresent or obfuscate the projected benefit employees will receive under a cash balance plan or any other pension arrangement, notwithstanding the fact that some pension consultants have advocated cash balance plans for that very purpose.

As I said upon introduction of my earlier legislation on this topic, it is time to let the sun shine on pension plan conversions. I urge the Senate to support this important measure.

I ask unanimous consent that a copy and summary of the bill be included in the RECORD.

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

S. 1708

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Pension Reduction Disclosure Act of 1999''.

SEC. 2. NOTICE REQUIRED FOR CERTAIN PLAN AMENDMENTS REDUCING FUTURE BENEFIT ACCRUALS.

(a) GENERAL NOTICE REQUIREMENTS.—Section 204(h) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1054(h)) is amended to read as follows:

''(h) NOTICE REQUIREMENTS FOR PENSION PLAN AMENDMENTS REDUCING ACCRUALS.—

''(1) IN GENERAL.—If an applicable pension plan is amended so as to provide for a significant reduction in the rate of future benefit accrual of 1 or more applicable individuals, the plan administrator shall—

''(A) not later than the 45th day before the effective date of the amendment, provide the written notice described in paragraph (2) to each applicable individual (and to each employee organization representing applicable individuals), and

''(B) in the case of a large applicable pension plan—

''(i) include in the notice under paragraph (2) the additional information described in paragraph (3),

''(ii) make available the information described in paragraph (4) in accordance with such paragraph, and

''(iii) provide individual benefit statements in accordance with section 105(e).

''(2) BASIC WRITTEN NOTICE.—The notice under paragraph (1) shall include a summary of the important terms of the amendment, including—

''(A) the effective date of the amendment,

''(B) a statement that the amendment is expected to significantly reduce the rate of future benefit accrual,

''(C) a description of the classes of applicable individuals to whom the amendment applies, and

''(D) a description of how the amendment significantly reduces the rate of future benefit accrual.

''(3) ADDITIONAL INFORMATION TO BE PROVIDED BY LARGE APPLICABLE PENSION PLANS.—

''(A) IN GENERAL.—The information described in this paragraph is—

''(i) a description of the plan's benefit formulas (including formulas for determining early retirement benefits) both before and after the amendment and an explanation of the effect of the different formulas on applicable individuals,

''(ii) an explanation of the circumstances (if any) under which (for appropriate categories of applicable individuals) the amendment is reasonably expected to result in a temporary period after the effective date of the amendment during which there are no or minimal accruals,

''(iii) illustrative examples of normal or early retirement benefits meeting the requirements of subparagraph (B), and

''(iv) notice of each applicable individual's right to request, and of the procedures for requesting, the information required to be provided under paragraph (4) and under section 105(e).

''(B) ILLUSTRATIVE EXAMPLES.—Illustrative examples meet the requirements of this subparagraph if such examples illustrate the adverse effects of the plan amendment. Such examples shall be prepared by the plan administrator in accordance with regulations prescribed by the Secretary of the Treasury, and such regulations shall require that the examples—

''(i) reflect fairly the different categories of applicable individuals who are similarly affected by the plan amendment after consideration of all relevant factors,

''(ii) show a comparison of benefits for each such category of applicable individuals under the plan (as in effect before and after the effective date) at appropriate future dates, and

''(iii) illustrate any temporary period described in subparagraph (A)(ii).

Such comparison shall be based on benefits in the form of a life annuity and on actuarial assumptions each of which is reasonable (and is so certified by an enrolled actuary) when applied to all participants in the plan.

''(4) SUPPORTING INFORMATION RELATING TO CALCULATION OF BENEFITS.—

''(A) IN GENERAL.—Each individual who receives or who is entitled to receive the information described in paragraph (3) may (after so receiving or becoming so entitled) request the plan administrator to provide the information described in subparagraph (B).

''(B) INFORMATION.—The plan administrator shall, within 15 days after the date on which a request under subparagraph (A) is made, provide to the individual information (including benefit formulas and actuarial factors) which is sufficient—

''(i) to confirm the benefit comparisons in the illustrative examples described in paragraph (3)(B), and

''(ii) to enable the individual to use the individual's own personal information to make calculations of the individual's own benefits which are similar to the calculations made in such examples.

Nothing in this subsection shall be construed to require the plan administrator to provide to an individual such individual's personal information for purposes of clause (ii).

''(C) TIME LIMITATION ON REQUESTS.—This paragraph shall apply only to requests made during the 12-month period that begins on the later of the effective date of the amendment to which it relates or the date the notice described in paragraph (2) is provided.

''(5) SANCTIONS.—

''(A) IN GENERAL.—In the case of any egregious failure to meet any requirement of this subsection with respect to any plan amendment, the provisions of the applicable pension plan shall be applied as if such plan amendment entitled all applicable individuals to the greater of—

''(i) the benefits to which they would have been entitled without regard to such amendment, or

''(ii) the benefits under the plan with regard to such amendment.

''(B) EGREGIOUS FAILURE.—For purposes of subparagraph (A), there is an egregious failure to meet the requirements of this subsection if such failure is—

''(i) an intentional failure (including any failure to promptly provide the required notice or information after the plan administrator discovers an unintentional failure to meet the requirements of this subsection),

''(ii) a failure to provide most of the individuals with most of the information they are entitled to receive under this subsection, or

''(iii) a failure which is determined to be egregious under regulations prescribed by the Secretary of the Treasury.

''(B) EXCISE TAX.—For excise tax on failure to meet requirements, see section 4980F of the Internal Revenue Code of 1986.

''(6) SPECIAL RULES.—

''(A) PLAIN LANGUAGE.—The notice required under paragraph (1) shall be written in a manner calculated to be understood by the average plan participant who is an applicable individual.

''(B) NOTICE TO DESIGNEES.—The notice and information required to be provided under this subsection may be provided to a person designated, in writing, by the person to which it would otherwise be provided.

''(7) ALTERNATIVE METHODS OF COMPLIANCE WITH ENHANCED DISCLOSURE REQUIREMENTS IN CERTAIN CASES.—The Secretary of the Treasury shall prescribe such regulations as may be necessary to carry out this subsection. The Secretary of the Treasury may—

''(A) prescribe alternative or simplified methods of complying with paragraphs (3) and (4) in situations where—

''(i) there is no fundamental change in the manner in which the accrued benefit of an applicable individual is determined under the plan, and

''(ii) such other methods are adequate to reasonably inform plan participants who are applicable individuals of the impact of the reductions,

''(B) reduce the advance notice period in paragraph (1)(A) from 45 days to 15 days before the effective date of the amendment for cases in which compliance with the 45-day advance notice requirement would be unduly burdensome because the amendment is contingent on a merger, acquisition, disposition, or other similar transaction involving plan participants who are applicable individuals or because 45 days advance notice is otherwise impracticable,

''(C) permit the comparison of benefits under paragraph (3)(B)(i) to be based on a form of payment other than a life annuity, or

''(D) specify actuarial assumptions that are deemed to be reasonable for purposes of the benefit comparisons under paragraph (3)(B)(i).

''(8) APPLICABLE INDIVIDUAL.—For purposes of this subsection, the term 'applicable individual' means, with respect to any plan amendment—

''(A) each participant in the plan, and

''(B) each beneficiary who is an alternate payee (within the meaning of section 206(d)(3)(K)) under a qualified domestic relations order (within the meaning of section 206(d)(3)(B)(i)),

whose future benefit accruals under the plan may reasonably be expected to be reduced by such plan amendment.

''(9) TERMS RELATING TO PLANS.—For purposes of this subsection—

''(A) APPLICABLE PENSION PLAN.—The term 'applicable pension plan' means—

''(i) a defined benefit plan, or

''(ii) an individual account plan which is subject to the funding standards of section 302.

''(B) LARGE APPLICABLE PENSION PLAN.—The term 'large applicable pension plan' means an applicable pension plan which had 100 or more active participants as of the last day of the plan year preceding the plan year in which the plan amendment becomes effective.''

(b) INDIVIDUAL STATEMENTS.—Section 105 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1025) is amended by adding at the end the following new subsection:

''(e)(1) The plan administrator of a large applicable pension plan shall furnish an individual statement described in paragraph (2) to each individual—

''(A) who receives, or is entitled to receive, under section 204(h) the information described in paragraph (3) thereof from such administrator, and

''(B) who requests in writing such a statement from such administrator.

''(2) The statement described in this paragraph is a statement which provides information which is substantially the same as the information in the illustrative examples

described in section 204(h)(3)(B) but which is based on data specific to the requesting individual and, if the individual so requests, information as of 1 other future date not included in such examples.

''(3) Paragraph (1) shall apply only to requests made during the 12-month period that begins on the later of the effective date of the amendment to which it relates or the date the notice described in section 204(h)(2) is provided. In no case shall an individual be entitled under this subsection to receive more than one such statement with respect to an amendment.

''(4) Notwithstanding section 502(c)(1), the statement required by paragraph (1) shall be treated as timely furnished if furnished on or before—

''(A) the date which is 90 days after the effective date of the plan amendment to which is relates, or

''(B) such later date as may be permitted by the Secretary of Labor.

''(5) Any term used in this subsection which is used in section 204(h) shall have the meaning given such term by such section.

''(6) A statement under this subsection shall not be taken into account for purposes of subsection (b).''

SEC. 3. EXCISE TAX ON FAILURE TO PROVIDE NOTICE BY DEFINED BENEFIT PLANS SIGNIFICANTLY REDUCING FUTURE BENEFIT ACCRUALS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end the following new section:

''SEC. 4980F. FAILURE OF DEFINED BENEFIT PLANS REDUCING BENEFIT ACCRUALS TO SATISFY NOTICE REQUIREMENTS.

''(a) IMPOSITION OF TAX.—There is hereby imposed a tax on the failure of a plan administrator of an applicable pension plan to meet the requirements of subsection (e) with respect to any applicable individual.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to any applicable individual shall be $100 for each day in the noncompliance period with respect to such failure.

''(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period beginning on the date the failure first occurs and ending on the date the failure is corrected.

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—

''(A) IN GENERAL.—In the case of failures that are due to reasonable cause and not to willful neglect, the tax imposed by subsection (a) for failures during the taxable year of the employer (or, in the case of a multiemployer plan, the taxable year of the trust forming part of the plan) shall not exceed $500,000 ($1,000,000 in the case of a large applicable pension plan).

''(B) TAXABLE YEARS IN THE CASE OF CERTAIN CONTROLLED GROUPS.—For purposes of this paragraph, if all persons who are treated as a single employer for purposes of this section do not have the same taxable year, the taxable years taken into account shall be determined under principles similar to the principles of section 1561.

''(2) 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) LIABILITY FOR TAX.—The following shall be liable for the tax imposed by subsection (a):

''(1) In the case of a plan other than a multiemployer plan, the employer.

''(2) In the case of a multiemployer plan, the plan.

''(e) NOTICE REQUIREMENTS FOR PENSION PLAN AMENDMENTS REDUCING ACCRUALS.—

''(1) IN GENERAL.—If an applicable pension plan is amended so as to provide for a significant reduction in the rate of future benefit accrual of 1 or more applicable individuals, the plan administrator shall—

''(A) not later than the 45th day before the effective date of the amendment, provide the written notice described in paragraph (2) to each applicable individual (and to each employee organization (as defined in section 3(4) of the Employee Retirement Income Security Act of 1974) representing applicable individuals), and

''(B) in the case of a large applicable pension plan—

''(i) include in the notice under paragraph (2) the additional information described in paragraph (3), and

''(ii) make available the information described in paragraph (4) in accordance with such paragraph.

''(2) BASIC WRITTEN NOTICE.—The notice under paragraph (1) shall include a summary of the important terms of the amendment, including—

''(A) the effective date of the amendment,

''(B) a statement that the amendment is expected to significantly reduce the rate of future benefit accrual,

''(C) a description of the classes of applicable individuals to whom the amendment applies, and

''(D) a description of how the amendment significantly reduces the rate of future benefit accrual.

''(3) ADDITIONAL INFORMATION TO BE PROVIDED BY LARGE APPLICABLE PENSION PLANS.—

''(A) IN GENERAL.—The information described in this paragraph is—

''(i) a description of the plan's benefit formulas (including formulas for determining early retirement benefits) both before and after the amendment and an explanation of the effect of the different formulas on applicable individuals,

''(ii) an explanation of the circumstances (if any) under which (for appropriate categories of applicable individuals) the amendment is reasonably expected to result in a temporary period after the effective date of the amendment during which there are no or minimal accruals,

''(iii) illustrative examples of normal or early retirement benefits meeting the requirements of subparagraph (B), and

''(iv) notice of each applicable individual's right to request, and of the procedures for requesting, the information required to be provided under paragraph (4) and under section 105(e) of Employee Retirement Income Security Act of 1974.

''(B) ILLUSTRATIVE EXAMPLES.—Illustrative examples meet the requirements of this subparagraph if such examples illustrate the adverse effects of the plan amendment. Such examples shall be prepared by the plan administrator in accordance with regulations prescribed by the Secretary, and such regulations shall require that the examples—

''(i) reflect fairly the different categories of applicable individuals who are similarly affected by the plan amendment after consideration of all relevant factors,

''(ii) show a comparison of benefits for each such category of applicable individuals under the plan (as in effect before and after the effective date) at appropriate future dates, and

''(iii) illustrate any temporary period described in subparagraph (A)(ii).

Such comparison shall be based on benefits in the form of a life annuity and on actuarial assumptions each of which is reasonable (and is so certified by an enrolled actuary) when applied to all participants in the plan.

''(4) SUPPORTING INFORMATION RELATING TO CALCULATION OF BENEFITS.—

''(A) IN GENERAL.—Each individual who receives or who is entitled to receive the information described in paragraph (3) may (after so receiving or becoming so entitled) request the plan administrator to provide the information described in subparagraph (B).

''(B) INFORMATION.—The plan administrator shall, within 15 days after the date on which a request under subparagraph (A) is made, provide to the individual information (including benefit formulas and actuarial factors) which is sufficient—

''(i) to confirm the benefit comparisons in the illustrative examples described in paragraph (3)(B), and

''(ii) to enable the individual to use the individual's own personal information to make calculations of the individual's own benefits which are similar to the calculations made in such examples.

Nothing in this subsection shall be construed to require the plan administrator to provide to an individual such individual's personal information for purposes of clause (ii).

''(C) TIME LIMITATION ON REQUESTS.—This paragraph shall apply only to requests made during the 12-month period that begins on the later of the effective date of the amendment to which it relates or the date the notice described in paragraph (2) is provided.

''(5) SPECIAL RULES.—

''(A) PLAIN LANGUAGE.—The notice required under paragraph (1) shall be written in a manner calculated to be understood by the average plan participant who is an applicable individual.

''(B) NOTICE TO DESIGNEES.—The notice or information required to be provided under this subsection may be provided to a person designated, in writing, by the person to which it would otherwise be provided.

''(6) ALTERNATIVE METHODS OF COMPLIANCE WITH ENHANCED DISCLOSURE REQUIREMENTS IN CERTAIN CASES.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection. The Secretary may—

''(A) prescribe alternative or simplified methods of complying with paragraphs (3) and (4) in situations where—

''(i) there is no fundamental change in the manner in which the accrued benefit of an applicable individual is determined under the plan, and

''(ii) such other methods are adequate to reasonably inform plan participants who are applicable individuals of the impact of the reductions,

''(B) reduce the advance notice period in paragraph (1)(A) from 45 days to 15 days before the effective date of the amendment for cases in which compliance with the 45-day advance notice requirement would be unduly burdensome because the amendment is contingent on a merger, acquisition, disposition, or other similar transaction involving plan participants who are applicable individuals or because 45 days advance notice is otherwise impracticable,

''(C) permit the comparison of benefits under paragraph (3)(B)(i) to be based on a form of payment other than a life annuity, or

''(D) specify actuarial assumptions that are deemed to be reasonable for purposes of the benefit comparisons under paragraph (3)(B)(i).

''(7) APPLICABLE INDIVIDUAL.—For purposes of this subsection, the term 'applicable individual' means, with respect to any plan amendment—

''(A) each participant in the plan, and

''(B) each beneficiary who is an alternate payee (within the meaning of section 414(p)(8)) under a qualified domestic relations order (within the meaning of section 414(p)(1)),

whose future benefit accruals under the plan may reasonably be expected to be reduced by such plan amendment.

''(8) TERMS RELATING TO PLANS.—For purposes of this subsection—

''(A) APPLICABLE PENSION PLAN.—The term 'applicable pension plan' means—

''(i) a defined benefit plan, or

''(ii) an individual account plan which is subject to the funding standards of section 412.

Such term shall not include any governmental plan (within the meaning of section 414(d)) or any church plan (within the meaning of section 414(e)) with respect to which the election provided by section 410(d) has not been made.

''(B) LARGE APPLICABLE PENSION PLAN.—The term 'large applicable pension plan' means an applicable pension plan which had 100 or more active participants as of the last day of the plan year preceding the plan year in which the plan amendment becomes effective.''

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980F. Failure of defined benefit plans reducing benefit accruals to satisfy notice requirements.''

SEC. 4. EFFECTIVE DATES.

(a) IN GENERAL.—The amendments made by this Act shall apply to plan amendments taking effect after the date of the enactment of this Act.

(b) SPECIAL RULES.—

(1) IN GENERAL.—The amendments made by this Act shall not apply to any plan amendment for which there was written notice before July 12, 1999, which was reasonably expected to notify substantially all of the plan participants or their representatives.

(2) TRANSITION.—Until such time as the Secretary of the Treasury issues regulations under sections 4980F(e)(3) and (4) of the Internal Revenue Code of 1986 and section 204(h)(3) and (4) of the Employee Retirement Income Security Act of 1974 (as added by the amendments made by this section), a plan shall be treated as meeting the requirements of such sections if it makes a good faith effort to comply with such requirements.

(3) NOTICE AND INFORMATION NOT REQUIRED TO BE FURNISHED BEFORE 120TH DAY AFTER ENACTMENT.—The period for providing any notice or information required by the amendments made by this section shall not end before the date which is 120 days after the date of the enactment of this Act.

THE PENSION REDUCTION DISCLOSURE ACT OF 1999

Present Law.—Under present law, when an employer amends a defined benefit pension plan in a manner which significantly reduces the rate of future benefit accrual, the employer must provide participants with an advance written notice of the amendment. The law does not, however, require employers to disclose the effect the amendment will have on participants.

SUMMARY OF PROVISIONS OF THE PENSION REDUCTION DISCLOSURE ACT

Notice Requirements for Pension Plan Amendments Reducing Future Benefit Accruals.—At least 45 days before the effective date of a pension plan amendment that reduces the rate of future benefit accruals, employees adversely affected by the amendment must receive notice of a reduction, as described below.

Basic Notice.—Pension plans with fewer than 100 participants must provide a basic written notice including: the effective date of the amendment; a statement that the amendment is expected to significantly reduce the rate of future benefit accrual; a description of the classes of applicable individuals to whom the amendment applies; and a description of how the amendment significantly reduces the rate of future benefit accrual.

Enhanced Notice.—Pension plans with 100 or more participants must provide the following information in addition to the basic written notice.

A description of the plan's benefit formulas before and after the amendments, and an explanation of the effects of the different formulas on participants;

An explanation of the circumstances under which any ''wearaway'' or other temporary suspension of benefit accruals may occur;

Illustrative examples showing the adverse effects of the plan amendment by comparing expected benefit accruals for various categories of participants (e.g., participants of similar age and years of service) under the old and new versions of the plan.

Alternative methods of compliance with enhanced notice in certain cases. The Secretary of the Treasury may prescribe alternative or simplified methods of compliance with the enhanced notice requirements in situations where there is no fundamental change in the manner in which benefits are determined (e.g., where the benefit formula is reduced from 1.25 percent of compensation to 1.0 percent of compensation). The Secretary may also reduce the advance notice period from 45 days to 15 days for cases in which compliance with the 45-day requirement would be unduly burdensome because the amendment is contingent on a merger, acquisition, disposition, or other similar transaction or because 45 days advance notice is otherwise impracticable.

In the case of plans with 100 or more participants, the plan must provide adversely-affected participants, within 15 days of request, the specific benefit formulas and actuarial factors used in the preparation of the illustrative examples. The information must be sufficient to confirm the benefit comparisons provided in the illustrative examples and to enable participants to make calculations of their own benefits under the old and new versions of the plan that are similar to the calculations made in the examples.

Individual Benefit Statements.—In the case of plans with 100 or more participants, an adversely-affected participant may request and receive an individual benefit statement providing information which is substantially the same as the information in the illustrative examples described above, but which is based on data specific to the requesting individual. If the individual so requests, the individual statement must reflect one other future date not included in the examples. As with current law regarding accrued benefit calculations, individual statements must be provided within 30 days of request. The earliest required date for providing individual statements shall be 90 days after the amendment effective date.

SANCTIONS FOR NONCOMPLIANCE

Egregious Failure to Supply Notice.—Employers failing to provide most of the required notice information to most affected participants, or intentionally failing to provide notice information to any affected participant, shall provide the greater of the benefits available under the old and new versions of the plan and shall also be subject to an excise tax of $100 per day for every day of the noncompliance period.

Nonegregious Failure to Supply Notice.—Employers failing to provide the required notice information, but not in the egregious manner described above, shall be subject to an excise tax of $100 per day for every day of the noncompliance period.

Maximum Excise Tax Where Failure Due to Reasonable Cause.—In a case where the failure was due to reasonable cause and not willful neglect, the excise tax is limited to $1 million for plans with 100 or more participants and $500,000 for plans with fewer than 100 participants.

● Mr. JEFFORDS. Mr. President, I am pleased to join Senators MOYNIHAN, LEAHY, ROBB, KERREY, ROCKEFELLER and GRAMS of Minnesota in the introduction of the Pension Reduction Disclosure Act. This bill greatly expands current law and will provide improved disclosure of the impact of the conversion of a traditional defined benefit pension plan to a cash balance or other hybrid pension plan. We believe that current law protections are insufficient to protect the interests of plan participants. The Pension Reduction Disclosure Act is an important first step in improving worker pension protections. I am also pleased that the President supports this bill.

Appropriate disclosure for cash balance pension plans is a serious public policy issue affecting the retirement benefits of millions of Americans. At a minimum, employees should have meaningful notice when their employer plans to reduce pension benefits in the switch from a traditional to a cash balance plan.

This bill does that.

First, employers have not always been candid with employees about what the changes in pension plans will mean for the employee's retirement. Our bill will require that they spell it out in black and white, and do so in language that anyone who is not an actuary or tax attorney can understand.

Second, plan sponsors will have to provide this information in a timely manner, so that employees can engage their employer and seek changes if they choose to do so. As we have seen at IBM and elsewhere, companies can misjudge the impact of these changes on their workforce.

Third, plan sponsors will be required to provide their employees with specifics about the effect that the change will have on their retirement benefits so that individuals can understand the financial impact that the conversion will have on their pension. Once we pass this bill, my guess is that employers will think long and hard about what changes they want to make to their pension plans.

Long-serving, loyal employees should not wake up to find their pension benefits slashed without even the chance to confront their employer. We can't expect people to save for retirement if the sand is forever shifting under their feet.

This bill addresses but one part of the conversion issue. But I think it deserves widespread bipartisan support. I believe that there are more issues at stake for workers, such as my own concerns regarding the pension benefit

''wear away''. However, the Pension Reduction Disclosure Act is a good first step we ought to take to address the legitimate concerns that have been raised about these plans.

We don't have a lot of time, but I hope we can send this bill to the President for his signature before we adjourn this fall.●

Mr. LEAHY. Mr. President, I am pleased to join Senator MOYNIHAN and Senator JEFFORDS as a cosponsor of the Pension Reduction Disclosure Act of 1999. I believe this bill is a good first step to providing American workers with the information they deserve to know about changes to their pensions. President Clinton has endorsed our legislation and is ready to sign it into law.

As the controversy surrounding IBM's decision to convert its traditional pension plan to a cash balance plan taught many Vermonters, Congress needs to revise our laws to require greater disclosure of pension changes. When IBM first announced its pension switch, many Vermont IBMers told me that they did not have enough information to judge the new plan's impact on their pensions. They discovered that current Federal law does not even require an employer to explain to its employees how any future pension benefits will be reduced. This is not right.

Unfortunately, Vermont IBMers are not alone. At least 325 companies, with more than $330 billion in pension-defined benefit assets, have adopted cash-balance plans in recent years. This phenomenon is the biggest development in the pension world in years. But, as we all know now thanks to the tireless efforts of IBMers in Vermont and elsewhere, there is a dark side to this corporate trend: the fact that many experienced workers face deep cuts in their promised pensions when their company switches to a cash-balance plan.

The Pension Reduction Disclosure Act would require all employers, regardless of the size of their pension plan, to notify their employees of pension plan changes that would reduce the future benefit accrual rate at least 45 days in advance of the change. In addition, this legislation would require employers to explain any differences in future accrual rates between the old and new plan in a clear and meaningful fashion, by providing employees with detailed examples showing the difference between the old and new plans.

This bill complements the Pension Right to Know Act, which Senator MOYNIHAN and I introduced earlier in the year. Our earlier bill would require employers to provide employees with individualized comparisons of future benefits under the old and new plans 15 days prior to the conversion for pension plans covering 1000 or more employees. Our legislation today also complements the Older Workers Pension Protection Act, S. 1600, which Senator HARKIN, Senator JEFFORDS and I introduced last month to prevent the wear away of an employee's promised pension benefits after a cash balance plan conversion.

Now is the time for Congress to act to ensure that all employers fully disclose the negative effects of their pension plan changes. Employees have a right to know how their futures will be affected by a company's decision to change its pension plan.

By Mr. KYL (for himself, Mr. MCCAIN, Mrs. HUTCHISON, Mr. DOMENICI, Mr. BINGAMAN, and Mrs. FEINSTEIN):

S. 1709. A bill to provide Federal reimbursement for indirect costs relating to the incarceration of illegal aliens and for emergency health services furnished to undocumented aliens; to the Committee on the Judiciary.

THE STATE CRIMINAL ALIEN ASSISTANCE PROGRAM II AND LOCAL MEDICAL EMERGENCY REIMBURSEMENT ACT

Mr. KYL. Mr. President, I rise today to introduce the State Criminal Alien Assistance Program II and Local Medical Emergency Reimbursement Act. Senators MCCAIN, HUTCHISON, DOMENICI, BINGAMAN, and FEINSTEIN join me.

Border counties and other jurisdictions throughout the Southwest are incurring overwhelming costs to process and incarcerate illegal immigrants who commit crimes. Hospitals are also bearing steep costs to treat illegal immigrants for medical emergencies.

Regarding the first issue, it should be pointed out that, when states and localities do not have the resources to deal with criminal illegal immigrants, disasters can happen. Just last week, it was discovered that illegal immigrants who, in some cases, had committed serious crimes in Maricopa County, Arizona—including first degree murder in one of the cases—were permitted to post bond to the county, were then released to the Immigration and Naturalization Service, and were then allowed to return to their home country. Needless to say, those cases did not go to trial. Because the alleged criminal aliens never returned for their court date, justice was not served.

I continue to work toward better cooperation between the INS and local criminal justice systems, to make sure that illegal immigrants who are charged with crimes prosecuted under state law—and murder is prosecuted under state law—are held in Arizona. That means before, during, and after trial. It means, if the person is convicted, serving out his time in Arizona.

I will continue to work toward full funding for the federal program Congress created in 1995 to reimburse states and localities for the costs of incarcerating criminal illegal immigrants, the State Criminal Alien Assistance Program (SCAAP). Incarceration of criminal illegal immigrants costs state and local governments over $1 billion a year. Last year's Commerce-Justice-State Appropriations bill provided $585 million for the program, and reimbursed states approximately 39 cents on the dollar for such costs. I will work to increase federal funding for SCAAP, and will work to ensure that the FY 2000 C–J–S funding bill maintains, at the very least, the FY 1999 funding level of $585 million.

It is my hope that the bill I am introducing today will further enhance the ability of states and localities to prevent the release of criminal illegal immigrants by giving them the resources they need, not only to incarcerate but to process and sentence such individuals. My bill creates SCAAP II and provides an additional authorization of $200 million per year between 2001 and 2004 to states and localities for such expenditures. When illegal immigrants commit crimes and are then caught, they drain the budgets of a locality's sheriff, justice court, county attorney, clerk of the court, superior and juvenile court, and juvenile detention departments, as well as using up a county's indigent defense budget. And, even though illegal immigration is a federal responsibility, states and local jurisdictions all along the southwestern border have incurred 100 percent of specifically processing-related costs to date. This bill will change that.

Unfortunately, we do not yet know the full financial burden the states and localities are bearing. I am hopeful that the FY 2000 Commerce-Justice-State Appropriations bill conference report will include funding for a study that will lay out realistic estimates of these costs.

What is known is that such expenditures comprise approximately 39 percent of the aforementioned budgets of just one Arizona county, Santa Cruz, with a population of just 36,000 residents. As a recent report conducted by the University of Arizona detailed, ''such illegal entry pressures place inequitable demands on the resources and taxpayers of Santa Cruz County.''

Other counties throughout the Southwest are in the same boat. Maricopa County, Arizona, for example, incurs costs of $9 million to incarcerate illegal criminal immigrants. It is unclear what its costs are to process and sentence such aliens. Cochise County incurs costs of approximately $406,000 per year to incarcerate criminal illegal immigrants and, therefore, must also incur significant costs to process and sentence these individuals. Providing resources to states and localities with such burdens will help prevent the release of criminals onto our nation's streets, and is clearly the financial responsibility of the federal government.

The second issue addressed by this bill is the burden borne by hospitals in southwestern states. The federal government is obligated to fully reimburse states, localities, and hospitals for the emergency medical treatment of illegal immigrants.

According to a preliminary Congressional Budget Office estimate provided two years ago, the total annual cost to treat illegal immigrants for medical emergencies is roughly $2.8 billion a

year. It is roughly estimated that the federal government reimburses states for approximately half of those costs. That means states must pay the remaining $1.4 billion. The state of Arizona estimates that it incurs unreimbursed costs of $20 million annually to treat undocumented immigrants on an emergency basis.

This legislation will provide states, localities, and hospitals an additional $200 million per year to help absorb the costs of adherence to federal law, under which all individuals, regardless of immigration status or ability to pay, must be provided with medical treatment in a medical emergency. I have heard from individual doctors in Arizona, and hospitals as well, conveying their frustration in the face of these daunting costs.

Mr. President, I hope we can address these very pressing issues in the coming months, and that Members will consider joining my cosponsors and me in support of this bill.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1709

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''State Criminal Alien Assistance Program II and Local Medical Emergency Reimbursement Act''.

TITLE I—STATE CRIMINAL ALIEN ASSISTANCE PROGRAM II

SEC. 101. SHORT TITLE.

This Act may be cited as the ''State Criminal Alien Assistance Program II Act of 1999''.

SEC. 102. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) Federal policies and strategies aimed at curbing illegal immigration and criminal alien activity implemented along our Nation's southwest border influence the number of crossings, especially their location.

(2) States and local governments were reimbursed approximately 60 percent of the costs of the incarceration of criminal aliens in fiscal year 1996 when only 90 jurisdictions applied for such reimbursement. In subsequent years, the number of local jurisdictions receiving reimbursement has increased. For fiscal year 1999, 280 local jurisdictions applied, and reimbursement amounted to only 40 percent of the costs incurred by those jurisdictions.

(3) Certain counties, often with a small taxpayer base, located on or near the border across from sometimes highly populated areas of Mexico, suffer a substantially disproportionate share of the impact of criminal illegal aliens on its law enforcement and criminal justice systems.

(4) A University of Arizona study released in January 1998 reported that at least 2 of the 4 counties located on Arizona's border of Mexico, Santa Cruz, and Cochise Counties, are burdened with this problem—

(A) for example, in 1998, Santa Cruz County had 12.7 percent of Arizona's border population but 50 percent of alien crossings and 32.5 percent of illegal alien apprehensions;

(B) for fiscal year 1998, it is estimated that, of its total criminal justice budget of 5,000,000 ($5,033,000), Santa Cruz County spent $1,900,000 (39 percent) to process criminal illegal aliens, of which over half was not reimbursed by Federal monies; and

(C) Santa Cruz County has not obtained relief from this burden, despite repeated appeals to Federal and State officials.

(5) In the State of Texas, the border counties of Cameron, Dimmit, El Paso, Hidalgo, Kinney, Val Verde, and Webb bore the unreimbursed costs of apprehension, prosecution, indigent defense, and other related services for criminal aliens who served more than 142,000 days in county jails.

(6) Throughout Texas nonborder counties bore similar unreimbursed costs for apprehension, prosecution, indigent defense, and other related services for criminal aliens who served more than 1,000,000 days in county jails.

(7) The State of Texas has incurred substantial additional unreimbursed costs for State law enforcement efforts made necessary by the presence of criminal illegal aliens.

(8) The Federal Government should reimburse States and units of local government for the related costs incurred by the State for the imprisonment of any illegal alien.

(b) PURPOSE.—The purpose of this title is—

(1) to assist States and local communities by providing financial assistance for expenditures for illegal juvenile aliens, and for related costs to States and units of local government that suffer a substantially disproportionate share of the impact of criminal illegal aliens on their law enforcement and criminal justice systems; and

(2) to ensure equitable treatment for those States and local governments that are affected by Federal policies and strategies aimed at curbing illegal immigration and criminal alien activity implemented on the southwest border.

SEC. 103. REIMBURSEMENT OF STATES FOR INDIRECT COSTS RELATING TO THE INCARCERATION OF ILLEGAL ALIENS.

Section 501 of the Immigration Reform and Control Act of 1986 (8 U.S.C. 1365) is amended—

(1) in subsection (a), by striking ''for'' and all that follows through ''State'' and inserting ''for—

''(1) the costs incurred by the State for the imprisonment of any illegal alien or Cuban national who is convicted of a felony by such State; and

''(2) the indirect costs related to the imprisonment described in paragraph (1).'';

(2) by striking subsection (c) and inserting the following:

''(c) INDIRECT COSTS DEFINED.—In subsection (a), the term 'indirect costs' includes—

''(1) court costs, county attorney costs, and criminal proceedings expenditures that do not involve going to trial;

''(2) indigent defense; and

''(3) unsupervised probation costs.''; and

(3) by amending subsection (d) to read as follows:

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $200,000,000 to carry out subsection (a)(2) for each of the fiscal years 2001 through 2004.''.

SEC. 104. REIMBURSEMENT OF STATES FOR COSTS OF INCARCERATING JUVENILE ALIENS.

(a) IN GENERAL.—Section 501 of the Immigration Reform and Control Act of 1986 (8 U.S.C. 1365), as amended by section 103 of this Act, is further amended—

(1) in subsection (a)(1), by inserting ''or illegal juvenile alien who has been adjudicated delinquent or committed to a juvenile correctional facility by such State or locality'' before the semicolon;

(2) in subsection (b), by inserting ''(including any juvenile alien who has been adjudicated delinquent or has been committed to a correctional facility)'' before ''who is in the United States unlawfully''; and

(3) by adding at the end the following:

''(f) JUVENILE ALIEN DEFINED.—In this section, the term 'juvenile alien' means an alien (as defined in section 101(a)(3) of the Immigration and Nationality Act) who has been adjudicated delinquent or committed to a correctional facility by a State or locality as a juvenile offender.''.

(b) ANNUAL REPORT.—Section 332 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1366) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

(3) by adding at the end the following:

''(5) the number of illegal juvenile aliens (as defined in section 501(f) of the Immigration Reform and Control Act) that are committed to State or local juvenile correctional facilities, including the type of offense committed by each juvenile.''.

(c) CONFORMING AMENDMENT.—Section 241(i)(3)(B) of the Immigration and Nationality Act (8 U.S.C. 1231(i)(3)(B)) is amended—

(1) by striking ''or'' at the end of clause (ii);

(2) by striking the period at the end of clause (iii) and inserting ''; or''; and

(3) by adding at the end the following:

''(iv) is a juvenile alien with respect to whom section 501 of the Immigration Reform and Control Act of 1986 applies.''.

SEC. 105. REIMBURSEMENT OF STATES BORDERING MEXICO OR CANADA.

Section 501 of the Immigration Reform and Control Act of 1986 (8 U.S.C. 1365), as amended by sections 103 and 104 of this Act, is further amended by adding at the end the following new subsection:

''(g) MANNER OF ALLOTMENT OF REIMBURSEMENTS.—Reimbursements under this section shall be allotted in a manner that takes into account special consideration for any State that—

''(1) shares a border with Mexico or Canada; or

''(2) includes within the State an area in which a large number of undocumented aliens reside relative to the general population of the area.''.

TITLE II—REIMBURSEMENT OF STATES AND LOCALITIES FOR EMERGENCY HEALTH SERVICES TO UNDOCUMENTED ALIENS.

SEC. 201. AUTHORIZATION OF ADDITIONAL FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—To the extent of available appropriations under subsection (e), there are available for allotments under this section for each of fiscal years 2002 through 2005, $200,000,000 for payments to certain States under this section.

(b) STATE ALLOTMENT AMOUNT.—

(1) IN GENERAL.—The Secretary shall compute an allotment for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2004 for each of the 17 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all such States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out

under subsection (c) shall be available for payment during the subsequent fiscal year.

(2) DETERMINATION.—For purposes of paragraph (1), the number of undocumented aliens in a State under this section shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved).

(c) USE OF FUNDS.—

(1) IN GENERAL.—From the allotments made under subsection (b) for a fiscal year, the Secretary shall pay to each State amounts described in a State plan, submitted to the Secretary, under which the amounts so allotted will be paid to local governments, hospitals, and related providers of emergency health services to undocumented aliens in a manner that—

(A) takes into account—

(i) each eligible local government's, hospital's or related provider's payments under the State plan approved under title XIX of the Social Security Act for emergency medical services described in section 1903(v)(2)(A) of such Act (42 U.S.C. 1396b(v)(2)(A)) for such fiscal year; or

(ii) an appropriate alternative proxy for measuring the volume of emergency health services provided to undocumented aliens by eligible local governments, hospitals, and related providers for such fiscal year; and

(B) provides special consideration for local governments, hospitals, and related providers located in—

(i) a county that shares a border with Mexico or Canada; or

(ii) an area in which a large number of undocumented aliens reside relative to the general population of the area.

(2) SPECIAL RULES.—For purposes of this subsection:

(A) A provider shall be considered to be ''related'' to a hospital to the extent that the provider furnishes emergency health services to an individual for whom the hospital also furnishes emergency health services.

(B) Amounts paid under this subsection shall not duplicate payments made under title XIX of the Social Security Act for the provision of emergency medical services described in section 1903(v)(2)(A) of such Act (42 U.S.C. 1396b(v)(2)(A)).

(d) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term ''hospital'' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e).

(2) PROVIDER.—The term ''provider'' includes a physician, another health care professional, and an entity that furnishes emergency ambulance services.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) STATE.—The term ''State'' means the 50 States and the District of Columbia.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $200,000,000 for each of fiscal years 2001 through 2005.

Mr. MCCAIN. Mr. President, I rise today in support of legislation Senator KYL and I are introducing with a number of our border-state colleagues to provide appropriate Federal reimbursement to states and localities whose budgets are disproportionately affected by the costs associated with illegal immigration. The premise of our bill, and of current law governing this type of Federal reimbursement to the states, is that controlling illegal immigration is principally the responsibility of the Federal government, not the states.

Our legislation would expand the amount and scope of Federal funding to the states for incarceration and medical costs that arise from the detention or treatment of illegal immigrants. Such funding currently flows to all 50 states, the District of Columbia, and two U.S. territories. Although our bill gives special consideration to border States and States with unusually high concentrations of illegal aliens in residence, it would benefit communities across the Nation. It deserves the Senate's prompt consideration and approval.

Many of my colleagues are probably not aware that the Federal government, under the existing State Criminal Alien Assistance Program (SCAAP), reimbursed states and counties burdened by illegal immigration for less than 40 percent of eligible alien incarceration costs in Fiscal Year 1998. Border counties estimate that more than 25 percent of their criminal justice budgets are spent processing criminal aliens. In my State of Arizona, Santa Cruz County last year spent 39 percent of its total criminal justice budget to process criminal illegal aliens, of which over half was not reimbursed by the Federal government. In its last budget cycle, New Mexico's tiny Luna County spent $375,000 on immigrant detention costs but received only $32,000 from the Federal government to offset jail expenses. Overall, SCAAP reimbursed states and counties along the border for only 33.7 percent of the cost of incarcerating illegal aliens in FY 1997 and 39.9 percent in FY 1998.

The State of California spent nearly $600 million last year to keep criminal aliens behind bars, but was reimbursed for only $183 million of those expenses. In Texas, prosecution of drug and immigration crime, principally in the form of illegal entry into the United States, accounted for an astonishing 70 percent of criminal filings during fiscal 1998. That figure represents a one-year increase of 58 percent in the number of immigration cases brought before the courts, an increase that was not matched by Federal reimbursement for associated legal expenses and incarceration costs to the state and its counties.

Earlier this year, the House voted to fund SCAAP at $585 million for FY 2000. This level is insufficient, but would at least roughly maintain existing levels of Federal support to states and localities for alien incarceration costs. Astonishingly, the Senate, in its version of the fiscal year 2000 Commerce, Justice, State, and the Judiciary Appropriations bill, proposed to slash SCAAP funding by 83 percent, to only $100 million, for reasons that escape me. In the words of the U.S./Mexico Border Counties Coalition, ''Given this program's history of not meeting its obligations to state and local governments even at higher levels of funding, this latest action will in essence leave state and local taxpayers to foot the Federal government's bill for the incarceration of criminal undocumented immigrants.''

A June 21, 1999, letter from the Governors of Arizona, California, New York, New Jersey, and Illinois to members of the United States Senate makes the same point: ''Control of the nation's borders is under the exclusive jurisdiction of the Federal government, yet State and local governments bear the brunt of the costs when the Federal government fails to meet its responsibility to prevent illegal immigration. By cutting funding for SCAAP by 83 percent, the Senate is abandoning its responsibility and forcing the states to pay for a Federally mandated service.'' It is my hope that Congress will restore SCAAP funding to at least $500 million, as the President requested for fiscal 2000 to help meet the needs of local communities across the country.

The legislation Senator KYL and I are introducing today would actually expand the State Criminal Alien Assistance Program by authorizing funding for state and local needs that currently go unmet. Although states receive Federal reimbursement for part of the cost of incarcerating illegal adult aliens, the Federal government does not reimburse States or units of local government for expenditures for illegal juvenile aliens. Nor does it reimburse states and localities for costs associated with processing criminal illegal aliens, including court costs, county attorney costs, costs for criminal proceedings that do not involve going to trial, indigent defense costs, and unsupervised probation costs. Our legislation would authorize the Federal government to reimburse such costs to States and localities that suffer a substantially disproportionate share of the impact of criminal illegal aliens on their law enforcement and criminal justice systems. It would also authorize additional Federal reimbursement for emergency health services furnished by States and localities to undocumented aliens.

Reimbursement to States and localities for criminal alien incarceration is woefully underfunded according to the existing limited criteria for SCAAP, which do not take into account the full detention and processing costs for illegal aliens. Nor does the existing SCAAP provide necessary support to local communities for the cost of emergency care for illegal immigrants, a growing problem in the Southwest, and one exacerbated by the increasingly desperate measures taken by undocumented aliens to cross our border with Mexico. Our legislation thus authorizes the expansion of SCAAP to cover costs wrongly borne by local communities under current law—costs which are a Federal responsibility and should not be shirked by those in Washington who do not live with the problem of illegal immigration in their midst.

As my colleagues know, illegal immigrants who successfully transit our

Southwest border rapidly disperse throughout the United States. That SCAAP funds flow to all 50 states reflects the pressures such aliens place on public services around the country. I hope the Senate will act expeditiously on this important legislation to alleviate those pressures by compensating state and local units for the costs they incur as unwitting hosts to undocumented aliens, even as we continue to fund border enforcement measures to reduce the flow of illegal immigrants into this country.

Mr. BINGAMAN. Mr. President, I rise to join with my colleagues from Arizona, California, and Texas in introducing the ''State Criminal Alien Assistance Program II and Local Medical Emergency Reimbursement Act of 1999.''

The purpose of the bill is to expand to scope of the current SCAAP law to allow counties and states to be reimbursed not only for the costs of incarcerating illegal aliens, but also for the costs of prosecuting them, defending them and detaining them. Currently, SCAAP only pays for the costs of incarcerating illegal aliens convicted of a felony in the United States. This means that counties and states do not get reimbursed for the indirect and direct costs leading to such a conviction. Because many illegal aliens arrested for drug smuggling or alien smuggling by federal agents are prosecuted by the county prosecutors, this has put an enormous strain on the county's prosecution budgets and has burdened the already struggling indigent defense programs. With the expansion of SCAAP, the counties will finally get some relief.

Another positive change to the SCAAP law is the addition of juvenile incarceration as a reimbursable expense. Many drug traffickers are using teenagers to transport drugs across the border, knowing that we do not currently have a good system for dealing with criminal illegal juvenile aliens. Because these teens' parents are not living in the United States, the county jails are required to detain the teens pending adjudication. The other option is to let the teens go. Neither option is good from a law enforcement perspective, but the cost of detaining a juvenile places an enormous burden on the counties' juvenile detention facilities. I am pleased that this bill considered the counties' concerns and included the costs of detaining juveniles as a reimbursable expense.

In 1994 I supported the original SCAAP bill. Between 1996 and 1999, the federal government has reimbursed the State of New Mexico $4.5 million for costs incurred in incarcerating criminal illegal aliens under this program. New Mexico counties have been reimbursed more than $1.4 million for similar costs. However, this $6 million reimbursement represents but a small fraction of the actual costs expended by New Mexico jails and prisons. This bill seeks to increase the amount available for reimbursement by raising the amount authorized to $200 million between 2002 and 2005.

The second part of this bill addresses another problem facing the border states. Because many towns near the US–Mexico border are a mere stones throw away from much larger Mexican towns and cities, many Mexican nationals often cross the border illegally in search of emergency medical services due to the lack of adequate facilities in Mexico. This bill will reimburse the health care providers required to provide emergency medical services to illegal aliens.

The border counties in New Mexico have repeatedly expressed their concern about the lack of federal assistance for emergency medical services provided to undocumented immigrants. Yet, under current law, New Mexico border communities are not eligible to be reimbursed for providing such emergency medical services. This has placed a significant financial burden on the public and private hospitals who are just trying to do what they think is right—provide emergency treatment to those in need. This lack of federal assistance has been very detrimental to New Mexico because the number of undocumented immigrants seeking medical attention in New Mexico is very high compared with the population of the New Mexico border community.

Between January 1, 1999 and August 31, 1999, Mimbres Memorial Hospital in Deming, New Mexico reported that 22 percent of its patients that were unable to pay for their medical care were residents of Mexico. These individuals accounted for $379,311 in charges that had to be absorbed by this hospital. In a town of roughly 10,000 people, this is a sizeable amount for a local hospital to write-off as uncollectible.

With the passage of this bill, New Mexico will be eligible to participate in this federal reimbursement program. Because the authorized amount for this program will be increased to $200 million between 2002 and 2005, this change will not affect the reimbursements to other states. This increase in funding is sorely needed to adequately address the financial burdens that illegal immigration imposes on the border communities.

I commend my fellow members of the Senate Southwest Border Caucus for working together on a bill what will make these necessary changes to the SCAAP program and address the financial hardship that illegal immigration imposes on our border communities.

I thank Senator KYL for introducing this bill and I encourage the Senate to take up this bill and pass this worthwhile legislation.

● Mrs. FEINSTEIN. Mr. President I am pleased to join my colleague Senator KYL in introducing the ''State Criminal Alien Assistance Program II and Local Medical Emergency Reimbursement Act.''

The control of illegal immigration is a Federal responsibility. However, more and more, this burden is shifting to the states. The ''State Criminal Alien Assistance Program II and Local Medical Emergency Reimbursement Act'' (SCAAP II), properly shifts the fiscal burden of illegal immigration into the hands of the Federal Government. This bill builds upon the existing Federal obligations under the ''State Criminal Alien Assistance Program'' (SCAAP I) by providing $200 million for each of the fiscal years 2002 through 2005 to help border communities defray the indirect costs of illegal immigration, and an additional $200 million to help state and local governments cope with the cost of providing emergency medical care to illegal immigrants.

The issue of illegal immigration, is one of national consequence that requires a Federal response. Unfortunately, Federal reimbursements have consistently failed to cover the actual costs borne by States and local communities confronting the effects of illegal immigration. For those communities that continue to shoulder this burden, the control of illegal immigration has become an unfunded mandate.

Mr. President, while I consider illegal immigration an issue that pervades communities across the nation, I would like to share with my colleagues how this issue has affected my home State of California. As you might imagine, the border counties in California are among the hardest hit in terms of dollars spent on incarceration, court costs, and emergency medical care for those who have entered the U.S. illegally.

San Diego County, for example, spent an estimated $10.1 million in 1998 to cover the costs of illegal alien incarceration and spends an estimated $50 million annually to provide emergency medical care for illegal immigrants. Imperial County estimates that it spent more than $4 million last year in detention costs and another $1.36 million in emergency medical expenses.

I am greatly concerned about the disproportionate burden these costs impose on the criminal justice system, hospitals and residents of San Diego and Imperial Counties, especially given the counties' limited tax base and fiscal resources. Given what I have witnessed in my own state, it is not hard for me to understand the frustration and concern of communities in a growing number of other states. Similar burdens have fallen on border communities in states like Arizona, New Mexico, and Texas. Each year, the costs borne by states to respond to illegal immigration continue to soar, while Federal involvement remains minimal at best.

Unfortunately, we can only expect these costs for border states to swell over the next few years as border enforcement initiatives force illegal migration to shift further eastward from San Diego County to neighboring southern States and counties as well as to the more porous northern state borders. In launching Operation Gatekeeper, for example, the INS has

achieved considerable success in deterring illegal border crossings along the San Diego border.

At the same time, Gatekeeper has had the effect of shifting a large volume of migrant crossings to the more rugged East San Diego County mountain area and the desert region of Imperial County where there have been numerous instances of illegal immigrants in need of emergency care. One county hospital in El Centro, for example, reports that the Border Patrol has dropped off countless numbers of undocumented aliens found in the desert suffering from hypothermia or dehydration, or from broken limbs and fractured skulls as result of failed attempts at scaling the fence along the San Diego border.

The more ''fortunate'' border crossers are being detained at state and county jails. Although states receive Federal reimbursement for some of the direct costs of incarcerating adult illegal immigrants, the Federal Government does not reimburse states and localities for the indirect costs relating to the incarceration or the control of illegal aliens, including: court costs, county attorney costs, indigent defense, criminal juvenile detention, and unsupervised probation costs. Nor does it compensate state and local hospitals for the emergency medical care provided to illegal immigrants who are not in Federal custody.

Mr. President, I join my colleagues in introducing the SCAAP II bill in hopes that it will alleviate some of the fiscal strains illegal immigration has imposed on border states and communities. I look forward to working with my colleagues to move it through the Senate.●

ADDITIONAL COSPONSORS

S. 59

At the request of Mr. THOMPSON, the name of the Senator from New Hampshire (Mr. GREGG) was added as a cosponsor of S. 59, a bill to provide Government-wide accounting of regulatory costs and benefits, and for other purposes.

S. 80

At the request of Ms. SNOWE, the name of the Senator from Georgia (Mr. COVERDELL) was added as a cosponsor of S. 80, a bill to establish the position of Assistant United States Trade Representative for Small Business, and for other purposes.

S. 472

At the request of Mr. GRASSLEY, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 472, a bill to amend title XVIII of the Social Security Act to provide certain medicare beneficiaries with an exemption to the financial limitations imposed on physical, speech-language pathology, and occupational therapy services under part B of the medicare program, and for other purposes.

S. 484

At the request of Mr. CAMPBELL, the name of the Senator from Alaska (Mr. MURKOWSKI) was added as a cosponsor of S. 484, a bill to provide for the granting of refugee status in the United States to nationals of certain foreign countries in which American Vietnam War POW/MIAs or American Korean War POW/MIAs may be present, if those nationals assist in the return to the United States of those POW/MIAs alive.

S. 659

At the request of Mr. MOYNIHAN, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 659, a bill to amend the Internal Revenue Code of 1986 to require pension plans to provide adequate notice to individuals whose future benefit accruals are being significantly reduced, and for other purposes.

S. 792

At the request of Mr. MOYNIHAN, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 792, a bill to amend title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to provide States with the option to allow legal immigrant pregnant women, children, and blind or disabled medically needy individuals to be eligible for medical assistance under the medicaid program, and for other purposes.

S. 914

At the request of Mr. SMITH, the name of the Senator from Washington (Mr. GORTON) was added as a cosponsor of S. 914, a bill to amend the Federal Water Pollution Control Act to require that discharges from combined storm and sanitary sewers conform to the Combined Sewer Overflow Control Policy of the Environmental Protection Agency, and for other purposes.

S. 1017

At the request of Mr. MACK, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1017, A bill to amend the Internal Revenue Code of 1986 to increase the State ceiling on the low-income housing credit.

S. 1029

At the request of Mr. COCHRAN, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1029, a bill to amend title III of the Elementary and Secondary Education Act of 1965 to provide for digital education partnerships.

S. 1044

At the request of Mr. KENNEDY, the names of the Senator from Nevada (Mr. REID) and the Senator from Illinois (Mr. DURBIN) were added as cosponsors of S. 1044, a bill to require coverage for colorectal cancer screenings.

S. 1053

At the request of Mr. BOND, the name of the Senator from Alaska (Mr. MURKOWSKI) was added as a cosponsor of S. 1053, a bill to amend the Clean Air Act to incorporate certain provisions of the transportation conformity regulations, as in effect on March 1, 1999.

S. 1091

At the request of Mr. DEWINE, the name of the Senator from Kentucky (Mr. MCCONNELL) was added as a cosponsor of S. 1091, a bill to amend the Public Health Service Act to provide for the establishment of a pediatric research initiative.

S. 1144

At the request of Mr. VOINOVICH, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. 1144, a bill to provide increased flexibility in use of highway funding, and for other purposes.

S. 1187

At the request of Mr. DORGAN, the names of the Senator from Louisiana (Ms. LANDRIEU), the Senator from Louisiana (Mr. BREAUX), the Senator from South Dakota (Mr. DASCHLE), and the Senator from New Mexico (Mr. BINGAMAN) were added as cosponsors of S. 1187, a bill to require the Secretary of the Treasury to mint coins in commemoration of the bicentennial of the Lewis and Clark Expedition, and for other purposes.

S. 1263

At the request of Mr. JEFFORDS, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of S. 1263, a bill to amend the Balanced Budget Act of 1997 to limit the reductions in medicare payments under the prospective payment system for hospital outpatient department services.

S. 1277

At the request of Mr. GRASSLEY, the names of the Senator from New Jersey (Mr. LAUTENBERG) and the Senator from North Carolina (Mr. EDWARDS) were added as cosponsors of S. 1277, a bill to amend title XIX of the Social Security Act to establish a new prospective payment system for Federally-qualified health centers and rural health clinics.

S. 1384

At the request of Mr. ABRAHAM, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1384, a bill to amend the Public Health Service Act to provide for a national folic acid education program to prevent birth defects, and for other purposes.

S. 1419

At the request of Mr. MCCAIN, the names of the Senator from Vermont (Mr. JEFFORDS) and the Senator from Nebraska (Mr. HAGEL) were added as cosponsors of S. 1419, a bill to amend title 36, United States Code, to designate May as ''National Military Appreciation Month.''

S. 1485

At the request of Mr. NICKLES, the names of the Senator from Maryland (Mr. SARBANES) and the Senator from Illinois (Mr. DURBIN) were added as cosponsors of S. 1485, a bill to amend the Immigration and Nationality Act to confer United States citizenship automatically and retroactively on certain

foreign-born children adopted by citizens of the United States.

S. 1500

At the request of Mr. HATCH, the names of the Senator from North Carolina (Mr. EDWARDS), the Senator from Virginia (Mr. WARNER), and the Senator from Arkansas (Mr. HUTCHINSON) were added as cosponsors of S. 1500, a bill to amend title XVIII of the Social Security Act to provide for an additional payment for services provided to certain high-cost individuals under the prospective payment system for skilled nursing facility services, and for other purposes.

S. 1536

At the request of Mr. DEWINE, the name of the Senator from Idaho (Mr. CRAIG) was added as a cosponsor of S. 1536, a bill to amend the Older Americans Act of 1965 to extend authorizations of appropriations for programs under the Act, to modernize programs and services for older individuals, and for other purposes.

S. 1547

At the request of Mr. BURNS, the name of the Senator from Minnesota (Mr. GRAMS) was added as a cosponsor of S. 1547, a bill to amend the Communications Act of 1934 to require the Federal Communications Commission to preserve low-power television stations that provide community broadcasting, and for other purposes.

S. 1555

At the request of Mr. KENNEDY, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 1555, a bill to provide sufficient funds for the research necessary to enable an effective public health approach to the problems of youth suicide and violence, and to develop ways to intervene early and effectively with children and adolescents who suffer depression or other mental illness, so as to avoid the tragedy of suicide, violence, and longterm illness and disability.

S. 1618

At the request of Mr. GRAHAM, the names of the Senator from Virginia (Mr. ROBB) and the Senator from New York (Mr. MOYNIHAN) were added as cosponsors of S. 1618, a bill to promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive benefits, and for other purposes.

S. 1633

At the request of Mr. MCCAIN, the names of the Senator from Alaska (Mr. MURKOWSKI) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 1633, a bill to recognize National Medal of Honor sites in California, Indiana, and South Carolina.

S. 1638

At the request of Mr. GRAMS, his name was added as a cosponsor of S. 1638, a bill to amend the Omnibus Crime Control and Safe Streets Act of 1968 to extend the retroactive eligibility dates for financial assistance for higher education for spouses and dependent children of Federal, State, and local law enforcement officers who are killed in the line of duty.

S. 1678

At the request of Mr. DASCHLE, the names of the Senator from South Carolina (Mr. HOLLINGS) and the Senator from North Carolina (Mr. EDWARDS) were added as cosponsors of S. 1678, a bill to amend title XVIII of the Social Security Act to modify the provisions of the Balanced Budget Act of 1997.

S. 1701

At the request of Mr. SESSIONS, the name of the Senator from Florida (Mr. MACK) was added as a cosponsor of S. 1701, a bill to reform civil asset forfeiture, and for other purposes.

SENATE RESOLUTION 118

At the request of Mr. REID, the names of the Senator from Wyoming (Mr. ENZI) and the Senator from Montana (Mr. BURNS) were added as cosponsors of Senate Resolution 118, a resolution designating December 12, 1999, as ''National Children's Memorial Day.''

SENATE RESOLUTION 190

At the request of Mr. CAMPBELL, the names of the Senator from Nevada (Mr. REID) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of Senate Resolution 190, a resolution designating the week of October 10, 1999, through October 16, 1999, as National Cystic Fibrosis Awareness Week.

AMENDMENT NO. 1825

At the request of Mr. SESSIONS his name was added as a cosponsor of amendment No. 1825 proposed to S. 1650, an original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

AMENDMENT NO. 1842

At the request of Mr. DOMENICI his name was added as a cosponsor of amendment No. 1842 proposed to S. 1650, an original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

AMENDMENT NO. 1845

At the request of Mr. HARKIN the names of the Senator from Massachusetts (Mr. KENNEDY), the Senator from Nevada (Mr. REID), the Senator from Washington (Mrs. MURRAY), and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of amendment No. 1845 proposed to S. 1650, an original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

AMENDMENT NO. 1861

At the request of Ms. LANDRIEU her name was added as a cosponsor of amendment No. 1861 proposed to S. 1650, an original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

SENATE RESOLUTION 198—EXPRESSING SYMPATHY FOR THOSE KILLED AND INJURED IN THE RECENT EARTHQUAKES IN TURKEY AND GREECE AND COMMENDING TURKEY AND GREECE FOR THEIR RECENT EFFORTS IN OPENING A NATIONAL DIALOGUE AND TAKING STEPS TO FURTHER BILATERAL RELATIONS

Ms. SNOWE (for herself, Mr. HELMS, Mr. SARBANES, Mr. BIDEN, and Mr. BYRD) submitted the following resolution; which was considered and agreed to:

S. RES. 198

Whereas in the wake of the tragic earthquakes which struck Turkey on August 17, 1999, leaving up to 16,000 dead, 24,000 injured, and 100,000 homeless, and Greece on September 7, 1999, killing 143, injuring 1,600, and leaving 16,000 homeless, an improvement of relations between Turkey and Greece has occurred;

Whereas within hours of the earthquake hitting Turkey, Greece sent rescue teams, doctors, firemen, and emergency supplies to Turkey;

Whereas immediately after the earthquake struck Greece, Turkey, already dealing with its own devastation, sent rescue personnel to Greece;

Whereas in July, senior foreign ministry officials of Greece and Turkey held talks, the first talks at this level since 1994, to discuss bilateral cooperation in the fields of tourism, the environment, trade, and the economy as well as cooperation in combating organized crime, illegal immigration, drug-trafficking, and terrorism;

Whereas in September 1999, a second round of talks between senior foreign ministry officials of Greece and Turkey were held as a follow-up to the July meeting, and a third round has been planned for October 1999;

Whereas this spirit of cooperation has led to a warming of relations and confidence building measures, including—

(1) a naval vessel of Greece calling at a port of Turkey for the first time in more than a century;

(2) Greek and Turkish news commentators agreeing to publish their columns in each other's newspapers;

(3) Greece indicating that it is prepared to accept the candidacy of Turkey for membership in the European Union as long as Turkey meets all criteria for membership in the Union; and

(4) Turkey and Greece praising the other for earthquake assistance; and

Whereas the desire to further cultivate relations between Turkey and Greece has created an atmosphere of hope: Now, therefore, be it

Resolved, That the Senate—

(1) expresses sympathy for those killed and injured in the recent earthquakes in Greece and Turkey;

(2) commends, encourages, and supports recent efforts by Greece and Turkey to improve bilateral relations between those countries; and

(3) reiterates the importance of promoting positive bilateral relations between Greece and Turkey, which are of paramount interest to the United States.

SENATE RESOLUTION 199—DESIGNATING THE WEEK OF OCTOBER 24, 1999, THROUGH OCTOBER 30, 1999, AND THE WEEK OF OCTOBER 22, 2000, THROUGH OCTOBER 28, 2000, AS ''NATIONAL CHILDHOOD LEAD POSONING PREVENTION WEEK''

Mr. REED (for himself, Ms. COLLINS, Mr. TORRICELLI, Mr. REID, Mr. LEVIN, Mr. WELLSTONE, Mr. LIEBERMAN, Mr. KERRY, Mr. KENNEDY, Mr. SARBANES, Mr. DORGAN, Mr. SCHUMER, Mr. AKAKA, Mr. INOUYE, Mr. CHAFEE, Mrs. BOXER, Ms. MIKULSKI, Mr. DODD, Mr. WYDEN, Mr. CONRAD, Mr. GRAHAM, Mr. DURBIN, Mr. DEWINE, Ms. LANDRIEU, Mr. JOHNSON, Mr. JEFFORDS, Mr. SMITH of Oregon, Mr. ROBB, and Mr. FRIST) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 199

Whereas lead poisoning is a leading environmental health hazard to children in the United States;

Whereas according to the United States Center for Disease Control and Prevention, 890,000 preschool children in the United States have harmful levels of lead in their blood;

Whereas lead poisoning may cause serious, long-term harm to children, including reduced intelligence and attention span, behavior problems, learning disabilities, and impaired growth;

Whereas children from low-income families are 8 times more likely to be poisoned by lead than those from high income families;

Whereas children may become poisoned by lead in water, soil, or consumable products;

Whereas most children are poisoned in their homes through exposure to lead particles when lead-based paint deteriorates or is disturbed during home renovation and repainting; and

Whereas lead poisoning crosses all barriers of race, income, and geography: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week of October 24, 1999, through October 30, 1999, and the week of October 22, 2000, through October 28, 2000, as ''National Childhood Lead Poisoning Prevention Week''; and

(2) requests that the President issue a proclamation calling upon the people of the United States to observe such day with appropriate programs and activities.

Mr. REED. Mr. President, I rise today to submit a resolution which would designate October 24–30, as ''National Childhood Lead Poisoning Prevention Week.'' Despite steady progress over the past two decades to regulate inappropriate uses of lead, the tragedy of childhood lead poisoning remains very real for nearly one million preschoolers in the U.S.

Most children are poisoned in their own homes by deteriorating lead-based paint and lead-contaminated dust. While lead poisoning crosses all barriers of race, income, and geography, most of the burden of this disease falls disproportionately on low-income families or families of color who generally live in older, poorer quality housing. In the United States, children from low-income families are eight times more likely to be poisoned than those from high income families. African American children are five times more likely to be poisoned than white children. Nationwide, almost 22 percent of African American children living in older housing are lead poisoned, a staggering statistic, particularly given the overall decline in blood lead levels in the last decade.

Unfortunately, many communities have not experienced a major decline in blood lead levels. In fact, in some communities, more than half of the preschool children are lead poisoned. Baltimore, Providence, Philadelphia, Milwaukee, St. Louis, and Chicago all have lead poisoning rates that are three to nine times the national average.

Even low levels of exposure to lead impair a child's ability to learn and thrive, causing reductions in IQ and attention span, reading and other learning disabilities, hyperactivity, aggressive behavior, hearing loss, and coordination problems. These effects are persistent and interfere with their success in school and later in life. Research shows that children with elevated blood lead levels are seven times more likely to drop out of high school and six times more likely to have reading disabilities. State health officials believe that the need for certain education services is 40 percent higher among children with significant lead exposure.

Mr. President, lead poisoning is entirely preventable, making its prevalence among children all the more frustrating. In addition, lead poisoning has many dimensions, and therefore we have to tackle it from all directions. Specifically, our efforts should include screening and treating poisoned children, identifying and removing the source of their exposure, educating parents, landlords and entire communities about the dangers of lead, and ensuring that resources to address the problem are available and accessible to all who need them.

I have been working on a number of initiatives in the Senate to address this problem including urging Senate leaders to provide for more funding for lead abatement. Last year, I sponsored an amendment that resulted in an increase of $20 million in funding to eliminate lead hazards in the homes of young children. This year, the Senate has supported a similar figure.

Also, I have become deeply concerned, along with my colleague Senator TORRICELLI, about recent reports that children at risk for lead poisoning are not adequately screened or treated for the disease, even if they are enrolled in Medicaid. Although children enrolled in Medicaid are three times more likely than other children to have high amounts of lead in their blood, the General Accounting Office (GAO) recently reported that less than 20 percent of these young children have been screened for lead poisoning. Even more disconcerting is that half of the states do not have screening policies that are consistent with federal requirements. For this reason, we have introduced the Children's Lead SAFE Act (S. 1120) to ensure that all children at risk of lead poisoning receive their required screenings and appropriate follow-up care by holding states accountable.

Mr. President, I have been working on making important, yet commonsense, policy changes to ensure that children are screened and treated for lead poisoning and to provide critical funding for leadsafe housing. Beyond these efforts, I believe we need to take further steps to raise pubic awareness about the dangers of lead poisoning. Last month, Senator COLLINS and I hosted a Public Health Subcommittee hearing in Rhode Island to highlight the importance of the issue and to hear about the successful approaches undertaken by organizations in my home state to address the problem. We plan to hold a similar hearing in Maine next month. Because lead poisoning is a national problem, we believe it deserves national attention.

That is why Senator COLLINS and I, along with 26 original co-sponsors are introducing this bipartisan resolution that would commemorate the week of October 24–30, 1999 as ''National Childhood Lead Poisoning Prevention Week.'' Designation of a national week for lead poisoning prevention would raise public awareness about the issue and highlight the need to protect children from lead poisoning to ensure their healthy development.

The Senate resolution would serve to further our efforts to recognize lead poisoning as a national problem and declare lead poisoning prevention as a national priority. The proposed resolution would also acknowledge the suffering of the many children with lead poisoning and their parents whose active involvement individually and through grassroots organizations has been instrumental in efforts to reduce lead poisoning. The resolution is supported by the Alliance to End Childhood Lead Poisoning, the Children's Defense Fund, the Environmental Defense Fund, and more than one hundred state and local organizations. Mr. President, I ask unanimous consent that letters of support from the Children's Defense Fund and the Alliance to End Childhood Lead Poisoning, along with the list of the 100 supporting organizations be printed in the RECORD.

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

CHILDREN'S DEFENSE FUND,
Washington, DC, September 27, 1999.

Hon. JACK REED,
Hart Senate Office Building, Washington, DC.

DEAR SENATOR REED: I am writing in strong support of resolution to commemorate the week of October 24–30, 1999 as ''National Childhood Lead Poisoning Prevention Week.''

Lead poisoning in children can cause learning disabilities, behavioral problems, and at extremely high levels of poisoning, seizures,

coma, and death. According to the Centers for Disease Control (CDC), about 890,000 children in the United States have elevated blood lead levels, including one in five African-American children living in housing built before 1946. Infants and toddlers are most susceptible because they spend so much of their time with their hands in their mouths—hands that may have been on the floor, on the windowsill, on the wall, along the stairway, places where lead paint particles exist.

Over 80% of the homes and apartments built before 1978 in the United States have lead-based paint in them. Paint doesn't have to be peeling to cause a health problem; particles can circulate in dust and air circulation systems. Although elevated blood lead levels in children have declined in the last few decades, lead poisoning is preventable; any level of lead poisoning in children is too high.

Your resolution will highten awareness of this tragic and preventable health problem. I commend your attention to the issue and look forward to working with you to ensure that all children have the chance to grow up healthy and reach their fullest potential.

Sincerely yours,

MARIAN WRIGHT EDELMAN.

ALLIANCE TO END
CHILDHOOD LEAD POISONING,
Washington, DC, October 7, 1999.

Hon. JACK REED,
Hart Senate Office Building, Washington, DC.

DEAR SENATOR REED: I am writing in support of your resolution to designate the last week of October ''National Childhood Lead Poisoning Prevention Week.'' This measure is supported by over 100 local health departments, housing agencies, community-based organizations and lead poisoning prevention programs from across the country (see attached list).

Despite steady progress over the past two decades to regulate inappropriate uses of lead, the tragedy of childhood lead poisoning remains very real for nearly one million preschoolers in the United States. Children are most often poisoned in their own homes by lead-contaminated dust from lead-based paint that is deteriorating or disturbed by repainting or renovation projects.

While lead poisoning crosses all barriers of race, income, and geography, the burden of this disease falls disproportionately on low-income families or families of color, who generally live in older, poorer quality housing. In some communities, more than half of preschool children are lead-poisoned. Even low levels of exposure to lead can impair young children's ability to learn and thrive, causing reduced IQ and attention span, learning difficulties and behavior problems. These effects are persistent and interfere with success in school and later life.

Formal designation of a national week for lead poisoning prevention will instrumentally advance national, state, and local efforts to educate communities about the threat of lead to children. Thank you again for supporting designation of the last week of October ''National Childhood Lead Poisoning Prevention Week.''

Sincerely,

DON RYAN,
Executive Director.

MEMBERS

Alabama State CLPPP, Montgomery, AL.
Alliance To End Childhood Lead Poisoning, Washington, DC.
Anne Arundel Co. Department of Health, Annapolis, MD.
Arab Community Center for Economic and Social Services, Dearborn, MI.
Association of Parents to Prevent Lead Exposure, Cleveland, OH.
Baltimore City Health Department, Baltimore, MD.
Bethel New Life, Inc., Chicago, IL.
Brooklyn Lead Safe House, Brooklyn, NY.
California State CLPPP, Oakland, CA.
California State Dept. of Community Services and Development, Sacramento, CA.
Center for Human Development, Pleasant Hill, CA.
Charlotte Organizing Project, Charlotte, NC.
Chesterfield Health Department, Chesterfield, VA.
Chicago Lawyers' Committee for Civil Rights, Chicago, IL.
Childhood Lead Action Project, Providence, RI.
Citizen Action of New York, Buffalo, NY.
City of Buffalo Division of Neighborhoods, Buffalo, NY.
City of Charlotte Neighborhood Development, Charlotte, NC.
City of Columbus, Columbus, OH.
City of Fort Worth Public Health Department, Fort Worth, TX.
City of Providence Mayor's Office, Providence, RI.
City of Springfield Office of Housing, Springfield, MA.
CLEAR Corps, Baltimore, MD.
Cook County CLPPP, Chicago, IL.
Detroit Health Department; LPPCP, Detroit, MI.
Dorchester Bay Economic Development Corporation, Dorchester, MA.
Douglas County Health Department, Omaha, NE.
Dover Office of LPPP, Dover, DE.
Dubuque Housing Services, Dubuque, IA.
Durham Department of Housing, Durham, NC.
Duval County Health Department, Jacksonville, FL.
Economic and Employment Development Center, Los Angeles, CA.
Ecumenical Social Action Committee, Jamaica Plain, MA.
Environmental Defense Fund, Washington, DC.
Esperanza Community Housing Corporation, Los Angeles, CA.
Greater Minneapolis Day Care Association, Minneapolis, MN.
Hawaii State Department of Health, Honolulu, HI.
Healthy Children Organizing Project, San Francisco, CA.
Houston CLPPP, Houston, TX.
Houston Department of Health and Human Services, Houston, TX.
Hunter College Center for Occupational and Environmental Health, New York, NY.
Indiana State Department of Health, Indianapolis, IN.
Infant Welfare Society, Chicago, IL.
Ironbound Community Corporation, Newark, NJ.
Just a Start Corporation, St. Cambridge, MO.
Kansas City, MO, Health Department—CLPPP, Kansas City, MO.
Kentucky State CLPPP, Frankfort, KY.
LaSalle University Neighborhood Nursing Center, Philadelphia, PA.
Lead-Safe Cambridge, Cambridge, MA.
Lead-Safe Cuyahoga, Cleveland, OH.
Lead Action Collaborative, Boston, MA.
Lead Poisoning Prevention Education and Training Program, Stratford, NJ.
LeadBusters, Inc., Kansas City, KS.
Lisbon Avenue Neighborhood Development, Milwaukee, WI.
Los Angeles County CLPPP, Los Angeles, CA.
Malden Redevelopment Authority, Malden, MA.
Maryland Department of Housing, Crownsville, MD.
Massachusetts State Housing and Community Reinvestment, Boston, MA.
Michigan ACORN, Detroit, MI.
Michigan Department of Community Health, Lansing, MI.
Michigan League for Human Services, Lansing, MI.
Minneapolis Lead Hazard Control Program, Minneapolis, MN.
Missouri Coalition for the Environment, St. Louis, MO.
Missouri State CLPPP, Jefferson City, MO.
Montgomery County Lead Hazard Reduction Program, Dayton, OH.
Mothers of Lead Exposed Children, Richmond, MO.
National Center for Lead-Safe Housing, Columbia, MD.
National Health Law Program, Chapel Hill, NC.
Natural Resources Defense Council, New York, NY.
New Haven Health Department, New Haven, CT.
New Jersey Citizen Action, Highland Park, NJ.
New York City CLPPP, New York, NY.
Ohio Department of Health, Columbus, OH.
Palmerton Environmental Task Force, Palmerton, PA.
Petersburg Health Department, Petersburg, VA.
Phillips Neighborhood Healthy Housing Collaborative, Minneapolis, MN.
Phoenix Lead Hazard Control Program, Phoenix, AZ.
Project REAL—Richmond Redevelopment Agency, Richmond, CA.
Quincy-Weymouth Lead Paint Safety Initiative, Quincy, MA.
Rhode Island Department of Health—CLPPP, Providence, RI.
Rhode Island State Housing, Providence, RI.
Richmond Department of Public Health—Lead-Safe Richmond, Richmond, VA.
San Francisco Mayor's Office of Housing, San Francisco, CA.
Savannah NPCD, Savannah, GA.
Scott Co. Health Department—CLPP, Davenport, IA.
South Jersey Lead Consortium, Bridgeton, NJ.
Southeast Michigan Coalition on Occupational Safety and Health, Detroit, MI.
St. Louis County Government, Clayton, MO.
Syracuse Department of Community Development, Syracuse, NY.
Tenants' Action Group, Philadelphia, PA.
The Way Home, Manchester, NH.
United for Change CDC, Washington, DC.
United Parents Against Lead of Michigan, Paw Paw, MI.
University of Massachusetts Dartmouth Lead Program, New Bedford, MA.
University of Nevada at Las Vegas Harry Reid Center, Las Vegas, NV.
Urban League of Portland, Portland, OR.
Vermont Public Interest Research Group, Montpelier, VT.
West County Toxics Coalition, Richmond, CA.
West Dallas Coalition for Environmental Justice, Dallas, TX.
Wisconsin State CLPPP, Madison, WI.
Wyoming Department of Health—Lead Program, Cheyenne, WY.

● Ms. COLLINS. Mr. President, I am very pleased today to join my colleague, Senator JACK REED, in submitting a resolution designating October 24th–30th as National Childhood Lead Poisoning Prevention Week. This designation will help increase awareness of the significant dangers and prevalence of child lead poisoning across our nation.

Recently, Senator REED and I held a hearing in Rhode Island to address the impact exposure to lead paint can have on children's health and development, and to explore ways to improve our efforts to prevent and eventually eliminate lead poisoning in children.

Great strides have been made in the last 20 years to reduce the threat lead poses to human health. Most notably, lead has been banned from many products including residential paint, food cans and gasoline. These commendable steps have significantly reduced the incidence of lead poisoning. But the threat remains, and continues to imperil, the health and welfare of our nation's children.

In fact, lead poisoning is the most significant and prevalent environmental health threat to children in the U.S. today. Even low levels of lead exposure can have serious developmental consequences including reductions in IQ and attention span, reading and learning disabilities, hyperactivity and behavioral problems. The Centers for Disease Control and Prevention currently estimates that 890,000 children aged 1–5 have blood levels of lead that are high enough to affect their ability to learn.

Today, the major lead poisoning threat to children in found in interior paint that has deteriorated. Unfortunately, it is all too common for older homes to contain lead-based paint. In fact, more than half the entire housing stock—and three quarters of the stock built prior to 1978—contain some lead-based paint. Paint manufactured prior to the residential lead paint ban often remains safely contained and unexposed for decades, but over time, often through the remodeling process or through normal wear and tear, the paint can become exposed, contaminating the home with dangerous lead dust.

Because of the prevalence of older homes in the Northeast, lead poisoning exposure is a significant problem in our region. In Maine, 42 percent of our homes were built prior to 1950. Although screening rates nationally and in my state are considered to be too low, the sampling that has been done in my state shows that in some areas of the state 7–15 percent of children tested have high blood lead levels. In some areas of our country, the percentage is even higher.

Next month, I will hold a hearing in Maine to address the lead-based paint threat in our homes, and what parents can do to protect their children from the risks associated with lead exposure.

Once childhood development is impaired by exposure to lead, the effect is largely irreversible. However, if the presence of lead is detected prior to exposure, then remedial steps can be taken, such as lead containment or abatement, to prevent children from ever being harmed by lead's presence in the home.

We are not helpless to stop this insidious threat. By raising awareness of the prevalence of lead paint in homes, and the steps that can be taken to prevent poisoning, we can stop the life-impairing effects of childhood lead poisoning. I urge my colleagues to support me in raising awareness about childhood lead poisoning by co-sponsoring Childhood Lead Paint Poisoning Prevention Week.●

AMENDMENTS SUBMITTED

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT 2000

BOND (AND OTHERS) AMENDMENT NO. 2270

Mr. BOND (for himself, Mr. NICKLES and Mr. HUTCHINSON) proposed an amendment to amendment No. 1825 proposed by Mr. BOND to the bill (S. 1650) making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, and for other purposes; as follows:

On page 1 of the amendment, strike all after the first word and insert the following:

___. (a) FINDINGS.—Congress makes the following findings:

(1) The Department of Labor, through the Occupational Safety and Health Administration (referred to in this section as ''OSHA'') plans to propose regulations during 1999 to regulate ergonomics in the workplace. A draft of OSHA's ergonomics regulation became available on February 19, 1999.

(2) A July 1997 report by the National Institute for Occupational Safety and Health that reviewed epidemiological studies that have been conducted of ''work related musculoskeletal disorders of the neck, upper extremity, and low back'' showed that there is insufficient evidence to assess the level of risk to workers from repetitive motions. Such evidence would be necessary for OSHA and the administration to write an efficient and effective regulation.

(3) An August 1998 workshop on ''work related musculoskeletal injuries'' held by the National Academy of Sciences reviewed existing research on musculoskeletal disorders. The workshop showed that there is insufficient evidence to assess the level of risk to workers from repetitive motions.

(4) In October 1998, Congress and the President agreed that the National Academy of Sciences should conduct a comprehensive study of the medical and scientific evidence regarding musculoskeletal disorders. The study is intended to evaluate the basic questions about diagnosis and causes of such disorders.

(5) To complete that study, Public Law 105-277 appropriated $890,000 for the National Academy of Sciences to complete a peer-reviewed scientific study of the available evidence examining a cause and effect relationship between repetitive tasks in the workplace and musculoskeletal disorders or repetitive stress injuries.

(6) The National Academy of Sciences currently estimates that this study will be completed late in 2000 or early in 2001.

(7) Given the uncertainty and dispute about these basic questions, and Congress' intention that they be addressed in a comprehensive study by the National Academy of Sciences, it is premature for OSHA to propose a regulation on ergonomics as being necessary or appropriate to improve workers' health and safety until such study is completed.

(b) PROHIBITION.—None of the funds made available in this Act may be used by the Secretary of Labor or the Occupational Safety and Health Administration to promulgate or issue, or to continue the rulemaking process of promulgating or issuing, any standard, regulation, or guideline regarding ergonomics prior to September 30, 2000.

WELLSTONE AMENDMENT NO. 2271

Mr. WELLSTONE proposed an amendment to amendment No. 1880 proposed by Mr. WELLSTONE to the bill, S. 2271, supra; as follows:

Beginning on page 1 of the amendment, strike ''$70,000,000'' and all that follows and insert the following: ''$358,816,000 shall be made available to carry out the mental health services block grant under subpart I of part B of title XIX of the Public Health Service Act ($48,816,000 of which shall become available on October 1, 2000 and remain available through September 30, 2001), and''.

BINGAMAN (AND OTHERS AMENDMENT NO. 2272

Mr. BINGAMAN (for himself, Mr. DOMENICI, and Mr. FEINGOLD) proposed an amendment to the bill, S. 1650, supra; as follows:

At the end of title II, add the following:

SEC. 216. STUDY AND REPORT ON THE GEOGRAPHIC ADJUSTMENT FACTORS UNDER THE MEDICARE PROGRAM.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on—

(1) the reasons why, and the appropriateness of the fact that, the geographic adjustment factor (determined under paragraph (2) of section 1848(e) (42 U.S.C. 1395w–4(e)) used in determining the amount of payment for physicians' services under the medicare program is less for physicians' services provided in New Mexico than for physicians' services provided in Arizona, Colorado, and Texas; and

(2) the effect that the level of the geographic cost-of-practice adjustment factor (determined under paragraph (3) of such section) has on the recruitment and retention of physicians in small rural states, including New Mexico, Iowa, Louisiana, and Arkansas.

(b) REPORT.—Not later than 3 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

BINGAMAN AMENDMENT NO. 2273

Mr. HARKIN (for Mr. BINGAMAN) proposed an amendment to the bill, S. 1650 supra; as follows:

At the appropriate place in the bill add the following:

SEC. . CONFOUNDING BIOLOGICAL AND PHYSIOLOGICAL INFLUENCES ON POLYGRAPHY.

(a) FINDINGS.—The Senate finds that—

(1) The use of polygraph tests as a screening tool for federal employees and contractor personnel is increasing.

(2) A 1983 study by the Office of Technology Assessment found little scientific evidence to support the validity of polygraph tests in such screening applications.

(3) The 1983 study further found that little or no scientific study had been undertaken on the effects of prescription and non-prescription drugs on the validity of polygraph tests, as well as differential responses to polygraph tests according to biological and physiological factors that may vary according to age, gender, or ethnic backgrounds, or other factors relating to natural variability in human populations.

(4) A scientific evaluation of these important influences on the potential validity of polygraph tests should be studied by a neutral agency with biomedical and physiological expertise in order to evaluate the further expansion of the use of polygraph tests on federal employees and contractor personnel.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that the Director of the National Institutes of Health should enter into appropriate arrangements with the National Academy of Sciences to conduct a comprehensive study and investigation into the scientific validity of polygraphy as a screening tool for federal and federal contractor personnel, with particular reference to the validity of polygraph tests being proposed for use in proposed rules published at 64 Fed. Reg. 45062 (August 18, 1999).

BINGAMAN (AND FEINGOLD) AMENDMENT NO. 2274

Mr. HARKIN (for Mr. BINGAMAN (for himself and Mr. FEINGOLD)) proposed an amendment to the bill, S. 1650, supra; as follows:

At the end of title II, add the following:

DENTAL SEALANT DEMONSTRATION PROGRAM

SEC. . From amounts appropriated under this title for the Health Resources and Services Administration, sufficient funds are available to the Maternal Child Health Bureau for the establishment of a multi-State preventive dentistry demonstration program to improve the oral health of low-income children and increase the access of children to dental sealants through community- and school-based activities.

BOND (AND OTHERS) AMENDMENT NO. 2275

Mr. SPECTER (for Mr. BOND (for himself, Mr. HARKIN, Mr. ASHCROFT, Mr. GRASSLEY, Mr. CHAFEE, Mr. BIDEN, Mr. WELLSTONE, and Mr. SMITH of Oregon)) proposed an amendment to the bill, S. 1650, supra; as follows:

At the end of title II, add the following:

WITHHOLDING OF SUBSTANCE ABUSE FUNDS

SEC. . (a) IN GENERAL.—None of the funds appropriated by this Act may be used to withhold substance abuse funding from a State pursuant to section 1926 of the Public Health Service Act (42 U.S.C. 300x–26) if such State certifies to the Secretary of Health and Human Services that the State will commit additional State funds, in accordance with subsection (b), to ensure compliance with State laws prohibiting the sale of tobacco products to individuals under 18 years of age.

(b) AMOUNT OF STATE FUNDS.—The amount of funds to be committed by a State under subsection (a) shall be equal to one percent of such State's substance abuse block grant allocation for each percentage point by which the State misses the retailer compliance rate goal established by the Secretary of Health and Human Services under section 1926 of such Act, except that the Secretary may agree to a smaller commitment of additional funds by the State.

(c) SUPPLEMENT NOT SUPPLANT.—Amounts expended by a State pursuant to a certification under subsection (a) shall be used to supplement and not supplant State funds used for tobacco prevention programs and for compliance activities described in such subsection in the fiscal year preceding the fiscal year to which this section applies.

(d) The Secretary shall exercise discretion in enforcing the timing of the State expenditure required by the certification described in subsection (a) as late as July 31, 2000.

BOXER AMENDMENT NO. 2276

Mr. HARKIN (for Mrs. BOXER) proposed an amendment to the bill, S. 1650, supra; as follows:

At the appropriate place add the following:

SEC. ___. (a) FINDINGS.—Congress makes the following findings:

(1) In 1999, prostate cancer is expected to kill more than 37,000 men in the United States and be diagnosed in over 180,000 new cases.

(2) Prostate cancer is the most diagnosed nonskin cancer in the United States.

(3) African Americans have the highest incidence of prostate cancer in the world.

(4) Considering the devastating impact of the disease among men and their families, prostate cancer research remains underfunded.

(5) More resources devoted to clinical and translational research at the National Institutes of Health will be highly determinative of whether rapid advances can be attained in treatment and ultimately a cure for prostate cancer.

(6) The Congressionally Directed Department of Defense Prostate Cancer Research Program is making important strides in innovative prostate cancer research, and this Program presented to Congress in April of 1998 a full investment strategy for prostate cancer research at the Department of Defense.

(7) The Senate expressed itself unanimously in 1998 that the Federal commitment to biomedical research should be doubled over the next 5 years.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) finding treatment breakthroughs and a cure for prostate cancer should be made a national health priority;

(2) significant increases in prostate cancer research funding, commensurate with the impact of the disease, should be made available at the National Institutes of Health and to the Department of Defense Prostate Cancer Research Program; and

(3) these agencies should prioritize prostate cancer research that is directed toward innovative clinical and translational research projects in order that treatment breakthroughs can be more rapidly offered to patients.

DEWINE AMENDMENT NO. 2277

Mr. SPECTER (for Mr. DEWINE) proposed an amendment to the bill, S. 1650 supra; as follows:

On page 59, line 25, strike ''$1,404,631,000'' and insert ''$1,406,631,000'' in lieu thereof.

On page 60, before the period on line 10, insert the following: '': *Provided further,* That $2,000,000 shall be for carrying out Part C of title VIII of the Higher Education Amendments of 1998.''

On page 62, line 23, decrease the figure by $2,000,000.

HUTCHISON (AND BINGAMAN) AMENDMENT NO. 2278

Mr. SPECTER (for Mrs. HUTCHISON (for herself and Mr. BINGAMAN)) proposed an amendment to the bill, S. 1650, supra; as follows:

At the appropriate place, insert the following:

SEC. . The United States-Mexico Border Health Commission Act (22 U.S.C. 290n *et seq.*) is amended—

(1) by striking section 2 and inserting the following:

''SEC. 2. APPOINTMENT OF MEMBERS OF BORDER HEALTH COMMISSION.

''Not later than 30 days after the date of enactment of this section, the President shall appoint the United States members of the United States-Mexico Border-Health Commission, and shall attempt to conclude an agreement with Mexico providing for the establishment of such Commission.''; and

(2) in section 3—

(A) in paragraph (1), by striking the semicolon and inserting ''; and'';

(B) in paragraph (2)(B), by striking ''; and'' and inserting a period; and

(C) by striking paragraph (3).

SPECTER AMENDMENTS NOS. 2279–2280

Mr. SPECTER proposed two amendments to the bill, S. 1650, supra; as follows:

AMENDMENT NO. 2279

On page 50, line 17, strike ''$459,500,000'' and insert in lieu thereof ''$494,000,000''.

AMENDMENT NO. 2280

On page 66, line 24, strike all after the colon up to the period on line 18 of page 67.

COCHRAN AMENDMENT NO. 2281

Mr. SPECTER (for Mr. COCHRAN) proposed an amendment to the bill, S. 1650 supra; as follows:

On page 42, before the period on line 8 insert the following: '': *Provided further,* That sufficient funds shall be available from the Office on Women's Health to support biological, chemical and botanical studies to assist in the development of the clinical evaluation of phytomedicines in women's health''.

WYDEN (AND OTHERS) AMENDMENT NO. 2282

Mr. HARKIN (for Mr. WYDEN (for himself, Mr. GRAHAM, and Mr. SMITH of Oregon)) proposed an amendment to the bill, S. 1650, supra; as follows:

On page 19, line 6, insert before the period the following: '': *Provided further,* That funds made available under this heading shall be used to report to Congress, pursuant to section 9 of the Act entitled 'An Act to create a Department of Labor' approved March 4, 1913 (29 U.S.C. 560), with options that will promote a legal domestic work force in the agricultural sector, and provide for improved compensation, longer and more consistent work periods, improved benefits, improved living conditions and better housing quality, and transportation assistance between agricultural jobs for agricultural workers, and address other issues related to agricultural labor that the Secretary of Labor determines to be necessary''.

MURRAY (AND OTHERS) AMENDMENT NO. 2283

Mr. HARKIN (for Mrs. MURRAY (for herself, Ms. MIKULSKI, Mr. ROBB, Mrs.

LINCOLN, and Mr. REID)) proposed an amendment to the bill, S. 1650, supra; as follows:

Beginning on page 1 of the amendment, strike all after the first word and insert the following:

___. SENSE OF THE SENATE ON WOMEN'S ACCESS TO OBSTETRICAND GYNECOLOGICAL SERVICES.

(a) FINDINGS.—Congress makes the following findings:

(1) In the 1st session of the 106th Congress, 23 bills have been introduced to allow women direct access to their ob-gyn provider for obstetric and gynecologic services covered by their health plans.

(2) Direct access to ob-gyn care is a protection that has been established by Executive Order for enrollees in medicare, medicaid, and Federal Employee Health Benefit Programs.

(3) American women overwhelmingly support passage of federal legislation requiring health plans to allow women to see their ob-gyn providers without first having to obtain a referral. A 1998 survey by the Kaiser FamilyFoundation and Harvard University found that 82 percent of Americans support passage of a direct access law.

(4) While 39 States have acted to promote residents' access to ob- gyn providers, patients in other State- or in Federally-governed health plans are not protected from access restrictions or limitations.

(5) In May of 1999 the Commonwealth Fund issued a survey on women's health, determining that 1 of 4 women (23 percent) need to first receive permission from their primary care physician before they can go and see their ob-gyn provider for covered obstetric or gynecologic care.

(6) Sixty percent of all office visits to ob-gyn providers are for preventive care.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Congress should enact legislation that requires health plans to provide women with direct access to a participating health provider who specializes in obstetrics and gynecological services, and that such direct access should be provided for all obstetric and gynecologic care covered by their health plans, without first having to obtain a referral from a primary care provider or the health plan.

REED AMENDMENT NO. 2284

Mr. HARKIN (for Mr. REED) proposed an amendment to the bill, S. 1650, supra; as follows:

At the appropriate place, insert the following:

SEC. . The applicable time limitations with respect to the giving of notice of injury and the filing of a claim for compensation for disability or death by an individual under the Federal Employees' Compensation Act, as amended, for injuries sustained as a result of the person's exposure to a nitrogen or sulfur mustard agent in the performance of official duties as an employee at the Department of the Army's Edgewood Arsenal before March 20, 1944, shall not begin to run until the date of enactment of this Act.

STEVENS AMENDMENT NO. 2285

Mr. SPECTER (for Mr. STEVENS) proposed an amendment to the bill, S. 1650, supra; as follows:

At the appropriate place in Title V—GENERAL PROVISIONS of the bill insert the following new section—

SEC. 5 . Section 169(d)(2)(B) of P.L. 105–220, the Workforce Investment Act of 1998, is amended by striking ''or Alaska Native villages or Native groups (as such terms are defined in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1602)).'', and inserting in lieu thereof, ''or Alaska Natives.''

DURBIN (AND OTHERS) AMENDMENT NO. 2286

Mr. HARKIN (for Mr. DURBIN (for himself, Mr. DEWINE, Mr. ABRAHAM, and Mr. SPECTER)) proposed an amendment to the bill, S. 1650, supra; as follows:

At the end of title II, add the following:

CHILDHOOD ASTHMA

SEC. . In addition to amounts otherwise appropriated under this title for the Centers for Disease Control and Prevention, 8.7 in addition to the $*** already provided for asthma prevention programs which shall become available on October 1, 2000 and shall remain available through September 30, 2001, and be utilized to provide grants to local communities for screening, treatment and education relating to childhood asthma.

INOUYE AMENDMENTS NOS. 2287–2288

Mr. HARKIN (for Mr. INOUYE) proposed two amendments to the bill, S. 1650, supra; as follows:

AMENDMENT NO. 2287

At the appropriate place, insert the following:

SEC. (a) The Centers for Disease Control and Prevention shall hereafter be known and designated as the ''Thomas R. Harkin Centers for Disease Control and Prevention''.

(b) Effective upon the date of enactment of this Act, any reference in a law, document, record, or other paper of the United States to the ''Centers for Disease Control and Prevention'' shall be deemed to be a reference to the ''Thomas R. Harkin Centers for Disease Control and Prevention''.

(c) Nothing in this section shall be construed as prohibiting the Director of the Thomas R. Harkin Centers for Disease Control and Prevention from utilizing for official purposes the term ''CDC'' as an acronym for such Centers.

AMENDMENT NO. 2288

At the appropriate place, insert the following:

SEC. ___. DESIGNATION OF ARLEN SPECTER DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—The National Library of Medicine building (building 38) at 8600 Rockville Pike, in Bethesda, Maryland, shall be known and designated as the ''Arlen Specter National Library of Medicine''.

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the building referred to in subsection (a) shall be deemed to be a reference to the Arlen Specter National Library of Medicine.

HARKIN AMENDMENT NO. 2289

Mr. HARKIN proposed an amendment to the bill, S. 1650, supra; as follows:

On page 39, line 8, strike ''$6,682,635,000'' and insert ''$6,684,635,000''.

On page 40, line 20, strike ''$928,055,000'' and insert ''$942,355,000''.

On page 41, line 14, reduce the figure by $10,300,000.

On page 62, line 23, strike ''$378,184,000'' and insert ''$372,184,000''.

NOTICES OF HEARINGS

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. MURKOWSKI. Mr. President, I would like to announce that a Full Committee hearing has been scheduled before the Committee on Energy and Natural Resources. The hearing will take place Thursday, October 14, 1999, at 9:30 a.m., in room SD–366 of the Dirksen Senate Office Building in Washington, D.C.

The purpose of this hearing is to receive testimony on S. 1683, a bill to make technical changes to the Alaska National Interest Lands Conservation Act, and for other purposes; S. 1686, to provide for the conveyances of land interests to Chugach Alaska Corporation to fulfill the intent, purpose, and promise of the Alaska Native Claims Settlement Act, and for other purposes; S. 1702, a bill to amend the Alaska Native Claims Settlement Act to allow shareholder common stock to be transferred to adopted Alaska Native Children and their descendants, and for other purposes; H.R. 2841, to amend the Revised Organic Act of the Virgin Islands to provide for greater fiscal autonomy consistent with other United States jurisdictions, and for other purposes; and H.R. 2368, the Bikini Resettlement and Relocation Act of 1999. There will be testimony from the Administration, and other interested parties.

Those who wish to testify or to submit written testimony should write to the Committee on Energy and Natural Resources, U.S. Senate, Washington, D.C. 20510. Presentation of oral testimony is by Committee invitation only. For further information, please contact Jo Meuse or Brian Malnak at (202) 224–6730.

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Ms. COLLINS. Mr. President, I would like to announce for the information of the Senate and the public that the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, will hold a hearing entitled ''Conquering Diabetes: Are We Taking Full Advantage of the Scientific Opportunities For Research?'' This Subcommittee hearing will examine the devastating impact that diabetes and its resulting complications have had on Americans of all ages in both human and economic terms. Additionally, we will review the recent recommendations of the Congressionally-established Diabetes Research Working Group and will look at the current Federal commitment to diabetes research to determine if sufficient funding has been provided to take advantage of the unprecedented opportunities to ultimately conquer this disease and its complications.

The hearing will take place on Thursday, October 14, 1999, at 9:30 a.m., in Room 628 of the Dirksen Senate Office Building. For further information, please contact Lee Blalack of the Subcommittee staff at 224–3721.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry, be allowed to meet during the session of the Senate on Thursday, October 7, 1999. The purpose of this meeting will be to discuss the regulation of products of biotechnology and new challenges faced by farmers and food businesses.

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

COMMITTEE ON ARMED SERVICES

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet at 9:30 a.m. on Thursday, October 7, 1999, in open and closed sessions, to receive testimony on the ability of the Stockpile Stewardship Program to adequately verify the safety and reliability of the U.S. nuclear deterrent under a comprehensive test ban treaty.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. COVERDELL. Mr. President, I ask unanimous consent that the full Committee on Environment and Public Works be granted permission to conduct a hearing Thursday, October 7, 10:00 a.m., Hearing Room (SD–406), on water infrastructure legislation, including the following three bills: S. 968, Alternative Water Sources Act of 1999; S. 914, Combined Sewer Overflow Control and Partnership Act of 1999; and the Clean Water Infrastructure Financing Act of 1999, a bill to be introduced by Senator VOINOVICH.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, October 7, 1999 at 10:30 a.m. and 2:00 p.m. to hold two hearings.

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

COMMITTEE ON THE JUDICIARY

Mr. COVERDELL. Mr. President, the Committee on the Judiciary requests unanimous consent to conduct a hearing on Thursday, October 7, 1999 beginning at 10:00 a.m. in Dirksen Room 226.

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

COMMITTEE ON THE JUDICIARY

Mr. COVERDELL. Mr. President, the Committee on the Judiciary requests unanimous consent to conduct a markup on Thursday, October 7, 1999 beginning at 10:00 a.m. in Dirksen Room 226.

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

COMMITTEE ON THE JUDICIARY

Mr. COVERDELL. Mr. President, the Committee on the Judiciary requests unanimous consent to conduct a hearing on Thursday, October 7, 1999 beginning at 2:00 p.m. in Dirksen Room 226.

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

SPECIAL COMMITTEE ON THE YEAR 2000 TECHNOLOGY PROBLEM

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Special Committee on the Year 2000 Technology Problem be permitted to meet on October 7, 1999 at 9:30 a.m. for the purpose of conducting a hearing.

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Thursday, October 7, 1999 at 2:00 p.m. to hold a closed hearing on intelligence matters.

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

SUBCOMMITTEE ON ENERGY RESEARCH, DEVELOPMENT, PRODUCTION AND REGULATION

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Subcommittee on Energy Research, Development, Production and Regulation of the Committee on Energy and Natural Resources be granted permission to meet during the session of the Senate on Thursday, October 7, for purposes of conducting a subcommittee hearing, which is scheduled to begin at 2:30 p.m. The purpose of this hearing is to receive testimony on S. 1183, a bill to direct the Secretary of Energy to convey to the city of Bartlesville, Oklahoma, the former site of the NIPER facility of the Department of Energy; and S. 397, a bill to authorize the Secretary of Energy to establish a multiagency program in support of the Materials Corridor Partnership Initiative to promote energy efficient, environmentally sound economic development along the border with Mexico through the research, development, and use of new materials.

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

SUBCOMMITTEE ON INTERNATIONAL SECURITY, PROLIFERATION AND FEDERAL SERVICES

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Governmental Affairs Committee Subcommittee on International Security, Proliferation and Federal Services be permitted to meet on Thursday, October 7, 1999, at 2:00 p.m. for a hearing on Guidelines for the Relocation, Closing, Consolidation or Construction of Post Offices.

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

SUBCOMMITTEE ON INTERNATIONAL TRADE

Mr. COVERDELL. Mr. President, I ask unanimous consent that the Committee on Finance, Subcommittee on International Trade be permitted to meet on Thursday, October 7, 1999 at 10:00 a.m. to hear testimony on the United States Agricultural Negotiating Objectives for the Seattle WTO Ministerial Conference.

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

ADDITIONAL STATEMENTS

1999 REUNION OF MEMBERS OF FOX DIVISION, USS ''ROCHESTER''

● Mr. ABRAHAM. Mr. President, I rise today to recognize the fighting men of the Fox Division, United States Navy, USS *Rochester* (CA–124), who bravely served our country in the Korean Conflict from June, 1950 to March, 1953. Aboard the USS *Rochester*—the flagship of the Commander Seventh Fleet—the men of the Fox Division participated in nearly every major naval engagement along the Korean Peninsula. The Fox Division's three teams: the Main Plot, the Sky Plot, and the Mark 56 directors, shared the critical responsibility of operating, repairing, and maintaining the complex equipment which ensured the accuracy of the *Rochester*'s weapons systems. They accomplished these tasks with outstanding success.

The Fox Division recently celebrated their 1999 reunion in Frankenmuth, Michigan. Some of these reunited shipmates had not seen each other in over 45 years. Included among their ranks were:

Jerry Barca; John Brothers; Robert Cadden; Russell Daniels; Farrell Ferguson; Sheri Holman, representing her late husband Bob Holman; Bill Hontz; Marv Hufford; Larry Kobie; Tony Kontowicz; Leo Lane; Charles Newsham; Bobby Page; Carl Ray; Ronald Richards; Pete Russell; Roland Schneider; Donald Spencer; and Joe West.

Today I join my colleagues in thanking the men of the Fox Division for defending the cause of democracy, and for preserving our country's national security. I am proud to say that these veterans are an inspiration to all of us. By dedicating a portion of their lives to the service of their country, they have helped guarantee the freedom we Americans hold so dear. Our nation is grateful to each and every member of the Fox Division, USS *Rochester*, for their outstanding dedication and commitment to the United States of America.●

VIOLENCE IN MICHIGAN

● Mr. LEVIN. Mr. President, this week, students at Erickson Elementary School and Willow Run High School are mourning the deaths of their peers. On Sunday afternoon, gun fire cut short the lives of two young boys in Ypsilanti Township. Sixteen year old Ernest Earl Lemons was shot in plain daylight, after a fight broke out between young people. Nine year old Cullen Ethington, who was a half a block away, was also killed by a stray bullet from that fight.

Both young people are now being remembered by their classmates and teachers. The tree where Lemons fell,

after he was shot, is now decorated with teddy bears. Students at Erickson are planning to plant a tree or flowers in honor of the short life of fourth grader Cullen Ethington, who will be memorialized by his classmates as a peer mediator who helped students resolve their disputes without violence.

School children are too often the victims of senseless gun violence. Gun violence results in injury and death, destroys families, and causes lasting psychological and emotional harm. In Michigan, each school is now forced to handle the trauma of children losing other children to gunfire. As many other school districts now know, violence and the fear of violence is not only tragic for individuals and families involved, it also interferes tremendously with the educational process. Students at Erickson, for example, are now spending time at school with trauma teams learning how to cope with death while their peers at other schools are learning about the pilgrims and practicing for the school play.

Congress must act now to end the proliferation of gun violence. Like young Cullen, we must not only make a pledge to live our lives without violence, but must also send a message to others that violence is never the answer.

My thoughts and prayers go out to the both the Ethington and the Lemons families.●

WILDERNESS DESIGNATIONS

● Mr. CRAIG. Mr. President, given the recent creation of the Wilderness and Public Lands Caucus and the ongoing debate on public land management, I think that all views on this complicated and emotional issue are vital to the discussion. Therefore, I ask that a brief statement from the Wilderness Act Reform Coalition, a group from my home State of Idaho be printed in the RECORD for all Senators to read and consider.

The article follows:

THE WILDERNESS ACT REFORM COALITION

WHY WE ARE ORGANIZING

September 3, 1999 marks the 35th anniversary of the passage of the Wilderness Act. During those 35 years, it has never been substantively amended. Yet, the history of the application of the Wilderness Act to the public's lands and resources provides overwhelming evidence that it must be significantly reformed if the public interest is to be served.

September 3, 1999 also marks the launch of the Wilderness Act Reform Coalition (WARC), the first serious effort to reform this antiquated and poorly-conceived law. Much has changed since the Wilderness Act became law in 1964. Dozens of other laws have been passed since then to protect and responsibly-manage all of the public's lands and resources. Underpinning all of these laws—and guaranteeing their enforcement—is a public sensitivity and commitment to wise resource management which was not present two generations ago when the Wilderness Act was enacted.

Over this same time period our knowledge and understanding of how to accomplish this kind of wise and responsible resource management has increased exponentially. The demand side of the public's interest in their lands and resources has also increased exponentially. Recreation demand, for example, has increased far beyond what anyone could have anticipated 35 years ago and it has done so in directions which could not have been foreseen in 1964. Demand for water, energy and minerals, timber and other resources continues to go up as well.

All of this means that as the 21st Century dawns we find ourselves facing more complex natural resources realities and challenges than ever before in our history. Meeting these challenges while at the same time serving the broad public interest will require careful and thoughtful balancing of all resource values with other social goals. It will also require integrating them all into a comprehensive management approach which will provide the greatest good for the greatest number of Americans over the longest period of time.

These lands and resources, after all, belong to all of the American people. They deserve to enjoy the maximum benefits from them. Yet, the Wilderness Act, with its outdated, inflexible, and anti-management requirements, presently locks away over 100 million acres of the public's lands and resources from this kind of intelligent and integrated resource management. The inevitable result is the numerous negative impacts and damage to other resource values which are becoming increasingly apparent on the public's lands. The Wilderness Act remains frozen in another era. Due to the exponential changes which have occurred since it was passed, that era lies much further in the past than a mere 35 year linear time line would suggest.

OUR GOALS AND OBJECTIVES

The Wilderness Act Reform Coalition is being organized by members of citizen's groups and local government officials who have experienced firsthand the limitations and problems the Wilderness Act has caused. It has a simple mission: to reform the Wilderness Act. In carrying out that mission, the Coalition has identified two primary goals towards which it will initially work.

The first goal is to make those changes in the wilderness law which are essential to mitigate the most serious resource and related problems it is causing. These problems range from prohibiting the application of sound resource management practices where needed to hampering important scientific research and jeopardizing our national defense.

The second goal of the coalition is to use the failings of the Wilderness Act to help educate the public, the media and policy makers on the fundamentals of natural resource management. Most of the ''conventional wisdom'' about natural resource management to which most of them presently subscribe is simply wrong. It is essential that the public be better educated on the facts, the realities, the challenges and the options before there can be any responsible or useful policy debate on the most fundamental problems with the Wilderness Act or, for that matter, any of the other federal management laws and policies which also need to be reformed. That is why the Coalition has chosen a comparatively limited reform agenda for this opening round in what we recognize ultimately must be a broader and more comprehensive national policy debate.

OUR REFORM AGENDA

The Coalition currently advocates the following reforms of the Wilderness Act:

1. Developing a mechanism to permit active resource management in wilderness areas to achieve a wide range of public benefits and to respond to local needs. The inability or unwillingness of managers to intervene actively within wilderness areas to deal with local resource management problems or goals has resulted in economic harm to local communities and damage to other important natural resource and related values and objectives. The Coalition supports the creation of committees composed of locally-based federal and state resource managers, local governments, local economic interests and local citizens which will initiate a process to override the basic non-management directive of the Wilderness Act on a case-by-case basis.

2. Establishing a mechanism for appeal and override of local managers for scientific research. Wilderness advocates often tout the importance of wilderness designation to science. The reality, however, is that agency regulations make it difficult or impossible to conduct many scientific experiments in wilderness, particularly with modern and cost-effective scientific tools. Important scientific experiments have been opposed simply because they would take place within wilderness areas. A simple, quick and cheap appeal process must be created for scientists turned down by wilderness land managers.

3. Making it clear that such things as use of mechanized equipment and aircraft landings can occur in wilderness areas for search and rescue or law enforcement purposes. There have been incidents where these have been prevented by federal wilderness managers.

4. Requiring that federal managers use the most cost-effective management tools and technologies. These managers have largely imposed upon themselves a requirement that they use the ''least tool'' or the ''minimum tool'' to accomplish tasks such as noxious weed control, wildfire control or stabilization of historic sites. In practice, this means that hand tools are often used instead of power tools, horses are employed instead of helicopters and similar practices which waste tax dollars.

5. Clarifying that the prohibition on the use of mechanized transportation in wilderness areas refers only to intentional infractions. This would be, in effect, the ''Bobby Unser Amendment'' designed to prevent in the future the current situation in which he is being prosecuted by the federal government for possibly driving a snowmobile into a wilderness area in Colorado while lost in a life-threatening blizzard.

6. Pulling the boundaries of wilderness areas and wilderness study areas (WSA's) back from roads and prohibiting ''cherrystemming.'' In many cases, the boundaries of wilderness areas and WSA's come right to the very edge of a road. Lawsuits have been filed or threatened against counties for going literally only a few feet into a WSA when doing necessary road maintenance work. It is clearly impossible to have a wilderness recreational experience in close proximity of a road. When formal wilderness areas are designated, the current practice is to pull the boundaries back a short distance from roads, depending on how the roads are categorized. That distance should be standardized and extended, probably to at least a quarter of a mile. The practice of ''cherrystemming,'' or drawing wilderness boundaries right along both sides of a road to its end, sometimes for many miles, is a clear violation of the intent of the Wilderness Act that wilderness areas must first and foremost be roadless. It must be eliminated.

7. Permitting certain human-powered but non-motorized mechanized transport devices in wilderness areas. This would include mountain bikes and wheeled ''game carriers'' and similar devices. The explosion of mountain biking was not envisioned by the Congress when the Wilderness Act was passed.

Opening up those wilderness areas which are suitable to mountain biking would provide a high quality recreation experience to more of the Americans who own these areas. Use of these human-powered conveyances would also reduce pressure on these areas in a number of ways, such as by dispersing recreation use over a wider area. At the same time opening these areas can also reduce the current or potential conflicts between various recreation uses on land outside of designated wilderness. The impact on the land from these types of mechanized recreation uses would be minimal to non-existent. Their presence in wilderness areas would not cause problems on aesthetic grounds for any but the most extreme wilderness purists and they represent only a tiny fraction of the Americans who own these lands.

8. Requiring that the resource potential in all WSA's and any other land proposed for wilderness be updated at least every ten years. For example, mineral surveys and estimates of oil and gas potential completed on many of the WSA's on BLM-managed land which have been recommended for wilderness designation are now 10 to 15 years old and in some cases even older. These reviews were often not very thorough even by the standards and technology available then, much less what is available now. Before any additional land is locked up in wilderness, Congress and the American people should at least have the best and most up-to-date information on which to weigh the resource trade offs and make decisions.

9. Stating clearly that wilderness designation or the presence of WSA's cannot interfere with military preparedness. In a number of instances, conflicts related to military overflights of designated or potential wilderness areas, or to the positioning of essential military equipment on the ground in these areas, poses a threat or a potential threat to our defense preparedness. The Coalition will push for clarification that when considering the impacts of any mission certified by the military as essential to the national defense, wilderness areas or WSA's will be treated exactly the same as any other land administered by that agency.

10. Clarifying that wilderness designation or WSA designation will not in and of itself result in any management or regulatory changes outside the wilderness or WSA boundaries. This change is essential to prohibit federal agencies or the courts from taking actions to impose any type of ''buffer zones'' around these areas, including such things as special management of ''viewsheds'' or asserting wilderness-based water rights.●

RECOGNIZING THE AMERICAN ASSOCIATION ON MENTAL RETARDATION ILLINOIS CHAPTER'S 1999 DIRECT SERVICE PROFESSIONAL AWARD WINNERS

● Mr. DURBIN. Mr. President, I take this opportunity to honor those who have enriched the lives of men and women with disabilities. Each year the Illinois chapter of the American Association on Mental Retardation recognizes the work of Illinoisans who have dedicated and committed their lives to helping people with disabilities.

These award winners live in Illinois and play an important role in the lives of Illinoisans with disabilities. A 1999 Direct Service Award winner is someone who devotes more than 50 percent of their time working hands-on with their client. These award winners work directly with their clients with commitment, sensitivity, professionalism, and patience. These qualities set them apart and increase their value to their patients.

It is important we recognize these individuals who go beyond the call of duty to improve the lives of others. We should note that these individuals do not only enrich the lives of those for whom they care, but enrich our lives as well. They represent the true spirit of community service.

It is my honor and privilege to recognize the achievements of the following distinguished Illinois direct service professionals: Linda Barnes, Karen Catt, Candace Fulgham, Ross Griswold, Delores Hardin, Cathey Hardy, Raterta Kalish, Eldora Madison, Anita Martin, Vickie Mckenny, Ida Mitchell, Michael Peters, Noreen Przislicki, Douglas S. Revolinski, Angelo Reyes, Karie Rosenown, Laureen Saathoff, Ruby Sandefur, Emma Smith, and Kathie Tillman. It is a privilege to represent these award winners in the United States Senate.

Again, I applaud them for their lifetime effort and their dedication to better the lives of others who are less fortunate. These distinguished men and women are heroes in their field, and I am proud to recognize their work.●

DAVID ''MOOSE'' MILLER

● Mr. BURNS. Mr. President, I rise today to pay tribute to David ''Moose'' Miller, husband, father, friend, community leader, sports enthusiast, and owner of the nationally known watering hole, Moose's Saloon, who lost his life to cancer recently. Moose had battled cancer for the last year and convinced himself and others that he would beat it. Today, in Kalispell, Montana, family and friends are remembering Moose Miller and I would like to take a moment to make a special acknowledgement to such a great man.

Moose played football for the University of Montana, served his country in the U.S. Army, and with his wife, converted the Corral Bar to the famous Moose's Saloon. Swinging doors, sawdust on the floor, initials carved into the heavy tables, the best pizza around, and the rustic atmosphere attracted people from all walks of life and all ages. Whether you're from Kalispell, Montana, Peoira, Illinois, or Washington, D.C., you likely know someone who knows of Moose's Saloon and Moose Miller.

I had the privilege of knowing Moose. Moose not only owned and ran a successful business in the Flathead Valley, he gave back to the community in many ways. The Kalispell Chamber of Commerce honored him as its Great Chief in 1986, recognizing his years of community service. He and his ''elves'' made Christmas special for many people, especially the handicapped, each year for several years, he donated proceeds from the kitchen to support the March of Dimes, was an active supporter of the University of Montana and helped administer the Flathead Youth Foundation.

Moose is leaving behind a wife, Shirley; his children; Bruce, Wallis, Royce, Lexie, Lee and Aimee; his grandchildren, Zach, Anne, Lexie, Leah, Alicia, Hannah, and Zane; and his sister, Marcie.

I know that Moose will be missed by his family and friends, as well as the entire community. May God bless them all and may his memory live on.●

JOHN ''JACK'' J. DRISCOLL

● Mrs. BOXER. Mr. President, on the occasion of his retirement as executive director of the Los Angeles World Airports, LAWA, I would like to recognize the important contribution Jack Driscoll has made to the City of Los Angeles and to the economy of Southern California over the past seven years.

Jack Driscoll was appointed executive director in December of 1992. His record of accomplishment can best be shown in the outstanding quality of management and development at the city's four airports: Los Angeles International, LAX, Ontario International, Palmdale Regional, and Van Nuys.

Under Mr. Driscoll's financial management, LAWA has increased its operating income by an overwhelming 329 percent through the combination of reorganization, streamlining measures, and renegotiating contracts with airport tenants. Revenues from non-aviation sources, including updated concessions and new vendor contracts, have nearly equaled revenues from aviation sources. In fact, leading investment rating agencies have rewarded LAX with their highest ratings for a stand-alone airport.

Even in adversity, Mr. Driscoll worked to maintain quality in service and operations. He was at the reins of LAWA during a major dispute between the City of Los Angeles and the airlines over landing fees. During litigation at LAX, he revived the dormant, 12-year-old plans to build new terminals at Ontario International Airport. With Mr. Driscoll's direction, this $270-million project was completed four months ahead of schedule and $26 million under budget. These new terminals put ONT in position to bring regional solutions to meet Southern California's ever-growing air transport needs and made it the only airport in the region with new facilities to do so.

In addition, Mr. Driscoll initiated the LAX Master Plan, a long-term process to guide development of LAX to meet air passenger and cargo demands for the next 20 years. Since 1992, LAX has become the third busiest passenger airport in the world and the second busiest air cargo airport in the world.

To offset this growth, Mr. Driscoll committed LAWA to undertake major noise reduction and management programs, including nearly $500 million in programs for residential soundproofing

and compatible land-use; recycle water programs; and a variety of clean air programs, including alternative-fuel vehicles and traffic mitigation. All of these programs have received awards from environmental organizations and regulatory agencies for outstanding achievement.

I wish Jack Driscoll well and thank him for his contribution towards improving Southern California's aviation gateway.●

IN MEMORY OF JIM DEFRANCIS

● Mr. ABRAHAM. Mr. President, I rise today in memory of Jim Upton DeFrancis: a great politician, a great historian, and a great family man, who died on January 1 of this year.

Jim DeFrancis was one of the most influential people in the political field, always maintaining political savvy—but not sacrificing perspective, an incredible sense of humor, and a belief that politics was an avenue for serving others. Very early in my career, I had the good fortune of working for Jim in Senator Bob Griffin's office. I will never forget the many lessons I learned from him—both directly and simply by working near him. One couldn't help but learn from Jim DeFrancis.

In addition to his 10 years with Senator Griffin, Jim DeFrancis was an integral member of the presidential campaigns of Gerald Ford and George Romney. As a member of the staff of these politicians, Jim was able to avoid the spotlight while serving Michigan and national politics, in the honorable and professional manner for which now he is recognized as a very significant member of Michigan political history.

Jim's love of politics was rooted in his love of history. He especially enjoyed reading about Winston Churchill. An avid reader, Jim collected any book on Winston Churchill that he could find, as well as other artifacts related to the late Prime Minister. During difficult times, Jim would look at Churchill's life as a model, gaining inspiration and guidance.

And while Jim's contribution to politics is exceptional—in his very actions, he inspired us to work for others through politics—his true love was his family. More than anything else, Jim DeFrancis was a family man. Survived by his wife, three sons, his mother and sister, his family was the real focus of his life. Everyone who came in contact with him would quickly learn about his family—as he always found a way to bring them up in a conversation.

Jim DeFrancis' devotion to his family, his friends, and his career was matched by few and will be deeply missed by those who knew him. We will never forget Jim—crossing paths with Jim DeFrancis was sure to leave a lasting impact. And it is this lasting, far-reaching impact that Jim's life has had on those who knew him which calls to mind a quote that I think Jim would appreciate, not only because it is a quote by Winston Churchill, but because I believe Jim would be moved to know what an influence he had on us:

''This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.''●

BUDDY CHARLES

● Mr. DURBIN. Mr. President, I rise today to take note of an upcoming milestone in the career of a man from Illinois whose musicianship, warmth and exuberance have brought joy to all who have heard him play and sing over the past 52 years.

On Saturday, October 9th, Mr. Buddy Charles will play the final night of his most recent engagement—a 9-year stand at the Drake Hotel in Chicago. Buddy Charles is no less than a living encyclopedia of what critics call the ''Golden Age'' of American popular music. During the period from about 1920 to 1950, the Gershwins, Arlens, Berlins and Carmichaels of the world produced a rich legacy of songs. Although recorded versions of these songs are numerous, they are kept alive in a special way by entertainers such as Buddy Charles.

Buddy is a lifelong Chicagoan, born there 72 years ago, raised on the North Side, and a graduate of Loyola University. The roster of clubs in which he has performed since 1946 reads like a history of night life and entertainment in Chicago: London House, Spaghetti Bowl, Dubonnet, Casino, Drum Lounge. . . .

Perhaps his most memorable stand—chronicled frequently by the Chicago news media—was his 18-year engagement, from 1972 to 1990, at the Acorn on Oak. There he could be found, as the Chicago Tribune wrote, ''shouting and singing when most sensible people are sleeping and dreaming, the most devilishly delightful creature of the city night.''

And it was there that Buddy became the favorite entertainer of two of Chicago's most famous personalities—Mike Royko and Harry Caray. When Mike's memorial service was held two years ago in Wrigley Field, there was Buddy at home plate, playing and singing Royko's favorite song.

Buddy's music and personality have provided refuge, relief and delight to four generations of music lovers. And through all those years, he has also been a loving husband to his wife of 45 years, Pat, a caring father to their now-grown children Teresa, Christopher, Tabitha and Amanda, and a daily churchgoer and teacher of catechism.

He has given himself to thousands of people through his music. Although it is a little sad that he won't be dispensing his brand of joy on a nightly basis any more, it is reassuring to know he is available to play when someone asks.

My sincerest good wishes to Buddy Charles and his family on this important occasion.●

FREDERIK MEIJER GARDENS DEDICATION OF LEONARDO DA VINCI SCULPTURE, IL CAVALLO

● Mr. ABRAHAM. Mr. President, I rise today to acknowledge and congratulate Frederik Meijer and the Frederik Meijer Gardens as they unveil and dedicate the Da Vinci sculpture Il Cavallo (the horse).

Frederik Meijer's incredible generosity and foresight enabled Il Cavallo to be seen at its permanent home in the Frederik Meijer Gardens. In an effort to fulfill his dream of creating a world class sculpture garden Frederik Meijer and the City of Milan, Italy (where an identical sculpture is located) allowed for the work of Da Vinci to be recommissioned and created. Il Cavallo was originally sketched and commissioned by Da Vinci in 1482 and he continued to work on it for fourteen years. However, the bronze intended to cast the sculpture was used to make cannons to defend the city of Milan, therefore Da Vinci never completed the work.

In 1977, after reading an article about the horse that Da Vinci never had the chance to create, amateur sculpture and pilot, Charles Dent created the first model of Il Cavallo. After his death in 1994 Nina Akamu sculpted the Il Cavallo that is on display today. The sculpture was cast using twenty thousand pounds of bronze, stands twenty-four feet tall and weighs fifteen tons.

Frederik Meijer is to be thanked and commended for carrying out his vision and giving a world class gift to the city of Grand Rapids and the people of Michigan. Nearly five hundred years ago Da Vinci had the vision for this great horse. Due to the acts of Frederik Meijer, a great humanitarian, this rare and magnificent work of art will stand tall in the Frederik Meijer Gardens for all to see for many years to come.●

EXPRESSING SYMPATHY FOR THOSE KILLED AND INJURED IN EARTHQUAKES IN TURKEY AND GREECE

Mr. SMITH of New Hampshire. Mr. President, on behalf of the majority leader, I ask unanimous consent that the Senate now proceed to the immediate consideration of S. Res. 198, submitted earlier by Senator SNOWE.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 198) expressing sympathy for those killed and injured in the recent earthquakes in Turkey and Greece and commending Turkey and Greece for their recent efforts in opening a national dialog and taking steps to further bilateral relations.

The Senate proceeded to consider the resolution.

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and

that any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 198) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 198

Whereas in the wake of the tragic earthquakes which struck Turkey on August 17, 1999, leaving up to 16,000 dead, 24,000 injured, and 100,000 homeless, and Greece on September 7, 1999, killing 143, injuring 1,600, and leaving 16,000 homeless, an improvement of relations between Turkey and Greece has occurred;

Whereas within hours of the earthquake hitting Turkey, Greece sent rescue teams, doctors, firemen, and emergency supplies to Turkey;

Whereas immediately after the earthquake struck Greece, Turkey, already dealing with its own devastation, sent rescue personnel to Greece;

Whereas in July, senior foreign ministry officials of Greece and Turkey held talks, the first talks at this level since 1994, to discuss bilateral cooperation in the fields of tourism, the environment, trade, and the economy as well as cooperation in combating organized crime, illegal immigration, drug-trafficking, and terrorism;

Whereas in September 1999, a second round of talks between senior foreign ministry officials of Greece and Turkey were held as a follow-up to the July meeting, and a third round has been planned for October 1999;

Whereas this spirit of cooperation has led to a warming of relations and confidence building measures, including—

(1) a naval vessel of Greece calling at a port of Turkey for the first time in more than a century;

(2) Greek and Turkish news commentators agreeing to publish their columns in each other's newspapers;

(3) Greece indicating that it is prepared to accept the candidacy of Turkey for membership in the European Union as long as Turkey meets all criteria for membership in the Union; and

(4) Turkey and Greece praising the other for earthquake assistance; and

Whereas the desire to further cultivate relations between Turkey and Greece has created an atmosphere of hope: Now, therefore, be it

Resolved, That the Senate—

(1) expresses sympathy for those killed and injured in the recent earthquakes in Greece and Turkey;

(2) commends, encourages, and supports recent efforts by Greece and Turkey to improve bilateral relations between those countries; and

(3) reiterates the importance of promoting positive bilateral relations between Greece and Turkey, which are of paramount interest to the United States.

APPOINTMENTS

The PRESIDING OFFICER. The Chair, on behalf of the Majority Leader, pursuant to Public Law 105–277, announces the appointment of the following individuals to serve as members of the Parents Advisory Council on Youth Drug Abuse: Robert L. Marginnis, of Virginia (two-year term); June Martin Milam, of Mississippi (Representative of a Non-Profit Organization) (three-year term).

DESIGNATING OCTOBER 15, 1999, AS ''NATIONAL MAMMOGRAPHY DAY''

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that the Senate now proceed to the immediate consideration of S. Res. 179, designating October 15, 1999, as ''National Mammography Day.''

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 179) designating October 15, 1999, as ''National Mammography Day.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that the resolution and preamble be agreed to, en bloc, the motion to reconsider be laid upon the table, and that any statements relating thereto be printed in the RECORD.

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

The resolution (S. Res. 179) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 179

Whereas according to the American Cancer Society, in 1999, 175,000 women will be diagnosed with breast cancer and 43,300 women will die from this disease;

Whereas in the decade of the 1990's, it is estimated that about 2,000,000 women will be diagnosed with breast cancer, resulting in nearly 500,000 deaths;

Whereas the risk of breast cancer increases with age, with a woman at age 70 years having twice as much of a chance of developing the disease as a woman at age 50 years;

Whereas at least 80 percent of the women who get breast cancer have no family history of the disease;

Whereas mammograms, when operated professionally at a certified facility, can provide a safe and quick diagnosis;

Whereas experts agree that mammography is the best method of early detection of breast cancer, and early detection is the key to saving lives;

Whereas mammograms can reveal the presence of small cancers up to 2 years or more before a regular clinical breast examination or breast self-examination, reducing mortality by more than 30 percent; and

Whereas the 5-year survival rate for localized breast cancer is currently 97 percent: Now, therefore, be it

Resolved, That the Senate—

(1) designates October 15, 1999, as ''National Mammography Day''; and

(2) requests that the President issue a proclamation calling upon the people of the United States to observe such day with appropriate programs and activities.

EXECUTIVE CALENDAR

Mr. SMITH of New Hampshire. Mr. President, as in executive session, I ask unanimous consent that the Agriculture Committee be discharged from further consideration of the following nomination; and further, the Senate proceed to its immediate consideration:

Andrew Fish, to be Assistant Secretary of Agriculture.

I further ask unanimous consent that the Senate proceed, en bloc, to the following nominations on the calendar:

Nos. 236, 250, 251, and 252.

Finally, I ask unanimous consent that the nominations be confirmed, the motions to reconsider be laid upon the table, that any statements relating to the nominations be printed in the RECORD, and the President be immediately notified of the Senate's action.

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

The nominations considered and confirmed en bloc are as follows:

DEPARTMENT OF AGRICULTURE

Andrew C. Fish, of Vermont, to be an Assistant Secretary of Agriculture.

DEPARTMENT OF THE TREASURY

John D. Hawke, Jr., of the District of Columbia, to be Comptroller of the Currency for a term of five years.

DEPARTMENT OF JUSTICE

Robert Raben, of Florida, to be an Assistant Attorney General.

Robert S. Mueller, III, of California, to be United States Attorney for the Northern District of California for a term of four years.

John Hollingsworth Sinclair, of Vermont, to be United States Marshal for the District of Vermont for the term of four years.

ORDERS FOR FRIDAY, OCTOBER 8, 1999

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until the hour of 9:30 a.m. on Friday, October 8. I further ask unanimous consent that on Friday, immediately following the prayer, the Journal of the proceedings be approved to date, the morning hour be deemed to have expired, the time for the two leaders be reserved for their use later in the day, and the Senate then proceed to executive session for consideration of the Comprehensive Nuclear Test Ban Treaty.

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

AMENDMENT FILING DEADLINE

Mr. SMITH of New Hampshire. Mr. President, as in executive session, I ask unanimous consent that the deadline for amendments to be filed at the desk on the Nuclear Test Ban Treaty be 9:45 a.m. on Tuesday, October 12.

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

UNANIMOUS CONSENT AGREEMENT—AGRICULTURE APPROPRIATIONS CONFERENCE REPORT

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that debate resume on the Agriculture appropriations conference report at 4:30 p.m. on Tuesday, October 12, and the time be equally divided between the two leaders.

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

PROGRAM

Mr. SMITH of New Hampshire. Mr. President, for the information of all Senators, the Senate will begin consideration of the Nuclear Test Ban Treaty at 9:30 a.m. on Friday. By previous consent, debate time is limited to 14 hours equally divided between the two leaders. Debate on the treaty is expected to take place throughout the day tomorrow and will resume at 9:30 a.m. on Tuesday.

As a reminder, cloture was filed on the conference report to accompany the Agriculture appropriations bill today.

By a previous consent, the Senate will proceed to the cloture vote Tuesday, October 12, at 5:30 p.m. It is hoped that the vote regarding the Nuclear Test Ban Treaty can be stacked to follow that 5:30 vote. Therefore, the next rollcall vote will occur at 5:30 p.m. on Tuesday, October 12.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. SMITH of New Hampshire. Mr. President, if there is no further business to come before the Senate, I now ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 8:15 p.m., adjourned until Friday, October 8, 1999, at 9:30 a.m.

CONFIRMATIONS

Executive nominations confirmed by the Senate October 7, 1999:

DEPARTMENT OF THE TREASURY

JOHN D. HAWKE, JR., OF THE DISTRICT OF COLUMBIA, TO BE COMPTROLLER OF THE CURRENCY FOR A TERM OF FIVE YEARS.

DEPARTMENT OF AGRICULTURE

ANDREW C. FISH, OF VERMONT, TO BE AN ASSISTANT SECRETARY OF AGRICULTURE.

THE ABOVE NOMINATIONS WERE APPROVED SUBJECT TO THE NOMINEES' COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

DEPARTMENT OF JUSTICE

ROBERT RABEN, OF FLORIDA, TO BE AN ASSISTANT ATTORNEY GENERAL.

ROBERT S. MUELLER, III, OF CALIFORNIA, TO BE UNITED STATES ATTORNEY FOR THE NORTHERN DISTRICT OF CALIFORNIA FOR A TERM OF FOUR YEARS.

JOHN HOLLINGSWORTH SINCLAIR, OF VERMONT, TO BE UNITED STATES MARSHAL FOR THE DISTRICT OF VERMONT FOR THE TERM OF FOUR YEARS.

EXTENSIONS OF REMARKS

HONORING RETIRING STAFF OF THE ARCHITECT OF THE CAPITOL

HON. STENY H. HOYER

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. HOYER. Mr. Speaker, on Friday, October 1, 1999, I celebrated a final day of work with twenty-seven members of the Architect of the Capitol staff from the House Office Buildings. Of the twenty-seven employees leaving us, eighteen are my constituents. These valued employees are retiring under a buyout program developed earlier this year by the Architect of the Capitol and approved by the House Administration Committee, of which I am the Ranking Member. The buyout program has provided excellent retirement opportunities, which at the same time creating new avenues of advancement for the staff of the Architect who continue with us.

The staffers retiring today have an average of twenty-nine years of service each, and together, they have provided 798 years of service. The Architect of the Capitol fields a work force that is indispensable to us, and often labors unnoticed in the shadows, or more aptly, in the basement and tunnels of these buildings. Like public employees everywhere, they do some of the toughest jobs under the most adverse conditions in the country. They do it always with smiles and friendly greetings, and a job well done. These employees were never looking to get rich and they do not do it for public acclaim. They do their jobs and they do them well because they know we all rely on them. Lyndon Johnson understood this. He said of public service ''so much of what we achieve as people depends upon the caliber and the character of the civil service.''

I would like to take this opportunity to say thank you on behalf of all my colleagues, both Democrat and Republican. Farewell to those employees leaving us today, we will miss them and we thank them for their contribution to our daily lives. They are: Lewis Bowles, Jr., John Callahan, Jr., Douglas Colbert, Ernest Cook, Margaret Donnelly, Lillie Drayton, Alvin Gayan, Hubert Gray, David Ingram, Solomon Landers, Earl Lemings, Carroll Lumpkins, Jr., Norman Lynch, James Mattingly, Luke Mattingly, William McWilliams, Bernard Merritt, Robert Merryman, Walter Montgomery, Allen Nichols, Talmadge Nowden, Anthony Pilkerton, James Quade, Robert Quade, Raymond Stager, George Stein, and Leonard Vanryswick.

''FIFTY YEARS OF SERVICE'' TO THE GREATER DUNDALK COMMUNITY

HON. ROBERT L. EHRLICH, JR.

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. EHRLICH. Mr. Speaker, on October 14, 1949, twenty-five members of the Dundalk community formed a new organization known as the Optimist Club of Dundalk, sponsored by the Optimist Club of Baltimore. They established their motto as ''Friend of the Boy'' and began to sponsor sports programs, oratorical contests, and archery programs in the schools to honor the male students that excelled in academics and athletics.

In 1950, The Dundalk Optimist Foundation, Inc. was formed to ensure the planned and approved programs were financially assured, and to plan for the construction of a building they could call their own. Through the years, the club grew in size and effectiveness. The club became a Century Club in 1969, and earned the District Achievement Award for the first time. Over the years, the programs began serving girls and the motto was changed to ''Friends of Youth.'' In January of 1988, the Optimist Club membership voted to allow women to be eligible for membership, and the Club continued to expand and increase their outreach in the community. The dream of a building was realized in 1995, with the opening of their Clubhouse at 4528 Northpoint Boulevard in Dundalk.

Today, the Optimist Club of Dundalk, Inc. continues to provide wonderful opportunities for the community's youth to learn, grow, and excel both in academics and athletics. I commend this organization for these first fifty years of excellent and dedicated service, and I join in looking forward to the next fifty.

PROFILES OF SUCCESS HONORS MR. ED DELCI

HON. ED PASTOR

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. PASTOR. Mr. Speaker, I rise before you today to pay tribute to an outstanding fellow Arizonan who is an exemplary role model for Arizona and the nation, Mr. Ed Delci.

Ed Delci is a committed and tenacious individual who recently received the Exemplary Leadership Award at Valley del Sol's Annual Profiles of Success Leadership Awards in Phoenix. Valle's award ceremony is the premiere Latino recognition event in Arizona each year that acknowledges Arizona's leaders and their contributions.

As an academic advisor at Arizona State University, Ed has dedicated himself to helping young people succeed in their pursuits of higher education. He inspires young Hispanics to succeed in their studies, graduate from ASU and maintain an active involvement in their community. I believe he has positively impacted the graduate rate of Latinos at ASU.

He also has been the principal advisor of ASU's MEChA (Movimiento Estudiantil Chicanos de Aztlan) chapter for many years. Due to Ed's dedication, the group has become a vibrant and forceful organization that received the Student Organization of 1999 and Social Conscience of 1998 and 1999 awards. At ASU, he also is involved in the Cesar Chavez Leadership Institute for Youth and the ASU Concilio, a student-led council of Hispanic students.

But his work does not end off campus. A former Peace Corps volunteer, Ed is one of the hardest working Latino ''activistas,'' or activist in Arizona who truly exemplifies the ''servant leader'' concept. Originally from Chandler, Ariz., he galvanized the community to fight against the city of Chandler for the unfair detainment of Mexican–American citizens by city police. In 1998, Ed organized the Chandler Coalition for Civil and Human Rights to help Chandler residents explore issues around immigration and to launch a lawsuit against the city government. He has also championed for issues significant to the Latino community as part of the Arizona Hispanic Community Forum. In addition, he works with the Arizona Friends of the United Farm Workers and Centro de Amistad in Guadalupe, Ariz.

Not only is Ed a tireless worker in education and civil rights issues, he spends many hours volunteering for voter registration and political campaigns. He leads by example, working hard in any type of activity that is needed, such as setting up sound systems, driving and talking to voters, walking door-to-door to obtain petition signatures, setting up tables and chairs and putting them away. He is not afraid of doing the ''dirty work'' when needed.

As you can see, Ed leads by example. He is truly an outstanding individual who deserves to be recognized. Therefore I ask you to please join me in thanking my friend Ed Delci and wishing him continued success.

TRIBUTE TO RICHARD MIZE, A TRUE COMPETITOR

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. McINNIS. Mr. Speaker, it is with great pleasure that I take this moment to recognize a man who has proven himself as one of the most successful mountaineers of our time. This man, who is now 63, is still competing and winning. He is a dedicated individual whose hard work deserves to be honored.

Richard Mize has always had a love for skiing. At Western State College in Gunnison, Colorado he took advantage of every opportunity to go skiing. It paid off when he was awarded the 1956 Don Johnson Memorial trophy, which is given to the outstanding American skier in the NCAA cross country championships. He also became a two time, All–American cross country skier. Since college, Richard has gone on to accomplish feats that are equally, if not more, impressive. He competed in the World Biathlon Championship in 1958 and 1959. Also, in 1960 he earned a spot on the U.S. Olympic Biathlon Team, where he placed 21st in the inaugural year of

the event in the Olympics. Since 1983, Richard Mize has competed on the Masters Circuit and, in every year since 1988 he has earned at least one first place finish in the U.S. Masters Division. In 1988, at the World and U.S. Championships in Lake Placid, New York he won the World Championship in the 20K freestyle and 10K classic races. As you can see, this man is a fierce competitor—his accolades however, do not stop there. Richard has won his age group seven times in the last nine years at the Tour of Anchorage 50K Freestyle competition.

Mr. Speaker, there are few people in our time that have accomplished so many amazing feats. Richard has done this and he has continued to do this well into his later years. So it is with this that I say congratulations to this man on his induction into the Mountaineer Sports Hall of Fame.

CELEBRATING THE LIFE OF MURIEL DARLENE GIST WINGATE

HON. JULIAN C. DIXON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. DIXON. Mr. Speaker, today I want to recognize and celebrate the life of Muriel Darlene Gist Wingate, a wonderful and loving mother and grandmother, who for more than 25 years served with distinction as a loyal and outstanding assistant to internationally acclaimed Howard University Hospital oncologist and general surgeon Dr. LaSalle D. Leffall, Jr.

Muriel, or ''Meme'' as she was affectionately known to her family and many friends, passed away on Tuesday, June 8, 1999. Kind, patient, and always ready with a reassuring word, Muriel was the person to whom hundreds of Dr. Leffall's patients turned in times of difficulty. She was the glue that helped many of them hold sway while dealing with troubling medical diagnoses.

For the hundreds of residents and medical students who secured a coveted spot on Dr. Leffall's rotation, she was the surrogate mother, the woman who provided constant encouragement and assurance that with determination, perseverance, stamina, and the same trademark sense of humor which had endeared her to so many and helped her too during periods of difficulty, they would indeed make it through their medical school and/or surgical residency program. As a show of how much she was loved, many of the young doctors and medical students whom she supervised while working with Dr. Leffall, returned to pay their respects at the service celebrating her life, which was held on Thursday, June 17, 1999, at Hemingway Memorial A.M.E. Church in Chapel Oaks, Maryland.

''Miss Wingate,'' as she was respectfully and fondly known to so many of Dr. Leffall's patients, was born in Washington, D.C., on November 11, 1941, to Ruby N. Gist and the late Sherwood Gist. She graduated from Fairmont Heights High School in 1959 and set course on a career in the field of health care. She loved to travel to exotic places, and often regaled others with stories about her adventures. She had a smile that simply illuminated the room, and an eternally optimistic outlook that would become an important and essential asset in her work with Dr. Leffall's patients.

Muriel Darlene Gist Wingate was beloved by many, but cherished most of all by her lovely daughters, Joy Arminta Diggs and Kelly Lynn Wingate, and granddaughter, Camille Nicole Wingate. Her untimely passing also leaves to mourn her loving mother, Mrs. Ruby N. Gist; three sisters: Shirley A. Courtney, Elaine T. Johnson, and Janiero L. Dougans; three brothers: Dennis, Milton, and Gregory, and a host of other relatives.

Mr. Speaker, to have the love, admiration, and respect of your family, friends, and colleagues, is, I believe the ultimate measure of success. Muriel Wingate was blessed with all of these. I am proud to have the occasion to celebrate her memory with my colleagues, and ask that you join me in extending our heartfelt condolences to her family, friends, and colleagues on the passing of a truly exceptional woman.

RECOGNIZING COMMANDER ARTHUR J. OHANIAN

HON. JOHN S. TANNER

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. TANNER. Mr. Speaker, I rise today to recognize Commander Arthur J. Ohanian, United States Navy. Commander Ohanian will retire after 20 years of distinguished and superior service to our country.

In his most recent position he served as the Manpower and Personnel analyst for the Programming, Planning and Development Branch, Chief of Naval Operations Staff. A P–3 Instructor Pilot, Commander Ohanian served in a number of leadership positions in the fleet, including the Commander Naval Education and Training Mobil Training Team. He also served in a number of different positions within squadrons deployed in the Mediterranean.

Commander Ohanian is the recipient of the Meritorious Service Medal, Navy Commendation Medal, and the Navy Achievement Medal.

Again, Mr. Speaker, I am proud to extend my best wishes to Commander Arthur J. Ohanian. May you continue the success you have enjoyed and thank you for your faithful service from a grateful Nation.

CONFERENCE REPORT ON H.R. 1906, AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2000

SPEECH OF

HON. SAXBY CHAMBLISS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Friday, October 1, 1999

Mr. CHAMBLISS. Mr. Speaker, I rise in support of H.R. 1906. H.R. 1906 contains funding for many vitally important programs in agriculture. This bill provides appropriations for those programs that were authorized in the 1996 farm bill. Furthermore, this bill provides important funding for the foundation of agriculture research. Continued research will provide answers that enable farmers to continue to improve efficiency in providing food for our table.

Specifically the bill includes funds for the National Center for Peanut Competitiveness, a program that establishes a broad-based research program directed toward assuring the competitiveness of U.S. peanuts in the world market. Also included is funding to allow the University of Georgia to research tomato spotted wilt virus, a plant virus that has become a major yield-limiting constraint on many important food crops in South Georgia. The bill also contains funds for peanut allergy collaborative research as well as onion research.

In addition, our farmers have once again faced another disastrous year. Farmers who were fortunate to have a crop are faced with the lowest prices in decades. Adverse weather conditions have resulted in another disaster. This bill also contains disaster assistance for farmers who have suffered yet another crop failure. My farmers cannot afford to wait any longer on relief.

Mr. Speaker, I am disappointed that dairy and sanction provisions were not included in the current appropriations bill. The funds appropriated in the bill will aid farmers in surviving another year of adverse weather conditions and low commodity. Peanut and tobacco farmers will all receive aid in the form of market assistance payments, market loss payments or direct payments. The bill also includes funds to replenish the step two cotton program. In addition fruit and vegetable growers along with dairy and livestock producers will receive assistance from this package and other essential measures that are critical to our producers.

This bill is not a cure all. However, it is imperative that we don't delay this funding any longer. I urge all my colleagues to support passage of conference report.

A SALUTE TO BOSTON LAW SCHOOL

HON. EDWARD J. MARKEY

OF MASSACHUSETTS

HON. WILLIAM D. DELAHUNT

OF MASSACHUSETTS

HON. MICHAEL E. CAPUANO

OF MASSACHUSETTS

HON. ROBERT C. SCOTT

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. MARKEY. Mr. Speaker, My colleagues, Messrs. DELAHUNT, CAPUANO, SCOTT and I submit the following proclamation:

Whereas, Boston College Law School was officially founded on September 26, 1929, in the Lawyer's Building at 11 Beacon Street with a class of 22 students, one full-time faculty and three part-time faculty members.

Whereas, after spending nearly 25 years in downtown Boston, the Law School continued its march toward the Heights by joining the Boston College campus community in 1954 at St. Thomas More Hall, under the leadership of the Rev. William J. Kenealy, S.J., the Dean who was charged with building a law school for a new era.

Whereas, it was Rev. Robert F. Drinan, S.J., the sixth dean of the Law School and later member of the United States House of Representatives from Massachusetts, whose foresight and indefatigable spirit brought about the Law School's rise in statute and

transformation from a regional to a highly-respected national law school.

Whereas, Dean Richard G. Huber built upon these traditions in expanding the law school faculty and program, and in 1975 secured the eventual move of the Law School to its current site on the Newton campus, providing urgently needed space for the educational component as well as for students and faculty offices and meeting facilities.

Whereas, under the leadership of Deans Daniel R. Coquillette and Aviam Soifer, the University embarked on a campaign to build a new physical plant for the Law School on its present site, which facility would reflect the breadth and statute of the law school's programs, and which would allow for the full integration of technology in legal teaching and research.

Whereas, we also celebrate a revered member of the Law School faculty, Professor Emil Slizewski, who this year retires from his teaching responsibilities at Boston College Law School after 56 years of distinguished service to the Law School and the legal profession.

Whereas, on October 8, 1999, members of the Law School and the Boston College communities join together in celebration of an institution which has launched the careers of illustrious government officials and leaders in the profession, and which has inspired an unwavering commitment to social justice among its esteemed graduates. After 70 years of academic excellence, students, administrators, alumni and faculty join together today to celebrate the opening of a new academic wing at Boston College Law School.

Now, therefore, I, Congressman Edward J. Markey, hereby request that my colleagues in the United States House of Representatives join me in saluting Boston College Law School as it celebrates 70 years of excellence in legal education.

PROFILES OF SUCCESS HONORS MS. LORRAINE LEE

HON. ED PASTOR

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. PASTOR. Mr. Speaker, I rise before you today to draw attention to the accomplishments of a woman who has long been an activist for all Arizonans and who has is at the ready when it comes to championing for the Latino community and the issues that affect them. The woman of whom I speak is Ms. Lorraine Lee, a good friend and an invaluable community leader in southern Arizona.

Ms. Lee has been the vice president of Chicanos Por La Causa in Tucson for the past 15 years. She is a much esteemed leader who has worked diligently on empowerment, self–sufficiency and goal attainment for not only members of the Tucson community but, Chicanos nationwide.

Recently, Lorraine was recognized at Valle del Sol's Annual Profiles of Success Leadership Awards. Valle's award ceremony is the premiere Latino recognition event in Arizona each year that acknowledges Arizona's leaders and their contributions.

Lorraine received the Special Recognition Award for her efforts in spearheading the anit–Unz initiative in southeastern Arizona and nationwide. This initiative is named after the man who started the movement against bilingual education in California. In Tucson, Unz is trying to bring the same movement to Arizona. But in Tucson, the birthplace of the first official bilingual education program, Lorraine has initiated efforts to raise social awareness in ethnically diverse segments of the community. She is currently working with several community representatives in organizing a coalition to ensure that the Unz initiative does not appear on this year's upcoming ballot. This effort consists of educating citizens from the public and private sector, including politicians and youth, about the importance of bilingual education programs.

But beyond the issue of bilingual education, Ms. Lee has been a well-respected activist in Arizona who does not shy from leadership roles and is ready to take on new challenges to strengthen the Latino community.

That is why I ask you to join me in paying tribute to my friend Lorraine Lee and in wishing her great success.

QUALITY CARE FOR THE UNINSURED ACT OF 1999

SPEECH OF

HON. RON PAUL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 6, 1999

Mr. PAUL. Mr. Speaker, as an MD, I know that when I advise on medical legislation I may be tempted to allow my emotional experience as a physician to influence my views, but nevertheless I am acting the role of legislator and politician. The MD degree grants no wisdom as to the correct solution to our managed care mess. The most efficient manner to deliver medical services, as it is with all goods and other services, is determined by the degree the market is allowed to operate. Economic principles determine efficiency of markets, even the medical care market; not our emotional experiences dealing with managed care.

Contrary to the claims of many advocates of increased government regulation of health care, the problems with the health care system do not represent market failure, rather they represent the failure of government policies which have destroyed the health care market. In today's system, it appears on the surface that the interest of the patient is in conflict with rights of the insurance companies and the Health Maintenance Organizations (HMOs). In a free market this cannot happen. Everyone's rights are equal and agreements on delivering services of any kind are entered into voluntarily, thus satisfying both sides. Only true competition assures that the consumer gets the best deal at the best price possible, by putting pressure on the providers. Once one side is given a legislative advantage, in an artificial system, as it is in managed care, trying to balance government dictated advantages between patient and HMOs is impossible. The differences cannot be reconciled by more government mandates which will only makes the problem worse. Because we are trying to patch up an unworkable system, the impasse in Congress should not be a surprise.

No one can take a back seat to me regarding the disdain I hold for the HMOs' role in managed care. This entire unnecessary level of corporatism that rakes off profits and undermines care is a creature of government interference in health care. These non-market institutions and government could have only gained control over medical care through a collusion among organized medicine, politicians, and the HMO profiteers, in an effort to provide universal health care. No one suggests that we should have ''universal'' food, housing, TV, computer and automobile programs and yet many of the ''poor'' do much better getting these services through the marketplace as prices are driven down through competition.

We all should become suspicious when it is declared we need a new ''Bill of Rights'' such as a Taxpayer's Bill of Rights, or now a Patient's Bill of Rights. Why don't more Members ask why the original Bill of Rights is not adequate in protecting all rights and enabling the market to provide all services. If over the last fifty years we had a lot more respect for property rights, voluntary contracts, state jurisdiction and respect for free markets, we would not have the mess we're facing today in providing medical care.

The power of special interests influencing government policy has brought us this managed care monster. If we pursue the course of more government management—in an effort to balance things—we're destined to make the problem much worse. If government mismanagement, in an area that the government should not be managing at all, is the problem, another level of bureaucracy—no matter how well intended—cannot be helpful. The law of unintended consequences will prevail and the principle of government control over providing a service will be further entrenched in the nation's psyche. The choice in actuality is government provided medical care and it's inevitable mismanagement or medical care provided by a market economy.

Partial government involvement is not possible. It inevitably leads to total government control. Plans for all the so-called Patient's Bill of Rights are a 100% endorsement of the principle of government management and will greatly expand government involvement, even if the intention is to limit government management of the health care system to the extent ''necessary'' to curtail the abuses of the HMOs. The Patients' Bill of Rights concept is based on the same principles that have given us the mess we have today. Doctors are unhappy, HMOs are being attacked for the wrong reasons, and the patients have become a political football over which all sides demagogue.

The problems started early on when the medical profession, combined with tax code provisions making it more advantageous for individuals to obtain first-dollar health care coverage from third-parties rather than pay for health care services out of their own pockets, influenced the insurance industry into paying for medical services instead of sticking with the insurance principle of paying for major illnesses and accidents for which actuarial estimates could be made. A younger, healthier and growing population was easily able to afford the fees required to generously care for the sick. Doctors, patients and insurance companies all loved the benefits until the generous third-party payment system was discovered to be closer to a Ponzi scheme than true insurance. The elderly started living longer, and medical care became more sophisticated, demands because benefits were generous and insurance costs were moderate until the demographics changed with fewer young people

working to accommodate a growing elderly population—just as we see the problem developing with Social Security. At the same time governments at all levels become much more involved in mandating health care for more and more groups.

Even with the distortions introduced by the tax code, the markets could have still sorted this all out, but in the 1960s government entered the process and applied post office principles to the delivery of medical care with predictable results. The more the government got involved the greater the distortion. Initially there was little resistance since payments were generous and services were rarely restricted. Doctors liked being paid adequately for services that in the past were done at discount or for free. Medical centers, always willing to receive charity patients for teaching purposes in the past liked this newfound largesse by being paid by the government for their services. This in itself added huge costs to the nation's medical bill and the incentive for patients to economize was eroded. Stories of emergency room abuse are notorious since ''no one can be turned away.''

Artificial and generous payments of any service, especially medical, produces a well-known cycle. The increase benefits at little or no cost to the patient leads to an increase in demand and removes the incentive to economize. Higher demands raises prices for doctor fees, labs, and hospitals; and as long as the payments are high the patients and doctors don't complain. Then it is discovered the insurance companies, HMOs, and government can't afford to pay the bills and demand price controls. Thus, third-party payments leads to rationing of care, limiting choice of doctors, deciding on lab tests, length of stay in the hospital, and choosing the particular disease and conditions that can be treated as HMOs and the government, who are the payers, start making key medical decisions. Because HMOs make mistakes and their budgets are limited however, doesn't justify introducing the notion that politicians are better able to make these decisions than the HMOs. Forcing HMOs and insurance companies to do as the policitians say regardless of the insurance policy agreed upon will lead to higher costs, less availability of services and calls for another round of government intervention.

For anyone understanding economics, the results are predictable: Quality of medical care will decline, services will be hard to find, and the three groups, patients, doctors and HMOs will blame each other for the problems, pitting patients against HMOs and government, doctors against the HMOs, the HMOs against the patient, the HMOs against the doctor and the result will be the destruction of the cherished doctor-patient relationship. That's where we are today and unless we recognize the nature of the problem Congress will make things worse. More government meddling surely will not help.

Of course, in a truly free market, HMOs and pre-paid care could and would exist—there would be no prohibition against it. The Kaiser system was not exactly a creature of the government as is the current unnatural HMO-government-created chaos we have today. The current HMO mess is a result of our government interference through the ERISA laws, tax laws, labor laws, and the incentive by many in this country to socialize medicine ''American style,'' that is the inclusion of a corporate level of management to rake off profits while draining care from the patients. The more government assumed the role of paying for services the more pressure there has been to managed care.

The contest now, unfortunately, is not between free market health care and nationalized health care but rather between those who believe they speak for the patient and those believing they must protect the rights of corporations to manage their affairs as prudently as possible. Since the system is artificial there is no right side of this argument and only political forces between the special interests are at work. This is the fundamental reason why a resolution that is fair to both sides has been so difficult. Only the free market protects the rights of all persons involved and it is only this system that can provide the best care for the greatest number. Equality in medical care services can be achieved only by lowering standards for everyone. Veterans hospital and Medicaid patients have notoriously suffered from poor care compared to private patients, yet, rather than debating introducing consumer control and competition into those programs, we're debating how fast to move toward a system where the quality of medicine for everyone will be achieved at the lowest standards.

Since the problem with our medical system has not been correctly identified in Washington the odds of any benefits coming from the current debates are remote. It looks like we will make things worse by politicians believing they can manage care better than the HMO's when both sides are incapable of such a feat.

Excessive litigation has significantly contributed to the ongoing medical care crisis. Greedy trial lawyers are certainly part of the problem but there is more to it than that. Our legislative bodies throughout the country are greatly influenced by trial lawyers and this has been significant. But nevertheless people do sue, and juries make awards that qualify as ''cruel and unusual punishment'' for some who were barely involved in the care of the patient now suing. The welfare ethic of ''something for nothing'' developed over the past 30 to 40 years has played a role in this serious problem. This has allowed judges and juries to sympathize with unfortunate outcomes not related to malpractice and to place the responsibility on those most able to pay rather than on the ones most responsible. This distorted view of dispensing justice must someday be addressed or it will continue to contribute to the deterioration of medical care. Difficult medical cases will not be undertaken if outcome is the only determining factor in deciding lawsuits. Federal legislation prohibiting state tort law reform cannot be the answer. Certainly contractual arrangements between patients and doctors allowing specified damage clauses and agreeing on arbitration panels would be a big help. State-level ''loser pays'' laws, which discourage frivolous and nuisance lawsuits, would also be a help.

In addition to a welfare mentality many have developed a lottery jackpot mentality and hope for a big win through a ''lucky'' lawsuit. Fraudulent lawsuits against insurance companies now are an epidemic, with individuals feigning injuries in order to receive compensation. To find moral solutions to our problems in a nation devoid of moral standards is difficult. But the litigation epidemic could be ended if we accepted the principle of the right of contract. Doctors and hospitals could sign agreements with patients to settle complaints before they happen. Limits could be set and arbitration boards could be agreed upon prior to the fact. Limiting liability to actual negligence was once automatically accepted by our society and only recently has this changed to receiving huge awards for pain and suffering, emotional distress and huge punitive damages unrelated to actual malpractice or negligence. Legalizing contracts between patients and doctors and hospitals would be a big help in keeping down the defensive medical costs that fuel the legal cost of medical care.

Because the market in medicine has been grossly distorted by government and artificially managed care, it is the only industry where computer technology adds to the cost of the service instead of lowering it as it does in every other industry. Managed care cannot work. Government management of the computer industry was not required to produce great services at great prices for the masses of people. Whether it is services in the computer industry or health care all services are best delivered in the economy ruled by market forces, voluntary contracts and the absence of government interference.

Mixing the concept of rights with the delivery of services is dangerous. The whole notion that patient's ''rights'' can be enhanced by more edicts by the federal government is preposterous. Providing free medication to one segment of the population for political gain without mentioning the cost is passed on to another segment is dishonest. Besides, it only compounds the problem, further separating medical services from any market force and yielding to the force of the tax man and the bureaucrat. No place in history have we seen medical care standards improve with nationalizing its delivery system. Yet, the only debate here in Washington is how fast should we proceed with the government takeover. People have no more right to medical care than they have a right to steal your car because they are in need of it. If there was no evidence that freedom did not enhance everyone's well being I could understand the desire to help others through coercive means. But delivering medical care through government coercion means not only diminishing the quality of care, it undermines the principles of liberty. Fortunately, a system that strives to provide maximum freedom for its citizens, also supports the highest achievable standard of living for the greatest number, and that includes the best medical care.

Instead of the continual demagoguery of the issue for political benefits on both sides of the debate, we ought to consider getting rid of the laws that created this medical management crisis.

The ERISA laws requiring businesses to provide particular programs for their employees should be repealed. The tax codes should give equal tax treatment to everyone whether working for a large corporation, small business, or is self employed. Standards should be set by insurance companies, doctors, patients, and HMOs working out differences through voluntary contracts. For years it was known that some insurance policies excluded certain care and this was known up front and was considered an acceptable provision since it allowed certain patients to receive discounts. The federal government should defer to state governments to deal with the litigation crisis

and the need for contract legislation between patients and medical providers. Health care providers should be free to combine their efforts to negotiate effectively with HMOs and insurance companies without running afoul of federal anti-trust laws—or being subject to regulation by the National Labor Relations Board (NLRB). Congress should also remove all federally-imposed roadblocks to making pharmaceuticals available to physicians and patients. Government regulations are a major reason why many Americans find it difficult to afford prescription medicines. It is time to end the days when Americans suffer because the Food and Drug Administration (FDA) prevented them from getting access to medicines that were available and affordable in other parts of the world!

The most important thing Congress can do is to get market forces operating immediately by making Medical Savings Accounts (MSAs) generously available to everyone desiring one. Patient motivation to save and shop would be a major force to reduce cost, as physicians would once again negotiate fees downward with patients—unlike today where the government reimbursement is never too high and hospital and MD bills are always at maximum levels allowed. MSAs would help satisfy the American's people's desire to control their own health care and provide incentives for consumers to take more responsibility for their care.

There is nothing wrong with charity hospitals and possibly the churches once again providing care for the needy rather than through government paid programs which only maximizes costs. States can continue to introduce competition by allowing various trained individuals to provide the services that once were only provided by licensed MDs. We don't have to continue down the path of socialized medical care, especially in America where free markets have provided so much for so many. We should have more faith in freedom and more fear of the politician and bureaucrat who think all can be made well by simply passing a Patient's Bill of Rights.

CONGRATULATING PROFESSOR KAY KAUFMAN SHELEMAY

HON. MICHAEL E. CAPUANO

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. CAPUANO. Mr. Speaker, I rise today to extend my congratulations to Professor Kay Kaufman Shelemay. Yesterday, Professor Shelemay was appointed to the Board of Trustees of the American Folklife Center at the Library of Congress; a position she had long sought and no doubt deserved.

Professor Shelemay is profoundly accomplished in the arts. Most of her life has been dedicated to the study and education of music and ethnomusicology. The distinguished author of several publications reflecting the relationship between ethnicity and music, Professor Shelemay has recently served as president of the Society for Ethnomusicology. On two occasions, she has served as a fellow for the National Endowment for Humanities. She was also chairwoman of the Fromm Music Foundation, and she has taught music at several prestigious universities including Harvard, Columbia, and NYU.

Professor Shelemay began her association with AFC as a panelist during 1987 and 1988 in the midst of her burgeoning career. Her involvement with the AFC has spanned over a decade, hence, overseeing operations at the American Folklife Center will come easily for her.

With her background, experience, and passion for ethnomusicology and the folk arts, I am certain Professor Shelemay will be a valuable addition to AFC's Board of Trustees as it pursues programs in the areas of multicultural education, preservation of national archives, and documentation of American Folklife and music.

I wish Professor Shelemay the best of luck in her new role at the American Folklife Center.

RECOGNITION OF OPPORTUNITY, INC.: AN ORGANIZATION THAT LIVES UP TO ITS NAME

HON. JOHN EDWARD PORTER

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. PORTER. Mr. Speaker, I am pleased to rise today to recognize Opportunity, Inc., an outstanding organization located in Highland Park, Illinois. This is truly a remarkable enterprise and a magnificent example of the initiative needed to help people move welfare to work and a better life.

Opportunity, Inc. is a unique, not-for-profit contract manufacturer of single-use medical products that has been registered with the FDA since 1977, and that employs persons with developmental physical and/or emotional disabilities. Founded in 1976 by local construction executive John Cornell, who still serves as an Emeritus member of the Board of Directors, the company will hold its annual ''Handicapable Leadership'' Award Dinner in Chicago on Tuesday, October 16, 1999. The keynote speaker will be Ted Kennedy, Jr., a nationally known spokesperson and a leading advocate for the civil rights of people with disabilities.

The company's mission is twofold: (1) to provide a mainstream plant environment in which Handicapable people can work and earn a paycheck as well as the dignity that comes from being employed productively on a full-time basis; and (2) to provide its private sector customers with the best possible quality, price and service.

As everyone understands, budget constraints compel us to look for ways to effectively address important needs without government subsidies, and Opportunity, Inc. is leading the way in this regard. A model of community response and innovation, the company demonstrates how competitive and productive handicapable employees can be. Opportunity, Inc. built and continues to operate the nation's only not-for-profit, certified class 100,000 ''clean rooms'' for medical and surgical packaging.

When I visited Opportunity, Inc., however, I learned that its business success, while impressive, pales in significance to the positive contributions it has made to its employees' lives. I experienced firsthand how proud, dedicated and competitive they are. As one man said to me, ''Congressman, all we need is a fair chance to compete. That's what we get there at Opportunity and just look at the results!'' Clearly, Opportunity, Inc. is an organization that lives up to its name.

Mr. Speaker, I am proud to represent a congressional district that includes enterprises of this caliber. It is my pleasure to salute the employees, management and directors of Opportunity, Inc., and the Grand Marshall of Ceremonies John Cortesi on the occasion of their annual dinner, and to extend my personal congratulations to Sage Products and Allegiance Healthcare, who are the recipient of this year's Handicapable Leadership Award.

CONFERENCE REPORT ON H.R. 2606, FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 2000

SPEECH OF

HON. ROBERT WEXLER

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 5, 1999

Mr. WEXLER. Mr. Speaker, I rise in strong opposition to the Foreign Operations conference report.

America loses when we fail to properly fund our foreign operations budget. The report we are considering is almost $2 billion below the level requested by President Clinton and $1 billion below last year's budget.

Without adequate funding for our international affairs operations, we will not be equipped to protect the security and the prosperity of Americans at home and abroad, and we risk losing our status as the world's remaining superpower.

American foreign policy should not embrace the short-sighted views of isolationists. Instead, we should meet the myriad of challenges facing the global community. America is at its best when we promote our values abroad by supporting struggling democracies and their efforts to make the transition to market economies.

Mr. Speaker, this conference report provides no Wye Aid funding which we promised our partners in the Middle East. It fails to provide adequate funding for emerging democracies in Africa and fails to assist our neighbors in the Western Hemisphere. It also ignores the needs of Asian countries recovering from financial devastation.

But the greatest disgrace of this conference report is our failure to lend a helping hand to the world's children. The children of Sierra Leone, for example, who have suffered the violent amputation of their limbs, sexual abuse, displacement from their homes, and the ravaging to their innocence and youth, lose yet again when we cut our foreign aid and humanitarian assistance. Programs to provide them food and medical intervention and to return them to their homes and neighborhoods can never succeed. And yet, what greater humanitarian purpose can our foreign policy serve than to bring prosthetic arms and hands to babies whose entire lives lie ahead of them?

I urge my colleagues to join me today and defeat this poorly funded conference report. America's front line of foreign policy should not be shortchanged.

RECOGNIZING BISHOP CHARLES BUSWELL

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. McINNIS. Mr. Speaker, I would like to take a moment to recognize a man whose dedication to his faith and community is unparalleled. Bishop Charles Buswell served selflessly as a priest for 60 years and this year marks 40 years since he was ordained bishop.

Bishop Buswell was born in Kingfisher, Oklahoma in July 1939. There, he served in a variety of positions in the diocese and also founded a parish, Christ the King. In September 1959, he was ordained Bishop of Pueblo. It was at this point in time he was elected to the Second Vatican Council in Rome, which he called the most significant event of his lifetime. There, during his service from 1962 to 1965, he was one of 2,500 Catholic bishops who discussed possible liturgical changes with Pope John XXIII. For Bishop Buswell it was an exciting time in which he felt he could truly make a difference. He is now one of only thirty living American bishops who attended the Council.

Bishop Buswell took on tough issues of the time. He led the way on issues such as antiwar, racism, just wages, and women's causes both in and out of the Church. Today, long after his 1979 resignation, he is regarded as a prominent clerical figure in the peace movement.

It is with this, Mr. Speaker, that I say thank you to a man who had a truly remarkable career of giving his time to help others. I would also like to recognize the 40th anniversary of his consecration as a bishop. The people of Colorado and every corner of the United States owe a debt of gratitude to this man who has fought so hard to make a difference.

TRIBUTE TO LEWIS E. PLATT

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Ms. ESHOO. Mr. Speaker, I rise today to honor Lewis E. Platt, Chairman of the Board, President and Chief Executive Officer of Hewlett-Packard who is retiring after 33 years of service to the Company.

Hewlett-Packard has flourished under Lew Platt's leadership. The Company, based in the heart of Silicon Valley, Palo Alto, has increased its revenues every year since Mr. Platt was elected President and Chief Executive Officer.

But Lew Platt's success cannot be measured by sales figures only. Lew Platt took it upon himself to create a workplace second-to-none in its acceptance of women and minorities. Because of his passion and commitment to create a level playing field for all his employees, he built upon the established ''HP Way,'' to the much-celebrated corporate values instituted by the Company's founders Bill Hewlett and David Packard. And because of Lew Platt's leadership, Hewlett-Packard is consistently among the top ten of Fortune's Best Companies to Work For in America.

Mr. Platt has focused Hewlett Packard's corporate giving on three objectives: significantly improving K–12 science and math achievement, increasing the number of women and minorities studying and teaching science and mathematics, and ensuring that all children are ready to learn when they begin school. Under Mr. Platt's guidance, the Company has donated approximately $55 million each year to education.

Lew Platt's leadership has extended well beyond Hewlett-Packard. In 1995, he was appointed by President Clinton to the Advisory Committee on Trade Policy Negotiations. He has served as Chairman of one of its three task forces, the World Trade Organization Task Force. He also serves on the Cornell University Council and the Wharton School Board of Overseers.

Lew Platt has also exemplified the best in leadership in his own community—Silicon Valley. In 1996, he was elected Co-Chair of the Board of Directors of Joint Venture: Silicon Valley, an organization formed to strengthen our local economy and help make our region a better place to live for everyone. Under his leadership, Joint Venture: Silicon Valley has launched a number of initiatives that bring people together from business, government, and education to identify and act on regional issues affecting our economic vitality and our quality of life. He has also served as a member of the California Business Roundtable.

Mr. Platt's leadership in California's 14th Congressional District and Silicon Valley which I'm so privileged to represent is a model for all to follow. Through his extraordinary leadership of H–P and the industry, Lew Platt has contributed mightily to our community and our country.

I ask my colleagues to join me in saluting Lew Platt for who he is and all he has done. We are indeed a better country and a better people because of this man.

CONGRATULATING MR. LEWIS E. PLATT

HON. ZOE LOFGREN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. LOFGREN. Mr. Speaker, today I wish to congratulate Mr. Lewis E. Platt, Chairman of the Board, President, and Chief Executive Officer of the Hewlett-Packard Company, who is retiring after six years as Chairman of the Board and 33 years of service to the Hewlett-Packard Company. A friend and a neighbor in Silicon Valley from the beginning of his tenure with HP, Lew Platt has understood the importance both of giving back to the community that has given so much to his company and of improving the cities in which he lives and does business. In 1996 Mr. Platt was elected Co-chair, along with San Jose Mayor Ron Gonzales, of the Joint Venture Silicon Valley (Calif.) Network, an organization formed in 1991 to strengthen the local economy and make the area a better place in which to live.

Yet by far, Mr. Platt's greatest contributions to my constituents in Silicon Valley and to the nation as a whole have come through the educational programs he has established and sponsored through Hewlett-Packard, aiding students at all levels of school. Lewis Platt has focused HP's national efforts around three stated company goals: significantly improving K–12 science and math achievements, increasing the number of women and minorities studying and teaching science and mathematics, and ensuring that all children are ready to learn when they begin school.

These platitudes might ring hollow were they not backed by substantive action, but under Mr. Platt's guidance Hewlett-Packard has established a tremendous philanthropy program in order to truly provide help to students of all ages. Because of Lew Platt's efforts and commitment, HP currently donates approximately $55 million each year to education, with $8 million going towards K–12 education. In my district, for instance, Hewlett-Packard has helped sponsor the San Jose Diversity in Education Partnership with San Jose State University, East Side Union High School District and Alum Rock Elementary School District. This initiative aims to increase the number of students who are prepared for college and interested in careers in engineering, and has worked with HP's Email Mentor Program, another initiative begun under Lew Platt, encouraging 5th through 12th graders to remain interested in math and science.

Mr. Platt has also helped establish a partnership between Hewlett-Packard and Independence, Silver Creek, and Overfelt High Schools in San Jose to encourage students to stay in school and continue their education after graduation from high school. The benefits of Lew Platt's belief in education, however, stretch far beyond the neighborhood of Hewlett-Packard's corporate headquarters in California. Under the guidance of Mr. Platt, Hewlett-Packard has undertaken and funded similar educational initiatives in Washington, Oregon, Colorado, Idaho, Georgia, Maryland, Delaware, and Massachusetts.

These broad educational efforts, which have meant so much to my constituents and to students across the country, have in many ways been a direct result of Lew Platt's vision, and for this all people who care about the education of our children owe him a debt of gratitude. Wrote Mr. Platt in an open company letter, ''At HP, we recognize that supporting education is one of the most important things we can do to realize success for future generations, for our company, and for society as a whole.'' Lew Platt's corporate achievements at the Hewlett-Packard Company will be long remembered, the successes of the children he helped educate through HP will remain as an even stronger living reminder of the fine work he has done.

TRIBUTE TO MICHAEL CATANEO

HON. ROBERT L. EHRLICH, JR.

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. EHRLICH. Mr. Speaker, recently the City of Baltimore lost a beloved and respected gentleman, Mr. Michael Cataneo. ''Big Mike'' as he was widely known throughout his long career on the docks of Baltimore owned Cataneo Line Service, truly an example of the American Dream. His family immigrated from Italy, built the business from scratch and became a leading force in the development of the Port of Baltimore.

Those who knew ''Big Mike'' often referred to him as the walking encyclopedia of the Baltimore waterfront—not only could he relate every facet about every ship that had ever been in the port of Baltimore, but he could provide one with all of his information, be it good or bad, about every person who worked on the waterfront, and all the politicians downtown, as well!

''Big Mike'' will be remembered for his hard work, compassion, and sense of humor; for being a respected business leader; and for his contributions on behalf of the working men and women of the Port of Baltimore. The priest who presided at his funeral characterized Mike as a person who related to the little guy. His treated everyone with the same respect others showed him. Mike would help a needy person because he wanted that person to then be able to help others.

He and his lovely wife, Annie, were residents of Lutherville, Maryland and the Second Congressional District of Maryland for 38 years, and it has been my honor to represent them in Congress.

HONORING IRENE HANSON

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. KILDEE. Mr. Speaker, I rise today to recognize the accomplishments of a woman, who, for nearly 40 years, has worked to improve the quality of life for our citizens. On Tuesday, October 12, members of Flint's International Institute will gather to present to Mrs. Irene Hanson, its prestigious Golden Door Award, given annually to an individual who has made a positive impact on the greater Flint community and the Institute itself.

Born in December of 1920, in Breslau, Germany, what is now Wroclaw, Poland, Irene spent her early years as an apprentice in a wholesale paper company, and upon completing her apprenticeship, remained with the company as its bookkeeper.

After the war, Irene and her family, including her mother and two daughters lived in Hanover, West Germany, until the Displaced Persons Act brought them to Flint in 1952, under the sponsorship of Calvary Lutheran Church. Soon after, a third child, a son, was born.

After settling in Flint, Irene sought out and forged a relationship with the International Institute, a relationship that has continued to this day. She has served a great number of roles, including teacher, presenter, activities chair, and board member. It is in each of these positions that she has excelled in her efforts to enhance the lives of those she comes into contact with. Other positions followed, such as in 1962, where she worked as a receptionist, bookkeeper, and fitter at Flint Limb and Brace Company. In 1964, Irene began teaching German for Mott Adult Education, which she still continued to do.

In addition to her work with the International Institute, Irene has also been involved and remains active with the German American National Congress, the American Association of Teachers of German, and the St. Cecilia Society. She has also been an avid supporter of the Flint Institute of Music, Flint Institute of Arts, and the Sloan Museum.

Mr. Speaker, I am always fascinated by stories such as Irene Hanson's. Through tremendous adversity, she was able to fulfill the true American Dream, and find success in her new homeland. She is truly an inspiration to all who come into contact with her. I ask my colleagues in the 106th Congress to please join me to congratulate and wish Irene the very best.

HONORING BISHOP VERNON RANDOLPH BYRD, 105TH BISHOP OF THE AFRICAN METHODIST EPISCOPAL CHURCH

HON. KAREN McCARTHY

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Ms. MCCARTHY of Missouri. Mr. Speaker, I rise to honor the newly elected and consecrated Bishop of the African Methodist Episcopal (AME) Church, the Right Reverend Vernon Randolph Byrd. He joins Rev. Dr. W. Bartalette Finney, Sr., Presiding Elder, Rev. Ralph J. Crabbe, and leaders in our community who contribute to the spiritual needs of our greater metropolitan area.

Bishop Byrd's spiritual education began at the age of twelve when he received his call to preach. By the time he was a teenager, he was ordained to preach by the late Bishop Frank Madison Reed, Sr. Bishop Byrd was a success In school and graduated from the public schools of South Carolina, and earned degrees at Allen University, and Boston University.

Prior to his tenure at the Northwest Missouri Conference Fifth District AME Church in Kansas City, Bishop Byrd served as a Pastor and Presiding Elder at several churches. His ministry served congregations including the Macedonia AME Church in Delware, the St. Paul AME Church in Bermuda, the Newark District-New Jersey Conference, the Macedonia AME Church in New Jersey, the Morris Brown AME Church in Pennsylvania, and the St. James AME Church in New Jersey.

In 1984, Bishop Byrd was elevated to the episcopacy at the seat of the Forty-Second Quadrennial Session of the General Conference. A recipient of numerous awards, he has been honored with the Trumiunz Award for outstanding work with retarded children in Delaware. He was recognized as an Honorary Member of the British Empire Medal by Her Majesty Queen Elizabeth II, who bestowed the award to him for helping bring order to the Bermuda Isles during a period of civil unrest in 1964. Byrd was also named the 1966 Outstanding Young Man of the Year by the Bermuda Chamber of Commerce and given an Honorary Doctorate Degree from the Payne Theological Seminary in 1994.

Always involved with his community, he is an active member of civil and fraternal organizations, the Phi Beta Sigma Fraternity, the Royal Masonic Lodge of Scotland, and the NAACP. Bishop Byrd is married to retired school teacher, Theora Lindsey Byrd who serves the Church as the Women's Missionary Society Supervisor where they teach to others that ''Unless Souls Are Saved * * * Nothing Is Saved!'' They are the parents of two daughters and two sons and grandparents to six grandchildren.

Mr. Speaker, I am proud to acknowledge and congratulate Bishop Vernon Randolph Byrd as the 105th Bishop of the African Methodist Episcopal Church.

RECOGNIZING RILEY HOSPITAL FOR CHILDREN'S 75TH BIRTHDAY

HON. JULIA CARSON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Ms. CARSON. Mr. Speaker, it is with a great deal of pleasure that I rise today to celebrate Riley Hospital for Children's 75th birthday.

Founded in 1924, Riley Hospital is named after the famous Hoosier poet, James Whitcomb Riley. Upon his death in 1916, Mr. Riley's heartfelt love for children inspired his friends to decide that a children's hospital would be a perfect memorial for Mr. Riley. More than 40,000 Hoosiers gave over 1.2 million dollars to build the James Whitcomb Riley Hospital for children.

As the New York Times observed on October 10, 1924, ''Indiana has made her monument [to Riley] one of ministry rather than of mourning . . . The institution which bears his name will do much to make the children of Indiana what he imagined them to be. Indiana has made, as human monuments go, the perfect memorial to her poet.''

Since opening its doors on October 7, 1924, Riley Hospital for Children has cared for thousands of children from the City of Indianapolis, the State of Indiana, and indeed across the country. Annually, there are more than 135,000 patient visits, including 7,100 admissions and more than 128,000 outpatient visits. Riley Hospital cares for children from each of Indiana's 92 counties. In 75 years, no Hoosier child has been turned away because of an inability to pay.

To continue to meet the needs of children and families, Riley Hospital has grown as it spanned the decades of the 20th century. Today, Riley Hospital is one of the ten largest children's hospitals in the nation, and is Indiana's only children's hospital located on a university campus. It is also one of the two most care-bedded children's hospitals in the United States.

As it has grown, Riley Hospital has endeavored to maintain a standard of excellence respecting patient care. In 1971, Indiana's only pediatric burn unit opened at Riley Hospital. In 1989, Riley Hospital performed Indiana's first newborn and infant heart transplants. Eighty to Ninety percent of Indiana's children with cancer are treated at Riley Hospital's—and Indiana's only—Children's Cancer Center. In addition, Riley Hospital houses the only pediatric dialysis center and pediatric stem cell transplant unit in the State of Indiana.

Though the medical technology at Riley Hospital is remarkable, it is the caring staff that the children and their families depend on to see them through difficult circumstances and turbulent times. Whether it be a doctor, nurse, therapist, social worker, teacher, administrative staff or maintenance worker, their professionalism is unparalleled.

Mr. Speaker, the children, families, and communities of Indiana have been enriched by the life-saving work of Riley Hospital for Children. As we approach the threshold of the

21st Century, I am confident that this wonderful tribute to James Whitcomb Riley will continue to make a brighter horizon for our children.

LEGISLATION TO AUTHORIZE REHABILITATION OF THE MUNICIPAL WATER SYSTEM ON THE JICARILLA APACHE RESERVATION

HON. TOM UDALL

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. UDALL of New Mexico. Mr. Speaker, today I rise to introduce a bill to authorize and direct the Bureau of Reclamation to conduct a feasibility study with regards to the rehabilitation of the municipal water system of the Jicarilla Apache Reservation, located in the State of New Mexico. I am very pleased to be joined by several of my colleagues in the introduction of this important bill—including the other two Representatives from New Mexico, Congressman SKEEN and Congresswoman WILSON; as well as Congressmen KILDEE, HAYWORTH, YOUNG, MILLER, KENNEDY, and BECERRA.

Sadly, Mr. Speaker, the Jicarilla Apache Reservation relies on one of the most unsafe municipal water systems in the country. While the system is a federally owned entity, the Environmental Protection Agency has nevertheless found the system to be in violation of national safe drinking water standards for several years running—and, since 1995, the water system has continually failed to earn renewal of its National Pollutant Discharge Elimination permit.

The sewage lagoons of the Jicarilla water system are now operating well over 100 percent capacity—spilling wastewater into the nearby arroyo that feeds directly into the Navajo River. Since this river serves as a primary source of groundwater for the region, the resulting pollution of the stream not only affects the Reservation but also travels downstream—creating public health hazards for families and communities both within and well beyond the Reservation's borders. Alarmingly, Jicarilla youth are now experiencing higher than normal incidences of internal organ diseases affecting the liver, kidneys and stomach—ailments suspected to be related to the contaminated water.

Moreover, because of the lack of sufficient water resources, the Jicarilla Tribe is not only facing considerable public health concerns, but it has also necessarily had to put a brake on other important community improvement efforts, including the construction of much needed housing and the replacement of deteriorating public schools. For all of these reasons, the Tribal Council has declared a state of emergency for the Reservation and has already appropriated over $4.5 million of its own funds to begin the process of rehabilitating the water system.

Following a disastrous 6-day water outage last October, the Jicarilla investigated and discovered the full extent of the deplorable condition of the water system. Acting immediately to address the problem, the tribe promptly contacted the Bureau of Indian Affairs, the Indian Health Service, the Environmental Protection Agency and other entities for help in relieving their situation. Yet, due to budget constraints and other impediments, these agencies were unable to provide financial assistance or take any other substantial action to address the problem. In particular, the Bureau of Indian Affairs, having found itself to be poorly suited for the operation and maintenance of tribal water systems, has discontinued its policy of operating its own tribal water systems in favor of transferring ownership directly to the tribes. Unfortunately, however, the dangerous condition of the Jicarilla water system precludes its transfer to the tribe until it has been rehabilitated.

Fortunately, the Bureau of Reclamation is appropriately suited to assist the Jicarilla Apache and the BIA in assessing the feasibility of rehabilitating the tribe's water system. In consultation with the Jicarilla Tribe, the Bureau of Reclamation has indicated both its willingness and its ability to complete the feasibility study should it be authorized to do so as required by law. Recognizing this as the most promising solution for addressing the serious water safety problems plaguing the Jicarilla, I and my fellow cosponsors are introducing this important bill to allow this process to move forward. I hope the rest of our colleagues will similarly join us in passing this bill to remedy this distressing situation.

A TRIBUTE IN HONOR OF BAY COUNTY WOMEN'S CENTER

HON. JAMES A. BARCIA

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. BARCIA. Mr. Speaker, I rise today to pay tribute to an organization which has done much to increase awareness of domestic violence in the United States as well as in my home town of Bay City, Michigan. The Bay County Women's Center provides essential support services for victims of physical or sexual assault, many of whom are women in violent domestic situations.

The Women's Center was established in 1975 by twelve dedicated volunteers who had recognized the need for a local support organization which provided essential services for abused persons. The Center now offers victims a wide range of crisis intervention services, such as counseling, advocacy, information and referral services, as well as extensive community education services. This means that a woman who is being abused has someone to turn to twenty-four hours a day, 365 days a year. The Women's Center has truly proved to be the saving grace for thousands upon thousands of women.

Mr. Speaker, the statistics on domestic violence are staggering. Approximately one family in three will experience domestic violence. And in our country, four women are killed each day by their husband or partner. The victim is killed by someone who, if one uses traditional marriage vows, has promised ''to cherish and honor until death do us part''—which, of course, is a far cry from ''to cherish and honor until I decide to kill you''. Battery and abuse are particularly horrific because they destroy a sacred bond through violence, and leave these women isolated from their community, their family and in mortal fear of their partner.

The Bay County Women's Center, funded in part by the United Way of Bay County, and sustained by many dedicated and caring individuals, is an organization which is a model for all community agencies devoted to protecting adults and child victims against domestic violence and sexual assault. This month is designated National Domestic Violence Awareness Month, and to mark this, the Women's Center plans their annual Candlelight Vigil for survivors to domestic violence. The Center is committed to ending domestic violence in Bay County, and for that very fact, it deserves our respect. Mr. Speaker, I invite you and all our colleagues to join me in honoring the work of the Bay County Women's Center. May I also offer my deepest condolences to the victims of domestic violence, and my support for all the survivors. It is my sincerest hope that with the guiding example of the Bay County Women's Center, we can all join together to work against the horrific crime of domestic violence and abuse.

PERSONAL EXPLANATION

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. KENNEDY of Rhode Island. Mr. Speaker, on October 4, 1999, I was unavoidably detained and consequently missed two votes. Had I been here I would have voted: ''Yes'' on the passage of H. Res. 181. ''Yes'' on the passage of H.R. 1451.

CONGRATULATIONS TO FRANZ FRUEHWIRTH ON HIS INDUCTION TO THE FLORICULTURE HALL OF FAME

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. CUNNINGHAM. Mr. Speaker, my district in San Diego is home to some of our nation's largest flower growers. This industry plays a key role in the economy of San Diego County, the state of California, and the entire country. Flower growers, wholesalers, and retail shops produce a product that makes all of our lives more beautiful.

Last week, the Society of American Florists recognized the achievements of two outstanding individuals in the floral industry. I want to personally commend one of those individuals, who also happens to be my constituent. The Society of American Florists gave out its highest award—induction into the Floriculture Hall of Fame—to Franz Fruehwirth, a scientist, inventor and breeder for the Paul Ecke Ranch, in Encinitas, California.

We should thank Franz every time a poinsettia—the number one flowering potted plant in the United States—is bought, sold and enjoyed. As one of the premier poinsettia breeders in the world, Franz has created many ''firsts,'' including Lilo, the first long-lasting, dark leaf poinsettia that set the standard for all future varieties. He also created the first yellow poinsettia, ''Lemon Drop.'' He bred the

classic Freedom poinsettia, which now represents more than 60 percent of the poinsettia production in the United States.

Franz is more than a plant breeder. He is also responsible for developing the first hanging basket container and the first self-watering container. He also premiered a technique to produce the poinsettia in a tree form. He has shown his dedication to the floral industry as a 31-year member of the Ohio Florists' Association and the San Diego County Flower Growers Association.

In his acceptance speech, Franz simply said that he had been privileged to spend his life doing what he really considers to be fun: playing with his plants and seeing what new and exciting varieties he can develop. What a great lesson for all of us: here is a man who, by loving his work and devoting his life to that love, has given a great gift to us all.

Few of us can remember a time when Christmas celebrations did not include the poinsettia, but we would not have poinsettias at Christmas time without Franz Freuhwirth. The floral industry, my good friend Paul Ecke, of the Paul Ecke Ranch, and all of us in America are fortunate to have Franz Fruehwirth, who has changed American floriculture forever. And I am very proud to have him as my constituent.

I have attached an article from the San Diego Union Tribune that further highlights Mr. Fruehwirth's career.

POINSETTIA BREEDER RECOGNIZED WITH A SLOT IN HORTICULTURAL HALL OF FAME

(By Dan Kraft)

Ecke, now that's a name synonymous with poinsettias.

Franz Fruehwirth's name may not be as well-known, but he, too, has been instrumental in the proliferation of the popular plants.

Fruehwirth's contributions to the floral industry were recognized in Tucson last week, when he was inducted into the Society of American Florists' Floriculture Hall of Fame at the group's annual convention.

Fruehwirth, 66, is the chief breeder, or hybridizer, at the Paul Ecke Ranch in Encinitas, which claims to be the world's largest producer and breeder of poinsettias. For the latter half of that claim, they have Fruehwirth to thank.

Although Ecke sells about 500,000 poinsettias grown in its own greenhouses each Christmas season, its genetic work has been licensed to growers around the globe and accounts for about 80 percent of poinsettias sold in the world. That genetic work is largely Fruehwirth's.

''Until he started breeding, almost all the poinsettias in the world had been mutations,'' said Marc Cathey, president emeritus of the American Horticultural Society and one of those who wrote letters recommending Fruehwirth for induction. ''He is unique because he has no scientific training to do what he does, yet he has beat all the big boys in the world.''

Fruehwirth, a native of Hungary, immigrated to the United States from Germany in 1960 with his wife, Lilo, and their daughter Monika. He was 27 at the time and did not speak English. He worked at a tailor's shop in Oceanside when Paul Ecke Jr., a customer at the shop, hired Lilo as a housekeeper and nanny and offered Fruehwirth a job caring for his plants. That was in 1962, at a time when the ranch was converting from field-grown plants to greenhouses.

''Very quickly it became obvious that he was intelligent and creative, and Dad and Grandpa began promoting him,'' said Paul Ecke III. ''He was instrumental in figuring out how to grow the poinsettias inside.''

In 1968, Fruehwirth introduced the first new poinsettia genetics created at the Ecke Ranch. In 1991, a new variety he bred, called Freedom, was introduced. Today, it accounts for 60 percent of the poinsettias sold in the United States and Canada.

''I feel there are a lot of people who deserve recognition like this, and I'm very fortunate that I have the honor,'' Fruehwirth said. ''I love my work and am humbled to get (the Hall of Fame induction).''

According to the Society of American Florists, induction into its Hall of Fame is reserved for those who have made a unique contribution to the industry and changed the way it does business.

''Most of those honored have a Ph.D. or are owners of major floral companies,'' Cathey said. ''It's very rare for someone like Franz to receive this award.''

During his 37-year tenure with the Eckes, Fruehwirth's ''cultivars'' have become increasingly dark in color and hearty, which enables florists to ship the plants greater distances and gives them a longer shelf life.

Fruehwirth, who lives in Encinitas with his wife, has no plans to retire. He is still hard at work evaluating the potential of 6,000 to 10,000 seedlings each year.

''As long as I have a positive influence, I'll keep working'', he said in Tucson last week. ''I still can't believe (the honor).''

A TRIBUTE TO PAYNE & DOLAN, INC., WINNER OF A 1999 EXEMPLARY VOLUNTEER EFFORTS AWARD FROM THE U.S. DEPARTMENT OF LABOR

HON. GERALD D. KLECZKA

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. KLECZKA. Mr. Speaker, I rise today to bring attention to an exemplary act of community spirit and corporate citizenship. A company located in Wisconsin's Fourth Congressional District, Payne & Dolan, Incorporated, a Waukesha, Wisconsin-based highway construction company, has been named a 1999 recipient of the prestigious Exemplary Volunteer Efforts (EVE) Award from the U.S. Department of Labor.

The Department of Labor has recognized Payne & Dolan for an innovative minority hiring, training and development program that has provided outstanding opportunities for more than 160 minorities and women and invested more than $3 million into Milwaukee's central city.

Payne & Dolan is the first highway construction company ever to receive this award. The company's comprehensive equal opportunity program includes proactive hiring efforts in Milwaukee's central city, community involvement and partnerships, scholarships, employee training and development, minority business mentoring and more.

The company has worked with the YWCA of Greater Milwaukee, the Wisconsin Department of Transportation and other community partners to develop a pilot program called Transportation Alliance for New Solutions, or TrANS. This program recruits and raises awareness of industry opportunities among minorities and women.

In addition, Payne & Dolan helped spearhead development of the Central City Workers' Center (CCWC), a centralized ''one-stop shop'' to link highway contractors with potential employees. This one-of-a-kind collaboration among unions, government, industry and community-based organizations seeks to provide family-sustaining incomes to a minimum of 150 central city residents over the next two years.

Payne & Dolan's success stories are the life stories of people like Sean McDowell, who began working for Payne & Dolan in 1993 and today, with the company's guidance and support, owns his own asphalt company. People like Roger Carson, who was hired as a laborer in 1991 and has been a foreman for two years. And people like Wendy Young, who was hired as an unskilled laborer in 1994 and is now an apprentice operating engineer.

Mr. Speaker, I would like to recognize the contributions and commitment of Payne & Dolan and its CEO, Ned Bechthold, as well as salute the employees who have worked hard to make this equal opportunity program succeed and to make the EVE award possible. It is clear that Payne & Dolan is building much more than highways—it is also building a direct path to opportunity. I commend Payne & Dolan, and I commend the United States Department of Labor for its recognition of this outstanding corporate citizen.

GERMAN-AMERICAN DAY

HON. ROD R. BLAGOJEVICH

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. BLAGOJEVICH. Mr. Speaker, I rise today to celebrate German-American Day and the many great contributions German-Americans made to our society. Through their loyalty, determination, spirit, and culture, German-Americans have significantly enriched the lives of all Americans.

In 1987, Congress formally recognized the achievements of German-Americans by proclaiming October 6th to be German-American Day. As we celebrate this October 6th, the thirteenth celebration of German-American Day, all Americans have the opportunity to reflect upon the cultural legacy of German-Americans.

America's German heritage predates our nation's independence. Our first German immigrants arrived in Philadelphia in 1683. Since that time, America has enjoyed the immeasurable contributions of such creative German-American minds as Carl Schurtz, Baron von Steuben, Levy Strauss, John Jacob Astor, and Peter Zenger. More recently, the works of Albert Einstein, Wernher von Braun, and Henry Kissinger are testimony to the industriousness, loyalty, and talent of German-Americans.

In addition to the contributions of these German-Americans, 57 million Americans of German descent have helped enrich America through their participation in the workforce and the arts. In the 1990s, when my home city of Chicago experienced rapid growth, German immigrants arrived in their largest numbers. By sharing their industry and arts with our city, they helped Chicago become one of the world's great cities. Although Germans were only twenty-nine percent of the city's population, they constituted fifty percent of the city's bakers, forty-four percent of brick and

tile makers, and thirty-seven percent of machinists. While German-American craftsmen and skilled workers fueled Chicago's industrial growth, German art, music, and literature also helped mold the cultural developments of the city.

After the Great Fire of 1871, German-Americans took an active role in rebuilding Chicago. Their efforts can be seen even today in the city's world renowned architectural beauty. The Chicago Symphony Orchestra was founded by a German-American violinist and flourished due to talented German musicians who made Chicago's Symphony Orchestra into one of the world's greatest musical institutions. In addition, German theater introduced the classical works of Schiller and Geothe as well as many other European works.

While the contributions of German-Americans have shaped American cultural and industrial development, they are easily overlooked, largely because they have been overwhelmingly embraced by Americans and are now thought of as simply ''American.'' October 6, 1999 once again calls attention to all Americans of German descent and their contributions to the vibrancy and strength of the United States.

ABRAHAM LINCOLN BICENTENNIAL COMMISSION ACT

SPEECH OF

HON. BARON P. HILL

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Monday, October 4, 1999

Mr. HILL of Indiana. Mr. Speaker, I want to offer my full support of H.R. 1451, the Abraham Lincoln Bicentennial Commission Act.

This bill would authorize the creation of the Abraham Lincoln Bicentennial Commission, a group charged with the responsibility of recommending to Congress activities to celebrate the bicentennial of President Lincoln's birth.

I am particularly pleased that the bill has been amended to include commission members from my home state of Indiana.

This is important because many people don't realize President Lincoln spent 14 years of his life on a small farm in Lincoln City, Indiana. There he helped his father on the farm and developed his love of reading. It was in Lincoln City that he also lost his mother, Nancy Hanks Lincoln, when he was nine years old. These events during his formative years in Indiana contributed greatly to the development of President Lincoln's extraordinary character.

Mr. Speaker, the residents of Indiana are proud of this heritage. H.R. 1451 will help highlight the extraordinary life of our 16th president. No commemoration would be complete without noting southern Indiana's part in the Abraham Lincoln story. I encourage all Americans wishing to learn more about this American hero to visit Lincoln City, Indiana, and the Lincoln Boyhood National Memorial.

I am pleased Congress is taking the initiative to promote and support the commemoration of such a remarkable figure in our American history.

RAY SAUL HONORED

HON. PAUL E. KANJORSKI

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. KANJORSKI. Mr. Speaker, I rise today to pay tribute to a distinguished journalist, community leader, and close friend from my District in Hazleton, Pennsylvania—Ray Saul. This month, the Sons of Italy Lodge 1043 will honor Ray as ''Italian American of the Year.'' I am pleased to have been asked to participate in this event.

A native of Hazleton, Ray is a graduate of Hazleton High School and Penn State, where he earned a Bachelor's degree in journalism. He was the editor of his college yearbook and was cited by the All College Board for outstanding achievement as a student leader. A Navy veteran of World War II, Ray entered the service as an apprentice seaman and retired as a Lieutenant Commander after a combined 21 years of active and reserve service.

Ray is best known to the community for his 47 years of dedicated journalism at the Hazleton Standard-Speaker newspaper. Ray was sports editor at the Standard-Speaker for twenty-seven years and managing editor for the last fifteen years. Since his retirement in 1997, he continues to write sports columns and other features for the newspaper. As a journalist, Ray was an active member of the Associated Press Sports Editors Association and the Managing Editors Association.

In 1995, he was honored by the Department of Defense for his feature stories of various Hazletonians serving in World War II. Ray received an Associated Press Citation for a story on a local basketball team's success. In recognition of his writing and participation in sports, he was honored by several chapters of the Pennsylvania Sports Hall of Fame and the PIAA District 2.

Ray Saul has always recognized the unique responsibilities inherent in leading a local newspaper which is truly the voice of its community. Under his leadership, the Standard-Speaker could be relied on for fair and accurate reporting of stories important to the Greater Hazleton area. Ray always put the interests of the community first.

Ray's accomplishments are far reaching into the community as well. He is an active Kiwanian and has been awarded the International Tablet of Honor once and the Kiwanian of the Year twice. He has been an active Penn State alum, helping to raise funds for new buildings on the Hazleton Campus. In 1984, he was the fifth person in the then-50 year history of the Hazleton campus to receive the Penn Stater Award, for outstanding service to the university.

Mr. Speaker, Ray is the son of the late Santo Saul and Genevieve DeJoseph. All four of his grandparents were Italian immigrants. From his distinguished Navy career his beloved journalism career, Ray is a true example of an American success story. Even in retirement, he and his wife Nell are respected, active members of the community. I applaud the Sons of Italy for their choice of this year's honoree and am proud to congratulate Ray on yet another prestigious award. I send him my heartiest best wishes for continued health and happiness.

PERSONAL EXPLANATION

HON. BOB ETHERIDGE

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. ETHERIDGE. Mr. Speaker, on Monday, October 4, I was unavoidably detained and missed four votes on the House floor. Had I been present, I would have voted ''yes'' on rollcall votes 470–473.

HONORING BILL WALTERS

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. GOODLING. Mr. Speaker, I rise today to honor Mr. Bill Walters, who holds the office of Registrar of Wills in York, Pennsylvania. Mr. Walters has never lost an election, primary or general, and has been on the ballot 38 consecutive times as either a candidate for Springettsbury township, Register of Wills, or Republican Committeeman. After years of committed service to the people of York and York County, he will be retiring at the end of this term.

Bill Walters came to York, Pennsylvania from Connecticut, but regards York as his home and plans to remain here after retirement. He has always been a big supporter of mine as well as good friend.

Mr. Speaker, I salute Bill Walters as he steps down from his position with the City of York, and wish him well in his upcoming retirement from a life of public service.

IN HONOR OF GEORGE LYKOURETZOS, 1999 CHARLES E. PIPER AWARD RECIPIENT

HON. WILLIAM O. LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. LIPINSKI. Mr. Speaker, I rise today to honor Mr. George Lykouretzos, a business owner in Berwyn, Illinois. Mr. Lykouretzos will be receiving the Charles E. Piper Award for Business Achievement.

The Charles E. Piper Award is named for one of Berwyn's original developers. Each year, the Berwyn Development Corporation honors business men and women from the community who contribute to the growth and economic development of the community. This year, George Lykouretzos has been chosen because of his commitment to the community.

George Lykouretzos is the owner of Skylite Family Restaurant and the Skylite West Banquets located in Berwyn, Illinois. Because of his outstanding business practices and his commitment to the investing back into the community, the Berwyn Development Corporation chose to honor George Lykouretzos with the Charles E. Piper Award on October 23, 1999.

I would like to commend George Lykouretzos and his family and staff on their excellent service to their customers. I would also like to extend my personal congratulations on Mr. Lykouretzos' achievement and

wish him and his family well with their future success and their commitment to the community.

20 YEARS OF AFFORDABLE HOUSING

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. FILNER. Mr. Speaker, I rise today to pay tribute to the San Diego Housing Commission on the occasion of its 20th anniversary. During these two decades, the Housing Commission has helped to provide approximately a half million San Diegans with quality housing opportunities. In the process, neighborhoods have been revitalized and the economy vastly improved.

The Housing Commission has invested billions of dollars in San Diego, resulting in the development of 10,000 apartment units—including nearly 5,500 designed for lower income San Diegans—and in the stabilization of rents for thousands of San Diegans through rental assistance.

The Housing Commission has been a leader in our nation. Its approach to developing and managing its 1,860 public housing units has earned it acclaim and national awards. The awards recognize the Commission for the design and maintenance of its properties and for the Commission's philosophy of distributing public housing throughout the city.

The residents in San Diego public housing benefit from the Housing Commission's programs that have set national standards in helping residents achieve self-sufficiency. The six learning opportunity centers at the Commission's sites provide a way for residents to escape dependence on welfare.

The residents are active partners with the Commission in improving their lives—the Small Business Administration and San Diego Chamber of Commerce Welfare-to-Work Entrepreneur of the Year in 1998 was won by a Housing Commission resident, Yohannes Miles, who became a painting contractor. Needless to say, Mr. Miles is now a former client of the Commission—he has moved into his own home!

The Housing Commission has improved our whole City. It has helped more than 8,000 families rehabilitate their homes and has paved the way for 3,100 low- to moderate-income people to purchase their first home.

The Housing Commission employees are dedicated—15 have been with the agency since its founding. In its 20 years, Commission employees have helped the agency win countless national awards and honors, including high performance ratings each year from the Department of Housing and Urban Development, the first Award of Excellence for Enduring Design from the National Association of Redevelopment Officials, and an award for consensus building in developing public housing.

I want to wish the employees and the officials of the San Diego Housing Commission, and the forward thinking city leaders who started the agency, a happy anniversary. May you provide many others with the basic opportunity and right of housing in San Diego in the years to come.

CALVARY CHILDREN'S CENTER

HON. BOB BARR

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. BARR of Georgia. Mr. Speaker, it is my distinct honor today to recognize an exceptional organization that has made a significant difference in the lives of hundreds of Georgia's children. That organization is Calvary Children's home.

The Calvary Children's Home was founded in 1966 by Reverend Ben F. Turner, and has been located in Cobb County, Georgia, for 33 years. Rev. Turner's first vision of Calvary took place on the streets of Jerusalem, when a poor woman offered to sell her baby to his tour group for money to support her other children. Then, in 1965 a local father and mother of six were returning from shopping when both were killed in an automobile accident. However, as much as the children were disturbed by the loss of their parents, they were equally upset with the prospect of being separated from each other in the foster care system, especially after such a great loss.

In September 1997, Rev. Turner's ultimate dream was finally realized, as the Calvary Children's Home moved from its original dormitory-style complex into three beautiful homes located on 13 acres of land near Powder Springs, Georgia. In January a new administrative center featuring a dining hall, library, and counseling center was completed on the property under the direction of Administrator Snyder Turner. The home has always been funded entirely by generous private funding from churches, businesses, organizations, and individuals dedicated to giving children in need a second chance.

The Calvary Children's Home presently houses 26 children, and has housed more than 400 children since first opening its doors 33 years ago. The center is a nonprofit, charitable organization providing long-term residential care for children who are victims of broken homes, abuse, neglect, or abandonment. The majority of its residents are brothers and sisters who otherwise would have been separated from each other and placed into separate homes through the foster care system.

The Calvary Children's Home is an excellent example of private individuals reaching out and making a difference in the lives of our youth, without public mandates or tax dollars. It speaks well of Georgia's Seventh District that such an organization can survive. I wish Administrator Turner, the staff, residents, and donors well in continuing their commitments to love, spiritual values, and improving the lives of our young people.

IN HONOR OF YOLANDA'S ACADEMY OF MUSIC AND DANCE ON ITS 25TH ANNUAL RECITAL AND ITS FOUNDER, MS. YOLANDA FERNANDEZ-QUINCOCES

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. MENENDEZ. Mr. Speaker, I rise today to recognize Yolanda's Academy of Music and Dance on the celebration of its 25th Annual Recital and its founder, Ms. Yolanda Fernandez-Quincoces, for her many accomplishments. She has made every effort to provide a forum in which the young people of Hudson County, and particularly of Union City, NJ, are able to express their interest in the arts.

Born in Havana, Cuba, Ms. Fernandez demonstrated tremendous artistic ability at a very young age. After moving to the United States with her family, Ms. Fernandez begun taking lessons in ballet and piano at the age of five. She continued her training at the New Jersey Ballet, Oneida's Dance Studio, and the American Ballet Theater, where she also excelled in Flamenco dance and piano while attending classes with renowned leaders in the fields of study.

Ms. Fernandez, since receiving her bachelor's degree in Music Education from New York University, has served as a music and dance educator at the Woodrow Wilson School for the Integrated Arts in my hometown of Union City, NJ, where she is known for her remarkable commitment to her student's education.

Ms. Fernandez has demonstrated her dedication to the arts and education through her involvement in such associations as the Dance Educators of America, the Dance Masters of America, the National Guild of Piano Teachers, and the National Education Association. Her participation in the advancement of the arts includes making personal appearances at the New Jersey Opera and on various television broadcasts. In addition, she produced and hosted her own television program called ''Art Beat.''

Ms. Fernandez's artistic contributions to the community and her unwavering commitment to promoting the arts in our schools have not gone unnoticed. In 1996, she was named ''Teacher of the Year'' by Union City, Hudson County, and the Governor of the State of New Jersey. In 1996 and 1997, she received the prestigious ''Outstanding Choreographer'' Award from the Dance Educators of America in New York City.

In recognition of Ms. Fernandez's impassioned devotion to promoting the arts in our schools and communities, I ask that my colleagues join me in congratulating her, as well as Yolanda's Academy of Music and Dance, on this occasion, the 25th Annual Recital, and wishing Ms. Fernandez continued success in her endeavors.

IN TRIBUTE TO SENIOR MASTER SERGEANT ALBERT M. ROMANO, JR.

HON. ELTON GALLEGLY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. GALLEGLY. Mr. Speaker, I rise to pay tribute to Senior Master Sergeant Albert M. Romano, Jr., one of 12 U.S. Air Force Outstanding Airmen of the Year.

''Buddy'' Romano hails from Oxnard, California, in my district, where he starred in varsity football and baseball at Santa Clara High School and was ranked 32nd in California for motocross racing.

He married his high school sweetheart, the former Jennifer Suytar, also of Oxnard. The

couple now have three children, 12-year-old Tyler, 9-year-old Megan, and 5-year-old Zachary, who must be very proud of their father for all he has achieved.

The Outstanding Airmen Award program began in 1956 during the Air Force Association's national convention as a way to highlight an Air Force military manpower crisis at the time. It proved so popular that it became an official Air Force award the following year.

Competition for Airman of the Year is strenuous. Nominations are sent from each command, separate operating agency, direct reporting unit, Air Force Reserve and Air National Guard to the Air Force Manpower Personnel Center. A high-ranking selection board narrows the field, then the final selections are validated and approved by the U.S. Air Force Chief of Staff.

The criteria for this honor is ''unique, unusual, or outstanding individual involvement and achievement within the preceding 12 months.'' Selection considerations include: superior general job performance; job knowledge and leadership qualities applied to a specific Air Force problem or situation; development of new techniques or procedures resulting in increased mission effectiveness; noteworthy self-improvement through on- or off-duty educational studies, participation in professional or cultural societies/associations, or development of creative abilities; participation in social, cultural, or religious activities in the military and/or civilian community which contribute directly or indirectly to community or group welfare, morale, or status; other significant achievements on- or off-duty which by their nature or results clearly distinguish the Airman from others of equal or higher grade; Air Force or civilian awards in recognition of personal service or contribution; and demonstrated ability as an articulate and positive Air Force spokesperson.

Buddy Romano must have been an easy selection.

He joined the Air Force in 1981 and quickly established himself as an outstanding airman. In 1983, he was named NCO of the Year. In 1984, he earned the Distinguished Graduate Award from the 15th Air Force NCO Leadership School at Ellsworth Air Force Base in South Dakota. He maintained a 96 percent fully mission capable rating during his first year—his unit's highest—as Dedicated Crew Chief at the 388th Fighter Wing, Hill Air Force Base, Utah. In 1987, he served in Operation Desert Storm. In 1988, he earned the NCO of the Year for the 548th Aircraft Generation Squadron, while maintaining a place on the Dean's List for Embry Riddle Aeronautical University. In 1992, he earned his degree in Aircraft Maintenance from the Community College of the Air Force.

Somehow, he has free time. Buddy has filled it by coaching or umpiring during almost every intramural varsity, high school, or youth basketball and baseball season since he became an airman. He has volunteered countless hours to the Equal Opportunity and Treatment Program, Anglo American sports day, Special Olympics, Arrive Alive Program, Toys for Tots Program, Top Three events, and countless other Air Force-sponsored events.

His military decorations include the Meritorious Service Medal, with two clusters; the Air Force Commendation Medal, with one cluster; the Air Force Achievement Medal; the Air Force Good Conduct Medal, with five oak leaf clusters; the National Defense Service Medal; the Armed Forces Expeditionary Medal; the Southwest Asia Service Medal, the Humanitarian Service Medal; and the Kuwait Liberation Medal.

Mr. Speaker, I had the pleasure of recently meeting with Senior Master Sergeant and Jennifer Romano. They serve as a model for military couples, dedicating their lives to their family and their country. I know my colleagues will join me in saluting Albert M. Romano, Jr., for earning the respect and gratitude of his peers, his officers, and his country.

RECOGNIZING BORUNDA INC. AND PLAZA VENTANA RESTAURANT

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. RADANOVICH. Mr. Speaker, I rise today to recognize David Borunda as President and CEO of Borunda Inc., along with Plaza Ventana Restaurant. Borunda Inc. is a corporation specializing in the food service business; and Plaza Ventana is a product of David's perseverance to become an entrepreneur.

David Borunda originally established his business in 1977 by opening Plaza Mexican Restaurant. Due to the tremendous success of the restaurant, Borunda was invited to join the food court at Fresno's Manchester Mall, in which his operation became the largest volume food operation in the facility. Borunda's career further escalated in 1984 when he was invited to join the food court at Fresno's Fashion Faire Shopping Center. Thus, he opened his third location and immediately assumed the number one volume store in the food court. Branching away from food courts, Borunda opened a full sit down restaurant located in the Times Square Shopping Center in Fresno. Plaza Ventana was well received and immediately became a success. As a result, this location was expanded by an additional one thousand square feet, which included a full service bar and an additional dining area.

Borunda was born and raised in Fresno, California and is well rooted in the community. He served as president of the California Restaurant Association Fresno Chapter in 1993 and 1994, and has over 50 employees. As proof of Borunda's enormous success, one has to look no further than the three Best Mexican Restaurant award, given by the California Restaurant Association, he has won.

Mr. Speaker, it is my pleasure to honor David Borunda for his tremendous success as an entrepreneur. I urge my colleagues to join me in wishing David many more years of continued success.

QUALITY CARE FOR THE UNINSURED ACT OF 1999

SPEECH OF

HON. HOWARD P. "BUCK" McKEON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 6, 1999

Mr. McKEON. Mr. Speaker, I join my colleagues today in supporting this bill that addresses the problem of the rising number of Americans who cannot afford health insurance. Under this plan, we will be able to extend health care options to the 44 million people in our country who remain uninsured.

We know that most people without health insurance have one thing in common: they cannot afford health care. They are either self-employed or they work in a small business that cannot afford to pay for health benefits.

The Quality Care for the Uninsured Act creates Association Health Plans to combat the high cost of health care in our country. Small businesses and self-employers will now have the ability to join together under the umbrella of trade and professional organizations to buy health insurance for themselves and their employees.

Association Health Plans will bring more choices and greater flexibility to those who need it most. Estimates show that small businesses will save between 10 and 20 percent on health care costs with Association Health Plans. By cutting costs, we can expand health care coverage for the millions of hard-working Americans that are currently uninsured.

I commend Representative TALENT and Representative SHADEGG for their dedication to this important issue, and I urge my colleagues to support this bill.

THE PENSION REDUCTION DISCLOSURE ACT OF 1999

HON. ROBERT T. MATSUI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. MARSUI. Mr. Speaker, I am pleased to introduce bipartisan legislation, developed with my colleague on the Ways and Means Committee Mr. WELLER and in conjunction with the Administration, which will provide increased notice to employees when their employers convert their pension plans from traditional defined benefit plans to so-called ''cash balance'' plans.

The Pension Reduction Disclosure Act of 1999 revises existing section 204(h) of ERISA and adds related ERISA and tax provisions providing for the following: (1) a basic advance notice must be given for amendments that reduce the rate of future benefit accrual in a pension plan; (2) an enhanced advance notice must be given when applicable large plans are converted to cash balance plans or otherwise amended to reduce the rate of future benefit accrual; (3) individuals receiving the enhanced notice have the right to receive supporting general plan information, such as the plan's benefit formula and actuarial factors; and (4) individuals receiving the enhanced notice also have the right to receive individual benefit statements relating to the projected effect of the amendment on them. In general, the information required to be provided under the Act must be written in a manner calculated to be reasonably understood by the average plan participant. The Act imposes minimum notice and information requirements; employers may choose to provide information (in the required notice or otherwise) that is in addition to that required under the Act.

Basic advance notice: Current law requires 15 days' advance notice for amendments that reduce the rate of future benefit accrual in a

pension plan. Pension plans subject to the Act requirements are those plans subject to existing section 204(h) of ERISA. The Act increases this to 45 days before the effective date. The Act eliminates the current law requirement that notice be provided only after the plan amendment has been adopted. A plan is not to be treated as failing to meet the notice requirements of the Act merely because notice is provided before the adoption of the amendment if no modification of the amendment occurs before the amendment is adopted that would affect the information required to be in the notice. The notice must include the effective date and the classes of individuals under the plan to which the amendment applies. The notice must state that the amendment significantly reduces the rate of future benefit accrual and must summarize the important terms of the amendment. For example, in the case of a money purchase pension plan in which the rate of future contributions for all salaried employees is reduced from 7% of compensation to 4% of compensation, the basic notice must state that the plan is being amended to significantly reduce the rate of future contributions, that the rate of future contributions is being reduced from 7% of compensation to 4% of compensation, and that the amendment applies to all participants who are salaried employees on or after the effective date, which must be specified in the notice.

Enhanced advance notice: The enhanced advance notice applies to plans with at least 100 active participants at the end of the prior plan year (this information is on the Form 5500). This notice must provide the following additional information concerning the amendment: (1) a more detailed description of the plan amendment; (2) illustrative examples; (3) supporting information; and (4) individual benefit statements.

More detailed description. The enhanced notice provided to an affected participant must be describe the normal and, if applicable, the early retirement benefit formulas under which the participant had been earning benefits before the amendment, describe the formulas under the plan as amended, and explain the effect of the amendment on the participant's normal and early retirement benefits. The enhanced notice, like the basic notice, must also state that the amendment is expected to significantly reduce the rate of future benefit accrual.

In addition, the enhanced notice must explicitly disclose any ''wearaway'' or ''benefit plateau'' or temporary period, expected to result from the amendment, during which there are no accruals or only minimal accruals. For example, if a large pension plan were amended from a traditional defined benefit plan to a cash balance plan through an amendment that reduced the rate of future benefit accrual, and the amendment provided for the establishment of an opening account balance using a formula or factors that resulted in the opening account balance being less than certain participants' section 417(e) lump sum value, the enhanced notice would have to identify the participants likely to experience a temporary cessation of accruals and explain why the wearaway occurred (for example, because the opening account balance was established using a different interest rate than required by the law to value lump sum benefits or because the formula used to establish the opening account balance did not take into account early retirement subsidies).

Illustrative examples. The enhanced notice must also include illustrative examples showing at representative future dates the estimated effect of the amendment on the participants in the examples. The illustrative examples will include estimates that provide a meaningful comparison of benefits that would be earned under the amended plan with benefits that would have been earned assuming the plan had not been amended. At a minimum, for a comparison to be meaningful, it must show benefits under the old and new formulas in the same form and at the same time. Accordingly, a comparison of an immediate lump sum under a new cash balance formula with an age 65 annuity under the pre-amendment final average pay formula would not satisfy the requirement that the comparison be meaningful; instead, the comparison must be in a life annuity form or a form authorized under Treasury regulations (which may, for example, authorize the comparison to be based on a lump sum form provided that that form is used for both the old and the new formulas). The notice (including the basic notice, but not including the supporting information) must be written in a manner reasonable calculated to be understood by the average plan participant.

Representative categories: The examples must be selected in a manner that is fully and fairly representative of the various categories of adversely affected individuals depending on whether the amendment results in similar reductions. While the classes of participants identified in the basic notice will generally be able to be determined under the plan document (e.g. salaried vs. hourly, Subsidiary A vs. Subsidiary B), it is intended that the categories used in the enhanced notice be more refined. While the determination of differing categories will depend on the plan's formulas before and after the amendment, the factors relevant to the determination of the number of categories appropriate to illustrate the effects of the amendment may include age, service and early or normal retirement eligibility. For example, in the case of an amendment that reduces the normal and early retirement benefits, employees who are already eligible for early retirement might be grouped together in a single category.

Supporting information required to be made available at time of advanced enhanced notice: The supporting information required to be made available upon a participant's request will include the factors used to convert the cash balance to an annuity, early retirement reduction factors, and similar assumptions for benefit projections, but the employer will not be required to make available the participant's personal information, such as the participant's date of hire, service history, or compensation. It is understood that, because the information may contain formulas and definitions of plan terms, it may not be practical for this information to be presented in a manner that can be readily understood by the average plan participant, but this information, along with the personal information, should be sufficient so that a professional advisor for the participant can perform the calculations. It is expected that employers could satisfy these requirements by making available appropriate computer programs or other appropriate technology, or providing a plan document with necessary supplemental schedules of current interest and mortality assumptions.

Individual benefit statements: Each individual to whom the enhanced advance notice has been, or is required to have been, furnished can make one request for an individual benefit statement at any time up to one year after the effective date of any amendment that requires section 204(h) enhanced disclosure. As under current law, no charge may be imposed for furnishing the required individual benefit statement. Under section 502(c)(2) of ERISA, an administrator is subject to liability up to $100 a day if the individual benefit statement is not provided within 30 days after the date of the request. In no event is the statement required to be provided earlier than 90 days after the effective date of the plan amendment. The Secretary of Labor may in her discretion determine that the statement may be provided at a later date. For example, the Secretary of Labor may determine in a particular case or by guidance of general applicability that the statement can be provided up to 60 days after the request (or, if later, six months after the effective date) in exceptional circumstances. Such exceptional circumstances might include, for example, cases in which the participant's accrual credit is in part based on periods during which the participant has worked for a predecessor or another party other than the plan sponsor, and the participant's work history with the other party is not readily available.

However, it is not intended that any such extension of time is to be permitted to be used as a pretext for a broad-based delay in delivering individual benefit statements that can reasonably be furnished at an earlier date.

Anti-abuse intent: It is intended that the protections of the Act are not to be evaded, so that, for example, if a plan seeks to evade the enhanced notice requirements by freezing benefits and then resuming accruals at a reduced accrual rate, a second enhanced notice would be required (taking into account the new accrual rate).

No inference: The fact that enhanced disclosure is required as to certain effects of an amendment on certain classes of participants is not intended to imply that the amendment or the plan design change effected by the amendment complies with current law.

Alternative methods of compliance: The Secretary of the Treasury is authorized to prescribe alternative or simplified methods of compliance with section 204(h) for the enhanced notice and related information, including and exemption, from some or all of these requirements, in situations not involving a fundamental change in the manner in which accruals are calculated where such other methods are adequate to reasonably inform applicable individuals of the nature of the reductions (such as a complete suspension of accruals under the plan, certain uniform reductions in the benefit accrual formula, or an incremental change in the period taken into account to determine career average or other plan compensation). A fundamental change in the manner in which accruals are calculated would not include certain changes in the compensation taken into account or a uniform reduction in the percentage of compensation on which contributions or accruals are based, but would include, for example, a conversion from a traditional plan (i.e., a flat dollar benefit, career average pay or final pay defined benefit pension plan) to a hybrid pension plan, such as a cash balance plan. A simplified or alternative method may also be permitted in order to ensure that the Act does not discourage

consolidation of an individual's plan benefits, for example, if a buyer's plan is involved in a merger or consolidation with the seller's plan or if the buyer's plan receives a transfer from the seller's plan, the buyer is not subject to requirements that would not apply if the buyer's plan had not accepted a transfer from the seller's plan.

The Secretary of the Treasury may also issue guidance under which a plan may provide the notice only 15 days before the effective date in cases in which a 45-day advance notice would be unduly burdensome either because the amendment is contingent on a merger, acquisition, disposition or other similar transaction or because 45-day advance notice would be impracticable (such as where benefits are being reduced as part of a liquidation or reorganization in bankruptcy or insolvency proceedings).

Sanctions: An excise tax applies to a failure to satisfy the notice requirements and, in the case of an egregious violation, the individual is entitled to the greater of the benefit under the amended plan or the plan before the amendment. Except in the case of a multiemployer plan, the tax is imposed on the employer. If a plan (other than a multiemployer plan) is sponsored by a party other than an employer, it is intended that the plan sponsor will be treated as the employer for this purpose. An egregious violation includes a situation in which there has been no intentional failure to provide notice, but the employer fails to take reasonable corrective steps after discovering that there was a failure to provide notice to some individuals.

Effective date exception where information provided within 120 days of enactment: The notice and information required under the Act is not required to be provided earlier than 120 days after the date of enactment of the Act. For example, if a large pension plan is amended to reduce benefits effective on the day after the enactment of the Act, the amendment could go into effect on the day after the enactment of the Act, but the plan could provide the required enhanced notice and related information (and also furnish any requested individual benefit statements) as late as 120 days after the date of enactment.

HONORING THE BROOKLYN CHINESE-AMERICAN ASSOCIATION'S EIGHTH AVENUE SENIOR CENTER ON ITS SIX YEARS OF SERVICE

HON. NYDIA M. VELÁZQUEZ

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Ms. VELÁZQUEZ. Mr. Speaker, I rise today to recognize the achievements of the Brooklyn Chinese-American Association, and the sixth anniversary of its Eighth Avenue Senior Center.

For more than a decade, the Brooklyn Chinese-American Association has provided vital assistance to tens of thousands of the Chinese-American residents who constitute one of New York's fastest-growing communities. Six years ago, recognizing a critical need in this community, the Association opened the Eighth Avenue Senior Center, which provides daily congregate meals, citizenship classes, medical check-ups and screenings, monthly birthday parties, field trips and many other services.

Operating out of modest facilities but with exceptional heart and dedication, the center has a membership of almost 2,000 and offers services to over 160 senior members daily.

The centerpiece of this year's sixth anniversary commemoration is the Millennial Roundtable Celebration. Fulfilling an extraordinary and touching ceremony, tables will be organized with seating for 12 seniors who are each at least 84 years of age—totaling 1,000 years. For the first time, to commemorate the end of the century and the turn of the millennium, a Double Millennial Roundtable will be featured, with seating for 23 seniors who are at least 87 years of age and totaling 2,000 years of age.

A poet wrote, ''I like spring, but it is too young. I like summer, but it is too proud. So I like best of all autumn, because its tone is mellower, its colors are richer, and it is tinged with a little sorrow. Its golden richness speaks not of the innocence of spring, nor the power of summer, but of the mellowness and kindly wisdom of approaching age.''

Mr. Speaker, I urge all my colleagues to join me when I commend the Eighth Avenue Senior Center, and the Brooklyn Chinese-American Association, for its work to ensure golden richness in the lives of our seniors.

PROVIDING FOR CONSIDERATION OF H.R. 2990, QUALITY CARE FOR THE UNINSURED ACT OF 1999, AND H.R. 2723, BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

SPEECH OF

HON. JAY INSLEE

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 6, 1999

Mr. INSLEE. Mr. Speaker, I rise in opposition to the rigged rule for debate on the patients' bill of rights. Ever since this session began, I have been working with my colleagues to bring 'bipartisan patients' bill of rights to the floor for a vote. But now that Republicans have been forced to allow a vote on the bipartisan consensus managed care bill, they have written a rule designed to kill the measure.

Instead of providing a fair and open rule considering the patients' bill of rights, the Republican Leadership has stacked the deck by writing a rule that blends the managed care bill with a measure riddled with special interest ''poison pills'' designed to kill the measure, and that denies us the opportunity to offset any potential revenue losses from the measure.

The Republican Leadership is combining the bipartisan managed care bill with a so-called insurance access bill, which is not paid for. In addition, the Republican leadership is denying a bipartisan group of members the right to offer an amendment to offset the cost of the bill and be fiscally responsible.

If we can defeat this flawed rule, bipartisan advocates of managed care reform will return with a fair and open rule that will permit enactment of managed care reform. My constituents deserve patients' bill of rights. I urge my colleagues to vote down this rule and to support real managed care reform and bipartisan patients' bill of rights.

HONORING THE RAMSEY FIRE DEPARTMENT ON ITS 100TH ANNIVERSARY

HON. MARGE ROUKEMA

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mrs. ROUKEMA. Mr. Speaker, I rise to congratulate the Ramsey Fire Department on its 100th Anniversary. This volunteer unit is one of the finest in New Jersey and deserves the thanks and support of every resident of our community.

Volunteer firefighters are among the most dedicated public servants in our communities. They set aside their own convenience—indeed, their own safety—to protect the lives and property of their neighbors and ask nothing in return. Volunteer firefighters turn out to do their duty in the darkness of freezing winter nights and in the heat of suffocating summer days without hesitation.

The Ramsey Fire Department was established in 1899 with 32 original members. The new fire company made a $25 deposit on their first fire engine, an 1885 Babcock Chemical Wagon purchased second-hand from the Rutherford Fire Department. The Dater family of Ramsey donated property near the railroad tracks for the first firehouse, built at a cost of $197, and the Ramsey Fire Department was in business. The first alarm was a brush fire near the tracks in April and the first building fire followed in January 1900.

The department grew quickly during the early years of the century, soon adding a horse-drawn ladder wagon and going to motorized fire trucks in 1912. A modern pumper was added in 1927 and the Ladies Auxiliary was founded in 1935 with 23 charter members. Additional equipment was purchased in subsequent years and the Island Avenue fire station constructed in 1951 to accommodate the growing fleet. A substation in the form of a three-bay addition to the borough garage was added in the 1960s. The 1970s saw the formation of the Junior Fire Brigade to encourage young people to become involved and a conversion from the traditional ''fire engine red'' paint scheme on equipment to lime yellow.

The Ramsey Fire Department has twice received the Box 54 Unit Citation Award from the New Jersey-New York Volunteer Firemen's Association for daring rescues, once in 1975 and again in 1984. In 1981, the department found itself the victim of arson when fire destroyed the second floor of the Island Avenue building. The building was repaired and rededicated the next year.

Major renovations of the fire department headquarters on Island Avenue were completed in 1992, including a room to display antique fire apparatus, a new radio room, a chief officer's room, an office for administrative officers and a 150-foot radio communications tower. Since 1996, the headquarters building has been known as the Robert E. Litchult Fire Safety Building in honor of Litchult, who served a record 63 years with the department.

Responding to nationwide difficulties in recruiting volunteer firefighters, the department

in 1994 formed a Recruitment and Retention Program to solicit new members.

Throughout its long and distinguished history, the Ramsey Fire Department has protected both lives and property through professionalism, dedication and skill of its many members. The department has grown vastly in personnel, equipment and other resources. Today, it is among the finest firefighting organizations in the State of New Jersey. Members constantly train to improve performance in order to do their jobs as safely and efficiently as possible.

The Ramsey Fire Department has come a long way from its founding. Today's state-of-the-art fire engines and high-tech equipment put Ramsey on par with any other fire department in the region. But it takes more than equipment and buildings to run a fire department. It takes dedicated, hard-working individuals willing to put the safety and property of their neighbors first. People like President Ken Bell and Fire Chief George Sutherland and all the officers and firefighters of the Ramsey Fire Department deserve our most special thanks.

The Ramsey Fire Department was founded 100 years ago on the principle of neighbors helping neighbors. That principal has made the department a success and will continue to do so in the future.

I would like to ask my colleagues in the House to join me in congratulating the Ramsey Fire Department on 100 years of meritorious service to the community, and in paying tribute to the brave and dedicated firefighters who have sacrificed personal safety in response to the needs of others. All past and present members of this very professional ''volunteer'' fire department deserve our deepest thanks for their work on the behalf of our community.

THE SENIOR CITIZENS PROTECTION ACT

HON. RICK LAZIO

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. LAZIO. Mr. Speaker, I rise today to introduce a bill to cut fraud and abuse in our Medicare system, restore balance in our health care system, and give us all a better quality of life. Federal, state, and local governments need more tools at their disposal to crack down on rampant health care fraud. Congress needs to empower law enforcement to preserve and protect Medicare, decrease the crime rate, and let each and every one of us feel safe and secure in our retirement years.

The Health and Human Services' Office of the Inspector General recently released startling information on their audit of the Health Care Financing Administration (HCFA). According to the audit, the Medicare Program lost $20 billion in fraud and improper payments in Fiscal Year 1997. What is unconscionable is that only $4 billion was recovered.

A recently published Focus Group Study of Medicare Insurance Counselors found that most officials believe a significant amount of fraud exists and continues to undermine the Medicare program. In the study, many experts said HCFA took no action after being notified of fraud. The May 1998 study further cited that HCFA did not have adequate systems and procedures in place to root out fraud.

A major reason health care fraud is at historic levels is because current law bars state officials from even investigating Medicare fraud. They are limited to investigating suspected fraud in the Medicaid. This creates an enforcement gap because an entity defrauding Medicaid is often linked to fraud in other federal health programs.

An example from my district on Long Island illustrates this predicament perfectly. A provider was suspected of defrauding Medicaid. The state and its Medicaid Fraud Control Unit began an investigation. That investigation spilled over into allegations of Medicare fraud and the state could not investigate because it lacked the requisite authority. Despite repeated requests from the state, the Federal Government did not investigate or prosecute the allegations. While the state was trying to wrest control of the investigation for the Federal Government, the provider billed nearly $2 million. If the state had the power to investigate, some fraud could have been stopped and stolen money would have been recovered and returned to the government coffers.

My bill, the Senior Citizens Protection Act of 1999, will empower the states and their Medicaid Fraud Control Units by allowing them to investigate Medicare fraud cases when Medicaid fraud has been alleged.

A second reason health care fraud remains unchecked is because current law prohibits states from investigating patient abuse in assisted living and residential-care facilities. Currently, a state only has the authority to investigate patient abuse in facilities that receive Medicaid reimbursement, usually nursing facilities. Yet today, more and more of our friends and family reside in assisted living and other residential-care facilities. Normally, federal and local governments do not investigate suspected patient abuse in these non-traditional health care facilities and the state lacks the power to delve into these cases. The result is a high number of cases falling through the cracks.

My bill would authorize the states and the Medicaid Fraud Control Units to investigate these patient abuse cases in long-term care facilities.

The government should be doing more—much more—to combat fraud and abuse. ''White collar'' crimes in the health care industry can be stopped. The Senior Citizens Protection Act requires coordination of anti-fraud efforts, keeps our senior citizens safe, returns all recoveries to the Federal Government, and does not cost the Federal Government anything.

Our government should be given all the tools necessary to combat fraud in our health care system and give Americans the peace of mind that their moms and dads are well cared for in their retirement years. We need to ferret out providers who rip off the system, and Americans need to rest comfortably at night knowing our family members and friends receive the highest quality health care without the fear of being physically, mentally, or financially abused. I urge my colleagues to support the Senior Citizens Protection Act of 1999 because it will provide health care security to our seniors and restore their trust in the people who care for them from morning until night.

HONORING THE MADERA COLLEGE CENTER

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. RADANOVICH. Mr. Speaker, I rise today to honor the Madera College Center for the State Center Community College District. The Board of Trustees for the college held a groundbreaking ceremony for the first permanent building on their campus on September 24, 1999.

The Madera Center has been in existence for approximately 15 years. The college offers a wide variety of programs and opportunities for students. The full-service campus includes a library, bookstore, distance learning classroom, cafeteria, and computer laboratories. Utilizing services and course catalogs from its sister institution, Reedley College, the Madera Community College Center is able to afford its students a choice of more than 40 Associate Degrees and Certificates of Achievement.

The building for which ground was broken will consist of a lecture hall, library, classrooms, laboratories and offices. It is projected that the facility will be completed by August 2000, allowing for the attendance of students for the fall 2000 semester. In addition, parking lots and play fields will be installed as a part of this $12.7 million development project.

Mr. Speaker, I rise to recognize the Madera College Center and its Board of Trustees, for their dedication to providing quality education to students in the Madera area. I urge my colleagues to join me in wishing the Madera Center many more years of success and continued growth.

IN HONOR OF CAPT. CLELL NEIL AMMERMAN, U.S. NAVY (RET.)

HON. ELTON GALLEGLY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. GALLEGLY. Mr. Speaker, I rise to honor Capt. Clell Neil Ammerman, U.S. Navy (Ret.), who passed away last week.

Captain Ammerman had a long and distinguished career serving his country in the United States Navy. He graduated with honors from the U.S. Naval Academy in 1954 and quickly proved himself as a capable officer. In 1957, he commanded the USS *Ely,* one of the first ships to transit the new St. Lawrence Seaway. In 1958, he was assigned to the National Security Agency, and in 1961 received his master's degree in applied mathematics and physics.

Captain Ammerman returned to the sea, and in August 1964 was involved in the initial action in the Gulf of Tonkin as an officer aboard the USS *Oklahoma City.* In 1967, he completed his work in the field of nuclear weapons effects at the Lawrence Radiation Laboratory in Livermore, California, for which he received the Joint Services Commendation Medal.

After another year at sea, Captain Ammerman served as Assistant to the Deputy Director, Research and Technology, ODDR&E. That stint earned him the Legion of

Merit for outstanding management of research and development programs. But a Navy man belongs to the sea, and in September 1971, Captain Ammerman assumed command of the USS *John S. McCain.* Between April and October 1972, Captain Ammerman actively engaged the enemy off the coast of the Republic of Vietnam and was awarded the Bronze Star with the Combat ''V.''

He then entered the academic life, serving as professor of naval science and commanding officer for the NROTC Unit at UCLA. In 1976, he again returned to sea, then moved to Newport, Rhode Island, in 1978 to command the Navy's prestigious Surface Warfare Officer's School. Finally, he served as Chief of Staff of Battle Force Seventh Fleet, homeported in Subic Bay, the Philippines.

In June of 1984, Captain Ammerman retired from the Navy and settled in Camarillo, California, which is in my district. Until 1995, he continued his relationship with the Navy through his work with naval contractors.

His wife of 20 years, Pamela, is national director of the Navy League of the United States. She has also served as my campaign manager for years. Aside from Pam, Captain Ammerman is survived by six children and four grandchildren.

Mr. Speaker, I know my colleagues will join me for a moment of prayer for Capt. Clell Neil Ammerman, and in sending our condolences to Pam and all of his family.

IN HONOR OF THE IRONBOUND COMMUNITY CORPORATION FOR 30 YEARS OF SERVICE TO NEWARK, NEW JERSEY

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. MENENDEZ. Mr. Speaker, I rise today to recognize the Ironbound Community Corporation as it celebrates its 30th anniversary of service and dedication to the people of the ''Ironbound'' and East Ward sections of Newark, NJ.

Serving one of the most ethnically and culturally diverse neighborhoods in the State, the Ironbound Community Corporation (ICC) has been a progressive and vocal force in the community since it opened its door in 1969. it has led the way in addressing the particular needs and concerns faced by a multicultural and multilingual community.

For 30 years, the ICC has planned, implemented, and operated a number of vital programs for residents of the Ironbound. From a nationally accredited preschool child care program to an extensive ''Meals on Wheels'' delivery service for seniors to environmental clean-ups to GED, English, and college courses, the ICC has worked diligently to improve the quality of life in Newark's Ironbound.

This weekend, led by President Susanna Stradiotti and Executive Director Joseph Della Fave, the ICC will commemorate its 30th anniversary by honoring three members of the community who embody the intent and purpose of the organization and three individuals who directly benefited from ICC's various programs.

This year's three honorees are: Patricia Moreira, Preschool Teacher for 30 years at the Ironbound Children's Center: June Kruszewski, resident of the community for 72 years, volunteer for 20 years, co-chair of the Ironbound Committee Against Toxic Waste, and member of the ICC Board of Trustees; and, Joseph Rendeiro, principal of the Hawkins St. School and former teacher at the Ironbound Adult Education Project.

This year's ICC Success Story honorees are: Rosa Coneicao, graduate of the ICC Adult Education Project, Director of Work First at Essex County College, Fellow at Leadership Newark, and member of the ICC Board of Trustees; Fred Linhares, graduate of the Ironbound Childern's Center, President of the Portuguese American Congress, and Municipal Judge; Ed Norton, graduate of the ICC Community School and Owner/Operator of the Dalfen Printing Co.

For its unwavering commitment to the Ironbound and East Ward sections of Newark, and for its continued leadership in community service, I ask my colleagues to join me in congratulating the Ironbound Community Center on its 30th anniversary.

YWCA OF COBB COUNTY

HON. BOB BARR

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 7, 1999

Mr. BARR of Georgia. Mr. Speaker, it is my distinct honor today to recognize the YWCA, and particularly the YWCA of Cobb County for its efforts to combat violence, by celebrating a ''Week Without Violence,'' from October 17–23.

The YWCA ''Week Without Violence'' is a public awareness campaign that seeks to advocate practical and sustainable alternatives to violence in our homes, schools, workplaces, and neighborhoods. Since it was launched in 1995, the YWCA ''Week Without Violence'' has grown from a grassroots initiative into a global movement with women, men, and children participating in events throughout all 50 dates and in more than 20 countries on six continents.

I especially applaud the YWCA of Cobb County for its efforts to bring together people from throughout the community to fight violence against all people, regardless of age, race, income, or sex. The grassroots efforts are an excellent example of Americans joining together to fight for what is right about our great nation. By devoting time and effort to this cause YWCAs across America are demonstrating a widespread desire to improve our communities

Daily Digest

HIGHLIGHTS

Senate passed Labor/HHS/Education Appropriations.

Senate

Chamber Action

Routine Proceedings, pages S12147–S12255

Measures Introduced: Five bills and two resolutions were introduced, as follows: S. 1705–1709, and S. Res. 198–199. **Page S12234**

Measures Reported: Reports were made as follows:

S. Res. 179, designating October 15, 1999, as ''National Mammography Day''. **Page S12233**

Measures Passed:

Labor/HHS/Education Appropriations: By 73 yeas to 25 nays (Vote No. 321), Senate passed S. 1650, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000, after taking action on the following amendments proposed thereto:

Pages S12147–76, S12178–85, S12188–S12215

Adopted:

Abraham Amendment No. 2269 (to Amendment No. 1828), to prohibit the use of funds for any program for the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug. **Pages S12148–50**

Abraham (for Coverdell) Amendment No. 1828, to prohibit the use of funds for any program for the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug. **Pages S12147–50**

By 98 yeas to 1 nay (Vote No. 318), Wellstone Amendment No. 1842, to express the sense of the Senate regarding the importance of determining the economic status of former recipients of temporary assistance to needy families. **Pages S12155–59, S12172**

Wellstone Amendment No. 1880, to increase funding for the mental health services block grant. **Pages S12183–85**

Wellstone Amendment No. 2271 (to Amendment No. 1880), to increase funding for the mental health services block grant. **Pages S12183–85**

Bingaman/Domenici Amendment No. 2272, to require the Secretary of Health and Human Services to conduct a study on the geographic adjustment factors used in determining the amount of payment for physicians' services under the medicare program. **Page S12189**

Harkin (for Bingaman) Amendment No. 2273, to provide for confounding biological and physiological influences on polygraphy. **Pages S12193, S12201**

Harkin (for Bingaman/Feingold) Amendment No. 2274, to provide funding for a dental sealant demonstration program. **Pages S12193, S12201**

Specter (for Bond) Amendment No. 2275, to limit the withholding of substance abuse funds from certain States. **Pages S12193–94, S12201**

Harkin (for Boxer) Amendment No. 2276, to express the sense of the Senate that funding for prostate cancer research should be increased substantially. **Pages S12193–94, S12201**

Specter (for DeWine) Amendment No. 2277, to provide for an increase and a decrease in certain education funding. **Pages S12193–94, S12201**

Specter (for Hutchison/Bingaman) Amendment No. 2278, to clarify provisions relating to the United States-Mexico Border Health Commission. **Pages S12193–94, S12201**

Specter Amendment No. 2279, to provide for certain funding increases. **Pages S12193–94, S12201**

Specter Amendment No. 2280, to strike certain provisions of the bill. **Pages S12193–94, S12201**

Specter (for Cochran) Amendment No. 2281, to make available certain funds from the Office on Women's Health to support biological, chemical and botanical studies to assist in the development of the clinical evaluation of phytomedicines in women's health. **Pages S12193–94, S12201**

Harkin (for Wyden) Amendment No. 2282, to provide for a report on promoting a legal domestic workforce and improving the compensation and working conditions of agricultural workers. **Pages S12193–94, S12201**

Harkin (for Murray) Amendment No. 2283, to express the sense of the Senate concerning women's access to obstetric and gynecological services.

Pages S12193–96, S12201

Harkin (for Kerry/Smith(OR)) Amendment No. 1882, to express the sense of the Senate regarding comprehensive education reform.

Pages S12193, S12200–01

Harkin (for Reed) Amendment No. 2284, to extend filing deadline for compensation of certain individuals exposed to mustard gas during World War II. **Pages S12193, S12196, S12201**

Specter (for Stevens) Amendment No. 2285, to correct a definition error in the Workforce Investment Act of 1998. **Pages S12193, S12196, S12201**

Harkin (for Durbin) Amendment No. 2286, to increase funds for the Centers for Disease Control and Prevention to provide grants regarding childhood asthma. **Pages S12193, S12196–98, S12201**

Harkin (for Reid) Amendment No. 1852, to express the sense of the Senate concerning needlestick injury prevention. **Pages S12193, S12198–99, S12201**

Harkin (for Inouye) Amendment No. 2287, to rename the Centers for Disease Control and Prevention as the Thomas Harkin Centers for Disease Control and Prevention. **Pages S12193, S12198, S12201**

Harkin (for Inouye) Amendment No. 2288, to designate the National Library of Medicine building in Bethesda, Maryland, as the ''Arlen Specter National Library of Medicine''.

Pages S12193, S12198, S12201

Harkin Amendment No. 2289, to increase funding for senior nutrition programs and rural community facilities, offset with administrative reductions.

Pages S12193, S12198, S12201

Harkin (for Reed) Amendment No. 1869, to increase funding for the leveraging educational assistance partnership program. **Pages S12193, S12199–S12201**

Rejected:

Bingaman Amendment No. 1861, to ensure accountability in programs for disadvantaged students. (By 53 yeas to 45 nays (Vote No. 317), Senate tabled the amendment.) **Pages S12150–55, S12157–58**

Smith (of N.H.) Amendment No. 1844, to limit the applicability of the Davis-Bacon Act in areas designated as disaster areas. (By 59 yeas to 40 nays (Vote No. 320), Senate tabled the amendment.)

Pages S12178–83

Withdrawn:

Bond Amendment No. 1825, to prohibit the use of funds for the promulgation or issuing of any standard relating to ergonomic protection. (By 2 yeas to 97 nays (Vote No. 319), Senate earlier failed to table the amendment.) **Pages S12159–76**

Subsequently, Bond Amendment No. 2270 (to Amendment No. 1825), to prohibit the use of funds for the promulgation or issuing of any standard, regulation, or guideline relating to ergonomic protection, fell when Amendment No. 1825 was withdrawn. **Pages S12159–76**

Harkin/Robb Amendment No. 1845, to express the sense of the Senate regarding school infrastructure. **Pages S12102–93**

A unanimous-consent agreement was reached providing that the bill not be engrossed and be held at the desk. **Page S12215**

Greece/Turkey Earthquake Victims: Senate agreed to S. Res. 198, expressing sympathy for those killed and injured in the recent earthquakes in Turkey and Greece and commending Turkey and Greece for their recent efforts in opening a national dialogue and taking steps to further bilateral relations.

Pages S12253–54

National Mammography Day: Senate agreed to S. Res. 179, designating October 15, 1999, as ''National Mammography Day''. **Page S12254**

Agriculture Appropriations—Conference Report: By unanimous consent, Senate agreed to the motion to proceed to the consideration of the conference report on H.R. 1906, making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies for the fiscal year ending September 30, 2000. **Pages S12215–26**

A motion was entered to close further debate on the conference report and, in accordance with the provisions of Rule XXII of the Standing Rules of the Senate, a vote on the cloture motion will occur on Tuesday, October 12, 1999, at 5:30 p.m.

Page S12216

A unanimous-consent agreement was reached providing for further consideration of the conference report on Tuesday, October 12, 1999 at 4:30 p.m.

Page S12254

Appointment:

Parents Advisory Council on Youth Drug Abuse: The Chair, on behalf of the Majority Leader, pursuant to Public Law 105–277, announced the appointment of the following individuals to serve as members of the Parents Advisory Council on Youth Drug Abuse: Robert L. Marginnis, of Virginia (two-year term), and June Martin Milam, of Mississippi (Representative of a Non-Profit Organization) (three-year term). **Page S12254**

Nominations Confirmed: Senate confirmed the following nominations:

John D. Hawke, Jr., of the District of Columbia, to be Comptroller of the Currency for a term of five years.

Robert Raben, of Florida, to be an Assistant Attorney General.

Andrew C. Fish, of Vermont, to be an Assistant Secretary of Agriculture.

Robert S. Mueller, III, of California, to be United States Attorney for the Northern District of California for a term of four years.

John Hollingsworth Sinclair, of Vermont, to be United States Marshal for the District of Vermont for the term of four years. **Pages S12254–55**

Enrolled Bills Presented: **Page S12232**

Communications: **Pages S12232–33**

Executive Reports of Committees: **Pages S12233–34**

Statements on Introduced Bills: **Pages S12234–43**

Additional Cosponsors: **Pages S12243–44**

Amendments Submitted: **Pages S12247–49**

Notices of Hearings: **Page S12249**

Authority for Committees: **Page S12250**

Additional Statements: **Pages S12250–53**

Record Votes: Five record votes were taken today. (Total—321)

Pages S12158, S12172, S12175, S12183, S12215

Adjournment: Senate convened at 9:30 a.m., and adjourned at 8:15 p.m., until 9:30 a.m., on Friday, October 8, 1999. (For Senate's program, see the remarks of the Acting Majority Leader in today's Record on page S12255.)

Committee Meetings

(Committees not listed did not meet)

AGRICULTURAL BIOTECHNOLOGY

Committee on Agriculture, Nutrition, and Forestry: Committee concluded hearings to review public policy related to agricultural biotechnology, focusing on domestic approval process, benefits of biotechnology and an emphasis on challenges facing farmers to segregation of product, after receiving testimony from Representative Kucinich; Bruce Alberts, President, National Academy of Sciences; James H. Maryanski, Biotechnology Coordinator, Center for Food Safety and Applied Nutrition, Food and Drug Administration, Department of Health and Human Services; Sally L. McCammon, Science Advisor, Animal and Plant Health Inspection Service, Department of Agriculture; Janet L. Andersen, Director, Biopesticides and Pollution Prevention Division, Office of Pesticide Programs, Office of Prevention, Pesticides, and Toxic Substances, Environmental Protection Agency; Mark Silbergeld, Consumers Union, Michael Philips, Biotechnology Industry Organization, Jeffrey Barach, National Food Processors Association, and Gary Kushner, Grocery Manufacturers of America, all of Washington, D.C.; Tim Hume, Walsh, Colorado, on behalf of the National Corn Growers Association; Marc Curtis, Leland, Mississippi, on behalf of the American Soybean Association; L. Dan Thompson, Minnesota Corn Processors, Marshall, on behalf of the Corn Refiners Association; and Robert Smigelski, The Anderson, Inc., Maumee, Ohio, on behalf of the National Grain and Feed Association.

COMPREHENSIVE TEST BAN TREATY

Committee on Armed Services: Committee concluded hearings on the Comprehensive Nuclear Test Ban Treaty (Treaty Doc. 105–28), focusing on the ability of the Stockpile Stewardship Program to adequately verify the safety and reliability of the U.S. nuclear deterrent, after receiving testimony from Bill Richardson, Secretary, C. Paul Robinson, Director, Sandia National Laboratories, C. Bruce Tarter, Director, Lawrence Livermore National Laboratory, and John C. Browne, Director, Los Alamos National Laboratory, all of the Department of Energy; Robert R. Barker, former Assistant to the Secretary of Defense for Atomic Energy; John Foster, former Director, Lawrence Livermore National Laboratory, and former Director, Defense Research and Engineering; Kathleen C. Bailey, former Assistant Director for Nuclear and Weapons Control, Arms Control and Disarmament Agency; Adm. Henry G. Chiles, Jr., USN (Ret.), former Commander-in-Chief, United States Strategic Command; and Sidney D. Drell, Stanford Linear Accelerator Center, Stanford, California.

BARTLESVILLE LAND CONVEYANCE/ MATERIALS CORRIDOR PARTNERSHIP INITIATIVE

Committee on Energy and Natural Resources: Subcommittee on Energy Research, Development, Production and Regulation concluded hearings on S. 1183, to direct the Secretary of Energy to convey to the city of Bartlesville, Oklahoma, the former site of the NIPER facility of the Department of Energy, and S. 397, to authorize the Secretary of Energy to establish a multiagency program in support of the Materials Corridor Partnership Initiative to promote energy efficient, environmentally sound economic development along the border with Mexico through the research, development, and use of new materials, after receiving testimony from Robert S. Kripowicz, Principal Deputy Assistant Secretary for Fossil Energy, and David L. Goldwyn, Assistant Secretary for International Affairs, both of the Department of Energy; Pam Dunlap, Bartlesville Area Chamber of Commerce, James Fram, Bartlesville Development Corporation, and Richard Gertsen, City of Bartlesville, all of Bartlesville, Oklahoma; Paul C. Maxwell, University of Texas, El Paso; Richard D.

Jimenez, Applied Sciences Laboratory, Inc., Albuquerque, New Mexico; and Van Romero, New Mexico Institute of Mining and Technology, Socorro.

WATER INFRASTRUCTURE

Committee on Environment and Public Works: Committee concluded hearings on S. 968, to authorize the Administrator of the Environmental Protection Agency to make grants to State agencies with responsibility for water source development, for the purposes of maximizing the available water supply and protecting the environment through the development of alternative water sources, S. 914, to amend the Federal Water Pollution Control Act to require that discharges from combined storm and sanitary sewers conform to the Combined Sewer Overflow Control Policy of the Environmental Protection Agency, and S. 1699, to amend the Federal Water Pollution Control Act to authorize appropriations for State water pollution control revolving funds, after receiving testimony from J. Charles Fox, Assistant Administrator for Water, Environmental Protection Agency; Mayor Raymond J. Wieczorek, Manchester, New Hampshire, on behalf the CSO Partnership; Gerald E. Dorfman, Dorfman Construction Company, Inc., Woodland Hills, California, on behalf of the National Utility Contractors Association; Greg Mason, Georgia Environmental Facilities Authority, Atlanta, on behalf of the Council of Infrastructure Financing Authorities; Tom Kamppinen, Michigan Department of Environmental Protection, Lansing, on behalf of the Association of State and Interstate Water Pollution Control Administrators; and E.D. Vergara, Southwest Florida Water Management District, Brooksville.

WTO AGRICULTURAL NEGOTIATIONS

Committee on Finance: Subcommittee on International Trade held hearings to examine the United States agricultural negotiating objectives for the Seattle World Trade Ministerial Conference, receiving testimony from David L. Aaron, Under Secretary of Commerce for International Trade; James Murphy, Assistant United States Trade Representative for Agricultural Affairs; August Schumacher, Jr., Under Secretary of Agriculture for Farm and Foreign Agricultural Services; Jon Caspers, Swaledale, Iowa, on behalf of the National Pork Producers Council; and Allen F. Johnson, National Oilseed Processors Association, Janet A. Nuzum, International Dairy Foods Association, and Lyn Withey, International Paper Company, on behalf of the American Forest and Paper Association, all of Washington, D.C.

Hearings recessed subject to call.

COMPREHENSIVE NUCLEAR TEST BAN TREATY

Committee on Foreign Relations: Committee concluded hearings to review the ratification of the Comprehensive Nuclear Test Ban Treaty (Treaty Doc. 105–28), after receiving testimony from Senators Warner, Shelby, Levin, and Kerrey; Madeleine K. Albright, Secretary of State; Caspar W. Weinberger, former Secretary of Defense; Jeane J. Kirkpatrick, American Enterprise Institute, Washington, D.C., former U.S. Permanent Representative to the United Nations; Stephen J. Ledogar, former Chief Negotiator of the Comprehensive Nuclear Test Ban Treaty, and Richard L. Garwin, Council on Foreign Relations, both of New York, New York; Ronald F. Lehman, Palo Alto, California, former Director, Arms Control and Disarmament Agency; and Troy E. Wade, Nevada Alliance for Defense, Energy, and Business, Las Vegas.

POST OFFICE FACILITIES

Committee on Governmental Affairs: Subcommittee on International Security, Proliferation and Federal Services concluded hearings on S. 556, to amend title 39, United States Code, to establish guidelines for the relocation, closing, consolidation, or construction of post offices, after receiving testimony from Senators Jeffords and Baucus; Rudolph K. Umscheid, Vice President, Facilities, United States Postal Service; Howard S. Foust, National Association of Postmasters of the United States Retired, Alexandria, Virginia; Richard Moe, National Trust for Historic Preservation, Washington, D.C.; and Edward J. Derwinski, National League of Postmasters, Alexandria, Virginia.

BUSINESS MEETING

Committee on the Judiciary: Committee ordered favorably reported the following business items:

S. Res. 179, designating October 15, 1999, as ''National Mammography Day''; and

The nominations of Ronald M. Gould, of Washington, to be United States Circuit Judge for the Ninth Circuit, Anna J. Brown, to be United States District Judge for the District of Oregon, Florence-Marie Cooper, to be United States District Judge for the Central District of California, Richard K. Eaton, of the District of Columbia, to be a Judge of the United States Court of International Trade, Ellen Segal Huvelle, to be United States District Judge for the District of Columbia, and Charles A. Pannell, Jr., to be United States District Judge for the Northern District of Georgia.

House of Representatives

Chamber Action

Bills Introduced: 20 public bills, H.R. 3035–3036, 3038–3055; 1 private bill, H.R. 3056; and 3 resolutions, H. Con. Res. 194 and H. Res. 324–325, were introduced. **Page H9644–45**

Reports Filed: Reports were filed today as follows:

H.R. 748, to amend the Act that established the Keweenaw National Historical Park to require the Secretary of the Interior to consider nominees of various local interests in appointing members of the Keweenaw National Historical Parks Advisory Commission, amended (H. Rept. 106–367);

H.R. 1615, to amend the Wild and Scenic Rivers Act to extend the designation of a portion of the Lamprey River in New Hampshire as a recreational river to include an additional river segment (H. Rept. 106–368);

H.R. 2140, to improve protection and management of the Chattahoochee River National Recreation Area in the State of Georgia, amended (H. Rept. 106–369); and

H.R. 3037, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2000 (H. Rept. 106–370).

Page H9644

Speaker Pro Tempore: Read a letter from the Speaker wherein he designated Representative Biggert as Speaker pro tempore for today. **Page H9517**

Guest Chaplain: The prayer was offered by the guest Chaplain, Rev. Carl W. Rehling of Lothian, Maryland. **Page H9517**

Access for the Uninsured and Managed Care Improvement Act: The House passed H.R. 2723, to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage by a recorded vote of 275 ayes to 151 noes, Roll No. 490. Subsequently, the text of H.R. 2723 was added as new matter to H.R. 2990, Quality Care for the Uninsured Act. H.R. 2723 was then laid upon the table.

Pages H9523–H9636

Rejected:

The Boehner amendment that sought to prohibit gag rules, ensure access to emergency medical care, direct access to an OB/GYN, access to a pediatrician as a primary care provider, establish continuity of care, make health care lawsuit reform with limits on ''non-economic damages'', and requires a patient choice of provider option (rejected by a recorded vote of 145 ayes to 284 noes, Roll No. 487;

Pages H9535–64

The Goss amendment that sought to establish utilization review procedures, require a timely appeals process and external review of benefit disputes, allow patients to sue for denials that cause harm, provide protection for employers, allow choice of medical professionals, prohibit gag clauses, and expand access to clinical trials (rejected by a recorded vote of 193 ayes to 238 noes, Roll No. 488); and

Pages H9564–H9604

The Houghton amendment that sought to allow lawsuits in Federal court against the final decision-maker who fails to exercise ordinary care decisions including employers, caps non-economic damages and prohibits punitive damages (rejected by a recorded vote of 160 ayes to 269 noes, Roll No. 489).

Pages H9604–29

H. Res. 323 the rule that provided for consideration of the bill was agreed to on October 6. Pursuant to the rule, the amendments printed in Part A of H. Rept. 106–366 that make technical changes and clarify provisions to ensure that employers cannot be held liable unless they are making medical decisions, were considered as adopted.

Late Report: Conferees received permission to have until midnight on Friday, October 8, to file a conference report on H.R. 2561, making appropriations for the Department of Defense for the fiscal year ending September 30, 2000. **Page H9636**

Legislative Program: Representative Lazio announced the Legislative Program for the week of October 11. **Pages H9636–37**

Meeting Hour—Friday, October 8: Agreed that when the House adjourns today it adjourn to meet at 10:00 a.m. on Friday, October 8. **Page H9637**

Meeting Hour—Tuesday, October 12: Agreed that when the House adjourns on Friday, October 8, it adjourn to meet at 12:30 p.m. on Tuesday, October 12 for morning-hour debates. **Page H9637**

Calendar Wednesday: Agreed to dispense with the Calendar Wednesday business of October 13.

Page H9637

Quorum calls—Votes: One yea and nay vote and four recorded votes developed during the proceedings of the House today and appear on pages H9522–23, H9564, H9603–04, H9628–29, and H9635–36. There were no quorum calls.

Adjournment: The House met at 10:00 a.m. and adjourned at 5:52 p.m.

Committee Meetings

SPARE AND REPAIR PARTS SHORTAGES

Committee on Armed Services: Subcommittee on Military Readiness held a hearing on spare and repair parts shortages. Testimony was heard from the following officials of the Department of Defense: William J. Lynn, III, Under Secretary (Comptroller and Chief Financial Officer); Gen. John G. Coburn, USA, Commander, Army Materiel Command; Gen. George T. Babbitt, USAF, Commander, Air Force Materiel Command; Rear Adm. Daniel H. Stone, USN, Commander Defense Logistics Support Command, Defense Logistics Agency; Vice Adm. James Amerault, USN, Deputy Chief of Naval Operations (Logistics); and Maj. Gen. Gary S. McKissock, USMC, Deputy Chief of Staff (Installations and Logistics), Headquarters, U.S. Marine Corps.

ELECTROMAGNETIC PULSE THREATS

Committee on Armed Services: Subcommittee on Research and Development held a hearing on electromagnetic pulse (EMP) threats to U.S. military and civilian infrastructure. Testimony was heard from Stanley J. Jakubiak, Deputy Chief, Command Center's Division, Joint Chiefs of Staff, Department of Defense; Michael Bernardin, Provost for Theoretical Institute of Thermonuclear Studies, Los Alamos National Laboratory; Lowell Wood, member, Director's Technical Staff, Lawrence Livermore National Laboratory and Hoover Institution; and a public witness.

PUHCA REPEAL

Committee on Commerce: Subcommittee on Finance and Hazardous Materials held a hearing on PUHCA Repeal: Is The Time Now? Testimony was heard from Isaac C. Hunt, Commissioner, SEC; Douglas W. Smith, General Counsel, Federal Energy Regulatory Commission, Department of Energy; and public witnesses.

STUDENTS RESULTS ACT

Committee on Education and the Workforce: Continued markup of H.R. 2, Students Results Act.

Will continue October 13.

MINIMUM WAGE IMPACT ON WELFARE TO WORK

Committee on Education and the Workforce: Held a hearing on Examining the Impact of Minimum Wage on Welfare to Work. Testimony was heard from public witnesses.

U.S. POLICY TOWARD RUSSIA

Committee on International Relations: Continued hearings on U.S. Policy Toward Russia, Part II: Corruption in the Russian Government. Testimony was heard from public witnesses.

MISCELLANEOUS MEASURES

Committee on the Judiciary: Subcommittee on Courts and Intellectual Property approved for full Committee action the following bills: H.R. 3028, Trademark Cyberpiracy Prevention Act; and H.R. 1714, amended, Electronic Signatures in Global and National Commerce Act.

MISCELLANEOUS MEASURES

Committee on the Judiciary: Subcommittee on Crime approved for full Committee action the following bills: H.R. 1887, amended, to amend title 18, United States Code, to punish the depiction of animal cruelty; and H.R. 1869, Stalking Prevention and Victim Protection Act of 1999.

MISCELLANEOUS MEASURES

Committee on Resources, Subcommittee on Water and Power held a hearing on the following bills: H.R. 2994, Sugar Pine Dam and Reservoir Conveyance Act; H.R. 1696, to direct the Secretary of the Interior to convey the Griffith Project to the Southern Nevada Water Authority; H.R. 2674, providing for conveyance of the Palmetto Bend project to the State of Texas; H.R. 2984, Middle Loup Conveyance Act; H.R. 2974, Lower Yellowstone Irrigation Project Facilities Conveyance Act of 1999; H.R. 2889, to amend the Central Utah Project Completion Act to provide for acquisition of water and water rights for Central Utah Project purposes, completion of Central Utah project facilities, and implementation of water conservation measures; and H.R. 1235, to authorize the Secretary of the Interior to enter into contracts with the Solano County Water Agency, California, to use Solano Project facilities for impounding, storage, and carriage of nonproject water for domestic, municipal, industrial, and other beneficial purposes. Testimony was heard from Eluid Martinez, Commissioner, Bureau of Reclamation, Department of the Interior; and public witnesses.

CRUISE SHIP SAFETY

Committee on Transportation and Infrastructure: Subcommittee on Coast Guard and Maritime Transportation held a hearing on Cruise Ship Safety. Testimony was heard from Rear Adm. Robert C. North, USCG, Assistant Commandant for Marine Safety, U.S. Coast Guard, Department of Transportation; James E. Hall, Chairman, National Transportation Safety Board; and public witnesses.

TRANSPORTATION APPROPRIATIONS—EFFECT ON MOTOR CARRIER SAFETY ENFORCEMENT

Committee on Transportation and Infrastructure: Subcommittee on Ground Transportation held a hearing on the Effect of the Fiscal Year 2000 Department of Transportation Appropriations Act on Motor Carrier Safety Enforcement. Testimony was heard from Nancy E. McFadden, General Counsel, Department of Transportation.

GSA'S FEDERAL BUILDING SECURITY PROGRAM

Committee on Transportation: Subcommittee on Oversight, Investigations, and Emergency Management held a hearing on GSA's Federal Building Security Program. Testimony was heard from Bernard L. Ungar, Director, Government Business Operations Issues, GAO; and the following officials of the GSA: Eugene L. Waszily, Assistant Inspector General, Auditing; and Robert Peck, Commissioner, Public Buildings Service.

The Subcommittee also met in executive session to continue hearings on this subject. Testimony was heard from Robert H. Hast, Acting Assistant Comptroller General, Office of Special Investigations, GAO; and the following officials of the GSA: Eugene L. Waszily, Assistant Inspector General, Auditing; Robert Peck, Commissioner, Public Buildings Service; Robin Graf, Assistant Regional Administrator, Region 10, Auburn, Washington; and Anthony Costa, Assistant Regional Administrator, National Capital Region.

NEW PUBLIC LAWS

(For last listing of Public Laws, see DAILY DIGEST, *p. D1085*)

H.R. 2981, to extend energy conservation programs under the Energy Policy and Conservation Act through March 31, 2000. Signed October 5, 1999. (P.L. 106–64)

S. 1059, to authorize appropriations for fiscal year 2000 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces. Signed October 5, 1999. (P.L. 106–65)

S. 293, to direct the Secretaries of Agriculture and Interior to convey certain lands in San Juan County, New Mexico, to San Juan College. Signed October 6, 1999. (P.L. 106–66)

S. 944, to amend Public Law 105–188 to provide for the mineral leasing of certain Indian lands in Oklahoma. Signed October 6, 1999. (P.L. 106–67)

S. 1072, to make certain technical and other corrections relating to the Centennial of Flight Commemoration Act. Signed October 6, 1999. (P.L. 106–68)

COMMITTEE MEETINGS FOR FRIDAY, OCTOBER 8, 1999

(Committee meetings are open unless otherwise indicated)

Senate

No meetings are scheduled.

House

No committee meetings are scheduled.

Next Meeting of the SENATE

9:30 a.m., Friday, October 8

Senate Chamber

Program for Friday: Senate will consider the Comprehensive Nuclear Test Ban Treaty (Treaty Doc. 105–28). Also, Senate will consider any conference reports when available.

Next Meeting of the HOUSE OF REPRESENTATIVES

10 a.m., Friday, October 8

House Chamber

Program for Friday: Pro forma session.

Extensions of Remarks, as inserted in this issue

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