United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 104th CONGRESS, SECOND SESSION

Vol. 142 WASHINGTON, THURSDAY, APRIL 18, 1996 No. 50

Senate

The Senate met at 9:30 a.m., and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

In our prayer this morning, let us think magnificently about God so that we may serve Him magnanimously throughout the day.

O God, whose love never lets us go, whose mercy never ends, whose strength is always available, whose guidance shows us the way, whose spirit provides us supernatural power, whose presence is our courage, whose joy invades our gloom, whose peace calms our pressured hearts, whose light illuminates our path, whose goodness provides the wondrous gifts of loved ones, family, and friends, whose will has brought us to the awesome tasks of this Senate today, and whose calling lifts us above party politics to put You and the good of our Nation first, we dedicate all that we have and are to serve You today with unreserved faithfulness and unfailing loyalty.

To God be the glory. Amen.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The able majority leader, Senator DOLE, is recognized.

SCHEDULE

Mr. DOLE. Mr. President, we will immediately begin consideration of Calendar No. 205, S. 1028, the Health Insurance Reform Act of 1996. Amendments are expected to be offered. Rollcall votes can be anticipated throughout the day and into the late evening. We want to finish this bill today. We had hoped to start it last evening.

It is also possible that the Senate could resume immigration legislation if agreement can be reached with respect to relevant amendments. That is probably unlikely.

Then, on next Monday, or tomorrow, we hope to start the debate on term limits. We will be announcing more on that later. But we do hope to complete action on the Health Insurance Reform Act of 1996 today or tomorrow. So we will be making an announcement about votes on tomorrow later today.

Mrs. KASSEBAUM. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. THOMAS). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

HEALTH INSURANCE REFORM ACT

The PRESIDING OFFICER. Under the previous order, the Senate will now proceed to consider S. 1028, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1028) to provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

The Senate proceeded to consider the bill, which had been reported from the Committee on Labor and Human Resources with an amendment to strike all after the enacting clause and inserting in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Reform Act of 1995''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Definitions.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

Sec. 101. Guaranteed availability of health coverage.
Sec. 102. Guaranteed renewability of health coverage.
Sec. 103. Portability of health coverage and limitation on preexisting condition exclusions.
Sec. 104. Special enrollment periods.
Sec. 105. Disclosure of information.

Subtitle B—Individual Market Rules

Sec. 110. Individual health plan portability.
Sec. 111. Guaranteed renewability of individual health coverage.
Sec. 112. State flexibility in individual market reforms.
Sec. 113. Definition.

Subtitle C—COBRA Clarifications

Sec. 121. COBRA clarifications.

Subtitle D—Private Health Plan Purchasing Cooperatives

Sec. 131. Private health plan purchasing cooperatives.

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

Sec. 201. Applicability.
Sec. 202. Enforcement of standards.

TITLE III—MISCELLANEOUS PROVISIONS

Sec. 301. HMOs allowed to offer plans with deductibles to individuals with medical savings accounts.
Sec. 302. Health coverage availability study.
Sec. 303. Sense of the Committee concerning Medicare.
Sec. 304. Effective date.
Sec. 305. Severability.

SEC. 2. DEFINITIONS.

As used in this Act:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(2) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of

● This ''bullet'' symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(3) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

(4) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''employee health benefit plan'' means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a group health plan offered by a health plan issuer as defined in paragraph (8); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be construed to be a group health plan, an individual health plan, or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(5) FAMILY.—

(A) IN GENERAL.—The term ''family'' means an individual, the individual's spouse, and the child of the individual (if any).

(B) CHILD.—For purposes of subparagraph (A), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN GENERAL.—The term ''group health plan'' means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.

(B) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(7) GROUP PURCHASER.—The term ''group purchaser'' means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(10) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

(11) SECRETARY.—The term ''Secretary'', unless specifically provided otherwise, means the Secretary of Labor.

(12) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) NONDISCRIMINATION.—Except as provided in subsection (b), section 102 and section 103—

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage; and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements under the terms of such plan, except that such requirements shall not be based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability.

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall prevent an employee health benefit plan or a health plan issuer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering a group health plan may cease offering coverage to group purchasers under the plan if—

(A) the health plan issuer ceases to offer coverage to any additional group purchasers; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is required to offer coverage to additional group purchasers.

Such health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer offers coverage to group purchasers under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a particular market. For the purposes of this paragraph, the term ''market'' means either the large employer market or the small employer market (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees).

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) GROUP PURCHASER.—Subject to subsections (b) and (c), a group health plan shall be renewed or continued in force by a health plan issuer at the option of the group purchaser, except that the requirement of this subparagraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the group purchaser in accordance with the terms of the group health plan or where the health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(C) the termination of the group health plan in accordance with subsection (b); or

(D) the failure of the group purchaser to meet contribution or participation requirements in accordance with paragraph (3).

(2) PARTICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit plan or group health plan shall be renewed or continued in force, if the group purchaser elects to continue to provide coverage under such plan, at the option of the participant (or beneficiary where such right exists under the terms of the plan or under applicable law), except that the requirement of this paragraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the participant or beneficiary in accordance with the terms of the employee health benefit plan or group health plan or where such plan has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application for coverage or claim for benefits;

(C) the termination of the employee health benefit plan or group health plan;

(D) loss of eligibility for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.); or

(E) failure of a participant or beneficiary to meet requirements for eligibility for coverage under an employee health benefit plan or group health plan that are not prohibited by this Act.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection, nor in section 101(a), shall be construed to—

(A) preclude a health plan issuer from establishing employer contribution rules or group participation rules for group health plans as allowed under applicable State law;

(B) preclude a plan defined in section 3(37) of the Employee Retirement Income Security Act of

1974 (29 U.S.C. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan, a group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the health plan issuer offers to each group purchaser covered under a group health plan of this type, the option to purchase any other group health plan currently being offered by the health plan issuer; and

(C) in exercising the option to discontinue a group health plan of this type and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS.—

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering all group health plans in a State, a group health plan may be discontinued by the health plan issuer only if—

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan; and

(ii) all group health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(B) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer—

(i) to all group health plans offered to small employers (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan issuer in the State.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any group health plan in the market sector (as described in paragraph (2)(B)) in which issuance of such group health plan was discontinued in the State involved during the 5-year period beginning on the date of the discontinuation of the last group health plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan (as defined in paragraph (2)) may deny continued participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition based on the fact that the condition existed prior to the coverage of the participant or beneficiary under the plan only if—

(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan;

(2) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption (as determined under section 609(c)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; and

(3) the limitation or exclusion does not apply to a pregnancy.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to an individual described in subsection (a)(2) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries whose coverage is terminated under the plan. Pursuant to regulations promulgated by the Secretary, the duty of an employee health benefit plan to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such employee health benefit plan provides documentation to a participant or beneficiary that includes the following information:

(A) the dates that the participant or beneficiary was covered under the plan; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation to such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition, subject to the limits in subsection (a)(1), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, with respect to a participant or beneficiary enrolling in an employee health benefit plan or a group health plan during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, coverage with respect to benefits or services relating to the treatment of a preexisting condition in accordance with subsections (a) and (b) may be excluded, except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

(d) AFFILIATION PERIODS.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting condition limitation or exclusion, if such plan does not utilize a limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary not to exceed 60 days (or in the case of a late participant or beneficiary described in subsection (c), 90 days) from the date on which the participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a health plan issuer offering a group health plan may also use alternative methods to address adverse selection as approved by the applicable certifying authority (as defined in section 202(d)). During such an affiliation period, the plan may not be required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(e) PREEXISTING CONDITION.—For purposes of this section, the term ''preexisting condition'' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(f) STATE FLEXIBILITY.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for under this section; or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 30-day period provided for under subsection (b)(3);

unless such laws are preempted by section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member who—

(1) through marriage, separation, divorce, death, birth or placement of a child for adoption, experiences a change in family composition affecting eligibility under a group health plan, individual health plan, or employee health benefit plan;

(2) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member;

each employee health benefit plan and each group health plan shall provide for a special enrollment period extending for a reasonable time after such event that would permit the participant to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual, participant, or beneficiary but for failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption shall be deemed to be covered under the plan as of the date of such birth or placement for adoption if such child is enrolled within 30 days of the date of such birth or placement for adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—

(1) IN GENERAL.—In connection with the offering of any group health plan to a small employer (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) the provisions of such group health plan relating to renewability of coverage;

(C) the provisions of such group health plan relating to any preexisting condition provision; and

(D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Information shall be provided to small employers under this paragraph in a manner determined to be understandable by the average small employer, and shall be sufficiently accurate and comprehensive to reasonably inform small employers, participants and beneficiaries of their rights and obligations under the group health plan.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(b) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof the following new sentences: ''If there is a modification or change described in section 102(a)(1) that is a material reduction in covered services or benefits provided, a summary description of such modification or change shall be furnished to participants not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1995, providing alternative mechanisms to delivery by mail through which employee health benefit plans may notify participants of material reductions in covered services or benefits.''.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(A) by inserting ''including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits'' after ''type of administration of the plan'';

(B) by inserting ''including the name of the organization responsible for financing claims'' after ''source of financing of the plan''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through which participants may seek assistance or information regarding their rights under this Act and the Health Insurance Reform Act of 1995 with respect to health benefits that are not offered through a group health plan.'' after ''benefits under the plan''.

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) LIMITATION ON REQUIREMENTS.—

(1) IN GENERAL.—With respect to an individual desiring to enroll in an individual health plan, if such individual is in a period of previous qualifying coverage (as defined in section 103(b)(3)(A)(i)) under one or more group health plans or employee health benefit plans that commenced 18 or more months prior to the date on which such individual desires to enroll in the individual plan, a health plan issuer described in paragraph (3) may not decline to offer coverage to such individual, or deny enrollment to such individual based on the health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of the individual, except as described in subsections (b) and (c).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.

(3) HEALTH PLAN ISSUER.—A health plan issuer described in this paragraph is a health plan issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) ELIGIBILITY FOR OTHER GROUP COVERAGE.—The provisions of subsection (a) shall not apply to an individual who is eligible for coverage under a group health plan or an employee health benefit plan, or who has had coverage terminated under a group health plan or employee health benefit plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact, or who is otherwise eligible for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) or under an equivalent State program.

(c) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering coverage to individuals under an individual health plan may cease enrolling individuals under the plan if—

(A) the health plan issuer ceases to enroll any new individuals; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to enroll additional individuals.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering coverage to individuals under an individual health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) MARKET REQUIREMENTS.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) CONVERSION POLICIES.—A health plan issuer offering group health plans to group purchasers under this Act shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan;

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered by the health plan issuer to individuals; and

(C) in exercising the option to discontinue the individual health plan and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of particular individuals.

(2) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—In any case in which a health

plan issuer elects to discontinue all individual health plans in a State, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each individual covered under the plan of such discontinuation at least 180 days prior to the date of the discontinuation of the plan; and

(B) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any individual health plan in the State involved during the 5-year period beginning on the date of the discontinuation of the last plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular individuals.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an individual health plan that arranges for the financing and delivery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) IN GENERAL.—With respect to any State law with respect to which the Governor of the State notifies the Secretary of Health and Human Services that such State law will achieve the goals of sections 110 and 111, and that is in effect on, or enacted after, the date of enactment of this Act (such as laws providing for guaranteed issue, open enrollment by one or more health plan issuers, high-risk pools, or mandatory conversion policies), such State law shall apply in lieu of the standards described in sections 110 and 111 unless the Secretary of Health and Human Services determines, after considering the criteria described in subsection (b)(1), in consultation with the Governor and Insurance Commissioner or chief insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for those individuals described in sections 110 and 111.

(b) DETERMINATION.—

(1) IN GENERAL.—In making a determination under subsection (a), the Secretary of Health and Human Services shall only—

(A) evaluate whether the State law or program provides guaranteed access to affordable coverage to individuals described in sections 110 and 111;

(B) evaluate whether the State law or program provides coverage for preexisting conditions (as defined in section 103(e)) that were covered under the individuals' previous group health plan or employee health benefit plan for individuals described in sections 110 and 111;

(C) evaluate whether the State law or program provides individuals described in sections 110 and 111 with a choice of health plans or a health plan providing comprehensive coverage; and

(D) evaluate whether the application of the standards described in sections 110 and 111 will have an adverse impact on the number of individuals in such State having access to affordable coverage.

(2) NOTICE OF INTENT.—If, within 6 months after the date of enactment of this Act, the Governor of a State notifies the Secretary of Health and Human Services that the State intends to enact a law, or modify an existing law, described in subsection (a), the Secretary of Health and Human Services may not make a determination under such subsection until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1997, whichever is later. With respect to a State that provides notice under this paragraph and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary shall not make a determination under subsection (a) prior to January 1, 1998.

(3) NOTICE TO STATE.—If the Secretary of Health and Human Services determines that a State law or program does not achieve the goals described in subsection (a), the Secretary of Health and Human Services shall provide the State with adequate notice and reasonable opportunity to modify such law or program to achieve such goals prior to making a final determination under subsection (a).

(c) ADOPTION OF NAIC MODEL.—If, not later than 9 months after the date of enactment of this Act—

(1) the National Association of Insurance Commissioners (hereafter referred to as the ''NAIC''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, adopts a model standard or standards for reform of the individual health insurance market; and

(2) the Secretary of Health and Human Services determines, within 30 days of the adoption of such NAIC standard or standards, that such standards comply with the goals of sections 110 and 111;

a State that elects to adopt such model standards or substantially adopt such model standards shall be deemed to have met the requirements of sections 110 and 111 and shall not be subject to a determination under subsection (a).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used in this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan under section 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(3) Coverage issued as a supplement to liability insurance.

(4) Liability insurance, including general liability insurance and automobile liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital or fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(II) by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1995''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(2) ELECTION.—Section 2205(1)(C) of the Public Health Service Act (42 U.S.C. 300bb-5(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof;

(B) in clause (ii), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb-6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb-8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(ii) by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1995''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(2) ELECTION.—Section 605(1)(C) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof;

(B) in clause (ii), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(3)) is amended by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section'';

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this subsection because of the provision of the Health Insurance Reform Act of 1995''; and

(C) in clause (v), by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(2) ELECTION.—Section 4980B(f)(5)(A)(iii) of the Internal Revenue Code of 1986 is amended—

(A) in subclause (I), by striking ''or'' at the end thereof;

(B) in subclause (II), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new subclause:

''(III) in the case of an qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of the enactment of this Act for plan years beginning after December 31, 1996.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effective, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this Act, the term ''health plan purchasing cooperative'' means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing individual health plans or group health plans offered by health plan issuers. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of insurance may not underwrite a cooperative.

(b) CERTIFICATION.—

(1) IN GENERAL.—If a group described in subsection (a) desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this Act, the Secretary shall certify and oversee the operations of such cooperatives in such State.

(3) INTERSTATE COOPERATIVES.—For purposes of this section, a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of certifying and overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a broad cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of individual health plans or group health plans may not hold or control any right to vote with respect to a cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

(3) CONFLICT OF INTEREST.—No member of the Board of Directors (or family members of such members) nor any management personnel of the cooperative may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of any health plan issuer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage offered through the cooperative.

(d) MEMBERSHIP AND MARKETING AREA.—

(1) MEMBERSHIP.—A health plan purchasing cooperative may establish limits on the maximum size of employers who may become members of the cooperative, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the cooperative shall, except as provided in subparagraph (B), accept all employers (or individuals) residing within the area served by the cooperative who meet such requirements as members on a first-come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing cooperative. With respect to a State that has not established such rules, a health plan purchasing cooperative operating in the State shall define the boundaries of the area to be served by the cooperative, except that such boundaries may not be established on the basis of health status or insurability of the populations that reside in the area.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN GENERAL.—A health plan purchasing cooperative shall—

(A) enter into agreements with multiple, unaffiliated health plan issuers, except that the requirement of this subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible;

(B) enter into agreements with employers and individuals who become members of the cooperative;

(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State;

(D) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning group health plans and individual health plans offered through the cooperative);

(E) actively market to all eligible employers and individuals residing within the service area; and

(F) act as an ombudsman for group health plan or individual health plan enrollees.

(2) PERMISSIBLE ACTIVITIES.—A health plan purchasing cooperative may perform such other functions as necessary to further the purposes of this Act, including—

(A) collecting and distributing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;

(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers;

(D) cooperating with (or accepting as members) employers who provide health benefits directly to participants and beneficiaries only for the purpose of negotiating with providers; and

(E) negotiating with health care providers and health plan issuers.

(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers;

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;

(3) establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements for participants, beneficiaries, or individuals based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability;

(4) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization—

(A) in which membership in such organization is not based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability; and

(B) that accepts as members all employers or individuals on a first-come, first-served basis, subject to any established limit on the maximum size of and employer that may become a member; or

(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this Act.

(g) LIMITED PREEMPTION OF CERTAIN STATE LAWS.—

(1) IN GENERAL.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State fictitious group laws shall be preempted.

(2) HEALTH PLAN ISSUERS.—

(A) RATING.—With respect to a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative that meets the requirements of this section, State premium rating requirement laws, except to the extent provided under subparagraph (B), shall be preempted unless such laws permit premium rates negotiated by the cooperative to be less than rates that would otherwise be permitted under State law, if such rating differential is not based on differences in health status or demographic factors.

(B) EXCEPTION.—State laws referred to in subparagraph (A) shall not be preempted if such laws—

(i) prohibit the variance of premium rates among employers, plan sponsors, or individuals that are members of a health plan purchasing cooperative in excess of the amount of such variations that would be permitted under such State rating laws among employers, plan sponsors, and individuals that are not members of the cooperative; and

(ii) prohibit a percentage increase in premium rates for a new rating period that is in excess of that which would be permitted under State rating laws.

(C) BENEFITS.—Except as provided in subparagraph (D), a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative shall comply with all State mandated benefit laws that require the offering of any services, category or care, or services of any class or type of provider.

(D) EXCEPTION.—In those States that have enacted laws authorizing the issuance of alternative benefit plans to small employers, health plan issuers may offer such alternative benefit plans through a health plan purchasing cooperative that meets the requirements of this section.

(h) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to—

(1) require that a State organize, operate, or otherwise create health plan purchasing cooperatives;

(2) otherwise require the establishment of health plan purchasing cooperatives;

(3) require individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State;

(5) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans; or

(6) confer authority upon a State (or the Federal Government) that the State (or Federal Government) would not otherwise have to regulate group purchasing arrangements, coalitions, or other similar entities that do not desire to become a health plan purchasing cooperative in accordance with this section.

(i) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 and 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101) shall apply to a health plan purchasing cooperative as if such plan were an employee welfare benefit plan.

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 201. APPLICABILITY.

(a) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) IN GENERAL.—A requirement or standard imposed under this Act on a group health plan or individual health plan offered by a health plan issuer shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act. In the case of a group health plan offered by a health plan issuer in connection with an employee health benefit plan, the requirements or standards imposed under this Act shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this Act as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a State enforce the requirements or standards of this Act as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this Act shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this Act; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this Act and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(c) CONTINUATION.—Nothing in this Act shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular participant or beneficiary in excess of those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this Act pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the State enforcement plan.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—With respect to employee health benefit plans, the Secretary shall enforce the reform standards established under this Act in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State to substantially enforce the standards and requirements set forth in this Act with respect to group health plans and individual health plans as provided for under the State enforcement plan filed under subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this Act in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this Act, each health plan issuer operating in such State shall be subject to civil enforcement as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(d) APPLICABLE CERTIFYING AUTHORITY.—As used in this title, the term ''applicable certifying authority'' means, with respect to—

(1) health plan issuers, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this Act for the State involved; and

(2) an employee health benefit plan, the Secretary.

(e) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this Act.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1995'' before the period.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. HMOS ALLOWED TO OFFER PLANS WITH DEDUCTIBLES TO INDIVIDUALS WITH MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 1301(b) of the Public Health Service Act (42 U.S.C. 300e(b)) is amended by adding at the end the following new paragraph:

''(6)(A) If a member certifies that a medical savings account has been established for the benefit of such member, a health maintenance organization may, at the request of such member reduce the basic health services payment otherwise determined under paragraph (1) by requiring the payment of a deductible by the member for basic health services.

''(B) For purposes of this paragraph, the term 'medical savings account' means an account which, by its terms, allows the deposit of funds and the use of such funds and income derived from the investment of such funds for the payment of the deductible described in subparagraph (A).''.

(b) MEDICAL SAVINGS ACCOUNTS.—It is the sense of the Committee on Labor and Human Resources of the Senate that the establishment of medical savings accounts, including those defined in section 1301(b)(6)(B) of the Public Health Service Act (42 U.S.C. 300e(b)(6)(B)), should be encouraged as part of any health insurance reform legislation passed by the Senate through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, such accounts.

(c) SENSE OF THE SENATE.—It is the sense of the Senate that the Congress should take measures to further the purposes of this Act, including any necessary changes to the Internal Revenue Code of 1986 to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits.

SEC. 302. HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, shall conduct a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—Not later than January 1, 1997, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning—

(1) an evaluation, based on the experience of States, expert opinions, and such additional data as may be available, of the various mechanisms used to ensure the availability of reasonably priced health coverage to employers purchasing group coverage and to individuals purchasing coverage on a non-group basis; and

(2) whether standards that limit the variation in premiums will further the purposes of this Act.

(c) EVALUATION OF EFFECTIVENESS.—Not later than January 1, 1998, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning the effectiveness of the provisions of this Act and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a nongroup basis.

SEC. 303. SENSE OF THE COMMITTEE CONCERNING MEDICARE.

(a) FINDINGS.—The Committee on Labor and Human Resources of the Senate finds that the Public Trustees of Medicare concluded in their 1995 Annual Report that—

(1) the Medicare program is clearly unsustainable in its present form;

(2) ''the Hospital Insurance Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range''; and

(3) the Public Trustees ''strongly recommend that the crisis presented by the financial condition of the Medicare trust fund be urgently addressed on a comprehensive basis, including a review of the programs's financing methods, benefit provisions, and delivery mechanisms''.

(b) SENSE OF THE COMMITTEE.—It is the Sense of the Committee on Labor and Human Resources of the Senate that the Senate should take measures necessary to reform the Medicare program, to provide increased choice for seniors, and to respond to the findings of the Public Trustees by protecting the short-term solvency and long-term sustainability of the Medicare program.

SEC. 304. EFFECTIVE DATE.

Except as otherwise provided for in this Act, the provisions of this Act shall apply as follows:

(1) With respect to group health plans and individual health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1996; and

(2) With respect to employee health benefit plans, on the first day of the first plan year beginning on or after January 1, 1996.

SEC. 305. SEVERABILITY.

If any provision of this Act or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this Act and the application of the provisions of such to any person or circumstance shall not be affected thereby.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, Congress has spent significant time during the past 4 years debating comprehensive health care reform and major reforms to the Medicaid and Medicare Programs. While we have filled pages of newspapers and the CONGRESSIONAL RECORD and hearing records, our actions have not equaled our words.

Meanwhile, many American families worry about the availability, portability, and cost of their own health care coverage.

The health insurance problem is not merely one of perception. The health care market continues to transform itself. An example is the rapid movement toward managed care. At the same time, the number of uninsured and underinsured Americans has continued to climb. There are now over 40 million Americans without health insurance, and that number continues to grow.

Over 1 million working Americans have lost health insurance in the last 2 years alone, and over 80 million Americans have preexisting conditions that could make it difficult for them to maintain health coverage when they change jobs.

The current health insurance system provides too little protection for individuals and families with health problems and makes it too difficult for employers, particularly small employers, to obtain adequate coverage for their employees. It also locks people into jobs out of fear they will lose their health care coverage if they change jobs or if they lose their jobs.

Let me remind my colleagues that Federal law preempts States from providing portability to the majority of Americans who get their coverage through so-called self-insured health plans. Therefore, only Congress, only the Federal Government, can guarantee insurance portability and an end to job lock. That is one of the main reasons all major organizations representing the States have endorsed S. 1028.

The Health Insurance Reform Act before the Senate today passed the Senate Labor and Human Resources Committee in August by a unanimous vote. It now has 65 cosponsors, 27 Republicans and 38 Democrats. It is clear that, if this bill were to come to a vote in its current form, it would have more than enough votes to overcome any potential filibuster. The House of Representatives already has passed legislation containing health insurance reform similar to S. 1028.

Moreover, the bill has been endorsed by a wide range of organizations, including the National Governors' Association, the National Association of State Insurance Commissioners, the Consortium for Citizens with Disabilities, Small Business United, the National Association of Manufacturers, the National Federation of Independent Business, the U.S. Chamber of Commerce, the American Medical Association, American Hospital Association, Families USA, Consumers Union, the American Association of Retired Persons, and the AFL–CIO.

The portability provisions of this bill are even supported by many health insurers, including the American Association of Health Plans, Aetna, Prudential, Cigna, United Healthcare and the Blue Cross and Blue Shield Association, which is the largest health insurance carrier in the individual market.

Doctors, hospitals, insurers, HMO's, large business, small business, organized labor, and consumer groups all support the bill before us today. When one looks at the history of health care reform and the difficult tradeoffs and policy choices that must be made, that fact alone, I suggest, is remarkable.

The majority of these organizations have made clear that their support is conditioned on S. 1028 remaining free of contentious amendments.

We have a historic opportunity to pass limited, but real, health reform for the American people. We must not squander this opportunity by expanding the scope of this bill. The lessons of the past are clear. If we try to do too much, we will fail to do anything.

This bill is too important to people who may not have a voice in the Halls of Congress by any major organization, but who will be helped tremendously by this legislation. People like Tom Hall, a retired construction worker and farmer from Oklahoma City.

After 30 years of being covered by his employer, Tom started his own company and tried to buy an insurance policy for his family. However, the same insurer that had covered him while he was employed turned him down. Several years later, he did find an insurance policy that covers everything but his preexisting heart condition.

Mr. Hall testified before our committee, and it was very powerful testimony in its own significant way. Clearly, Mr. Hall would be protected by the group-to-individual portability provisions of this bill.

There are other families who would benefit. One is from Herndon, VA. A daughter who has cerebral palsy is excluded from coverage for at least 12 months every time the husband, Robert, changes jobs. While they have waited for these preexisting conditions to expire, they have had to pay both COBRA coverage and coverage under the new employer plan.

Mr. President, I also visited with a young woman who is an employee of the U.S. Senate. She has cancer. Her husband is completing his graduate work, and they hope to move to Florida. She is afraid to leave the coverage she has under her Federal employees health insurance for fear if they move to Florida, she may not be able to get insurance which would cover her because of her having cancer.

These are just some examples of people who would be helped directly by this legislation.

Only a year after President Clinton waved his veto pen and said he would not sign any bill that did not contain universal coverage, the President now says he will sign this carefully targeted health insurance portability bill. We should take him up on that offer.

The bill before us today does not achieve universal coverage. It is a far cry from the comprehensive health reform proposals that were considered by Congress only in the last Congress. However, it would immediately and measurably improve the lives of millions of Americans.

Through sensible, market-based reforms, the Health Insurance Reform Act would, first, limit the ability of insurers and employers to impose exclusions for preexisting conditions; second, prevent insurers from dropping coverage when an individual changes jobs or family members become sick; and third, help small companies gain more purchasing clout in the marketplace.

Despite its limited scope, the General Accounting Office estimates that the Health Insurance Reform Act would

help at least 25 million Americans each year, and the Congressional Budget Office predicts that it would do so without any cost to the American taxpayers.

Mr. President, I do not know whether it is 25 million. I do not know if it is 10 million or if it is 5 million. What matters is each and every one of us in this U.S. Senate knows someone it would help. And if it only helps those few that we know even, it would be well worth positive consideration on the floor of the Senate.

I believe the legislation has achieved broad consensus for two main reasons. First, it is narrowly focused. It does not contain employer mandates, mandatory purchasing alliances, new taxes or new bureaucracies. Instead, the legislation focuses only on those areas where broad bipartisan agreement existed during the health care debate in the 103d Congress and where State insurance reforms have demonstrated the ability to work.

Second, the legislation was crafted with a significant input from consumers, insurers, businesses, hospitals and doctors. It is carefully attuned to the rapidly changing private health care market.

The Health Insurance Reform Act is not without some detractors. We have worked closely with the health insurance industry, and insurers generally support the bill. For example, the Health Insurance Association of America submitted testimony in favor of the vast majority of the bill's provisions. However, some continue to raise concerns about one provision of the legislation that is designed to help individuals and families who have played by the rules to maintain health coverage if they lose their job or leave a job to work for an employer that does not offer coverage.

I believe, however, that this provision strikes a careful balance between the need to provide consumers access to individual coverage and the need to protect the fragile individual insurance market.

The Health Insurance Reform Act would provide access to individual insurance only for those who have maintained prior continuous coverage under an employer-sponsored health plan for at least 1½ years, who have exhausted their COBRA benefits, and who are ineligible for coverage under another group policy.

Moreover, S. 1028 contains no restrictions on premiums. There are many who wish that it did, and it leaves broader reforms, such as guaranteed issue for individuals who have not had prior coverage, guaranteed issue for self-employed and portability between individual health plans to the States.

As a result, the bill requires individuals to pay into the system before being able to use its provisions for continued health coverage. This group-to-individual portability provision is carefully circumscribed precisely to avoid potential premium increases and adverse selection problems that could result from broader individual market reforms.

The American Academy of Actuaries, the Congressional Budget Office, the Rand Corp., the Hay Huggins Group and other credible independent actuaries have confirmed that this narrow provision would have only a minimal impact on the cost of health coverage in the individual market. There are some who have vastly exaggerated what the premium increase would be, but those that I have mentioned are sources that have no ax to grind in this area and whose reliability on projections are totally objective.

The substitute goes even further. It expressly provides that if a State has adopted or adopts in the future a high-risk pool or other means of allowing individuals to maintain health coverage, that State law or program will apply in lieu of the group-to-individual portability provision contained in the bill.

Instead of preempting State reforms that are working or prescribing a one-size-fits-all solution from Washington, S. 1028 allows each State to fashion individual market solutions that are appropriate for individuals in that State. This is another reason why both the Governors and the State insurance commissioners support the bill.

Mr. President, I think we all know those who would be helped by this legislation, as I said. The Health Insurance Reform Act does not strike out in a bold new direction, but it is a positive step forward that will help reduce barriers to health coverage for millions of working Americans. It is also an opportunity to demonstrate to the American people that Republicans and Democrats can work together to address their most serious concerns regarding health care.

As Robert Samuelson stated in his column on April 17 in the Washington Post:

> The virtue of this proposal is its modesty. There is nothing wrong with constructive tinkering. We've had enough of grand reforms, which promise much and deliver little. However, if enacted, it would provide a little extra peace of mind for those who have already had employer-paid insurance.

He concludes:

> This legislation isn't exciting but then again good government often isn't.

Mr. President, it may not be exciting, but let me tell you, if you know one person this legislation would help, it is, indeed, exciting.

I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER (Mr. INHOFE). The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I want, first of all, as we begin the consideration of the legislation which can make such an extraordinary difference to millions of our fellow citizens in this country, mention at the outset my great respect, and I think the respect all of us in the Senate should have, for the chairperson of our committee of the Labor and Human Resources Committee.

I can remember going back the last time that the Senate was considering major legislation—we have had other legislation in the meantime—the comprehensive legislation that we considered now some 2 years ago. During that period of time, Senator KASSEBAUM was tireless in trying to find some common ground. We had some areas of agreement. We were unable, obviously, to get to the full measure of agreement during those considerations. But I think all of us who were a part of that effort knew that Senator KASSEBAUM was trying to find the areas of common ground on which we could move forward. At the end of the consideration of that legislation, I can remember a conversation that we had.

In her typical manner, she expressed a very compelling view that we should not let the issues of health care fall by the wayside and that we ought to try to look through the various proposals that had been considered at that period of time and that we ought to try to piece what we could together that could make an important difference for the American people and see if we could not work out a bipartisan effort.

It was really from that initiative and from that energy that she has spent hour after hour after hour in small meetings, large meetings, hearings, in visiting with various interested members of our committee and other Members of the Senate, and really helped in developing this legislation. In an extraordinary committee action, we were able to bring all the members and get a unanimous vote in support of this legislation, which is really an extraordinary achievement and accomplishment at any time. It certainly is now in this Congress, which in many instances has had more contentious debates and less agreement on many public policy issues.

But in this area, it is really a result of her own particular skills and talents and energy and strong commitment that we are here today with the extraordinary support that she has mentioned in regard to both Republicans and Democrats. I think all Members of the Senate, obviously, who know her and know her perseverance pay tribute to her extraordinary leadership on this issue.

I certainly at the outset of this debate and discussion acknowledge that and pay tribute to it. I think when the history of health policy is written, her imprint on not just this legislation but on so many other measures of health will be very, very much recognized, as it should be. It has been a personal pleasure to have the chance to work with her. I know all the members of the committee feel the same way.

Mr. President, the legislation we are considering today will end many of the most serious health insurance abuses and provide greater protection to millions of families. It is an opportunity we cannot afford to miss.

The abusive practices addressed by this bill create endless, unnecessary suffering. Millions of Americans are forced to pass up opportunities to accept jobs that would improve their standard of living or offer them greater opportunities because they are afraid they will lose their health insurance. Many others have to abandon the goal of starting their own business because health insurance would be unavailable to them or members of their families.

Children who age out of their parents' policies often find themselves unable to obtain their own insurance if they have any significant health problems. Early retirees can find themselves uninsured just when they are entering the years of highest health risks.

Other Americans lose their health insurance because they become sick or lose their job or change their job, even when they have faithfully paid their insurance premiums for many years.

With each passing year, the flaws in the private health insurance market become more serious. More than half of all insurance policies impose exclusions for preexisting conditions. As a result, insurance is often denied for the very illnesses most likely to require medical care. The purpose of such exclusions is reasonable to prevent people from gaming the system by purchasing coverage only when they get sick, but current practices are indefensible.

No matter how faithfully people pay their premiums, they often have to start over again with a new exclusion period if they change jobs or lose their coverage. And 81 million Americans have conditions that could subject them to such exclusions if they lose their current health care coverage. Sometimes the exclusions make them completely uninsurable.

Insurers impose exclusions for preexisting conditions on people who do not deserve to be excluded from the coverage they need. Sometimes insurers deny coverage to entire firms if one employee of the firm is in poor health or exclude that employee from the coverage. In other cases, entire categories of businesses with millions of employees are red lined out of coverage.

Even if people are fortunate enough to gain coverage and have no preexisting condition, their coverage can be canceled if they have the misfortune to become sick, even after paying premiums for years.

Robert Frasher from Mansfield, OH, works for an employer who offers health coverage to employees, but the insurance company will not cover him. Why? Because he has Crohn's disease.

Jean Meredith of Harriman, TN, and her husband Tom owned Fruitland USA, a mom-and-pop convenience store. They had insurance through their small business for 8 years until Tom was diagnosed with non-Hodgkin's lymphoma, and their insurance company dropped them. When the Merediths asked why, they were told they were no longer profitable insurance risks. Without health insurance, Tom Meredith had to wait a year to get the surgery he needed. After spending $60,000 of his own funds, his cancer recurred and he died of cancer about a year ago. Tom Meredith might still be alive today if he had not been forced to wait that year.

One of the most serious consequences of the current system is job lock. Workers who want to change jobs to improve their careers or provide a better standard of living for their families must give up that opportunity because it means losing their health insurance. A quarter of all American workers say they are forced to stay in a job they otherwise would have left because they are afraid of losing their health insurance.

Diane Bratten, from Grove Heights, MN, her family had insurance through Diane's employer. Because of a history of breast cancer—now in remission—Diane and her family will not be able to get decent coverage if she decides to change jobs or is laid off.

The legislation that Senator KASSEBAUM and I have introduced will address these problems effectively. The Kassebaum-Kennedy Health Insurance Reform Act is a health insurance bill of rights for every American and for every business as well. The legislation contains many of the provisions from the 1994 health reform debate which received bipartisan support, such as an increased access to health insurance, increased portability, protection of health benefits for those who lose their jobs or want to start their own business, and greater purchasing power for individuals and small businesses.

Those who have insurance deserve the security of knowing that their coverage cannot be canceled, especially when they need it the most. They deserve the security of knowing that if they pay their insurance premiums for years, they cannot be denied coverage, be subjected to a new exclusion for a preexisting condition when they change jobs, join another group policy, or when they need to purchase coverage in the individual market. Businesses, especially small businesses, deserve the right to purchase health insurance for their employees at a reasonable price.

Our Health Insurance Reform Act addresses these fundamental flaws in the private insurance system. The bill limits the ability of insurance companies to impose exclusions for preexisting conditions. Under the legislation, no exclusion can last for more than 12 months. Once someone has been covered for 12 months, no new exclusion can be imposed as long as there is no gap in coverage, even if someone changes jobs, loses their job, or changes insurance companies.

The bill requires insurers to sell and renew group health policies for all employers who want coverage for their employees. It guarantees renewability of individual policies. It prohibits insurers from denying insurance to those moving from group coverage to individual coverage. It prohibits group health plans from excluding any employee based on health status.

The portability provisions of the bill mean that individuals with coverage under a group health plan will not be locked into their job for fear that they will be denied coverage or face a new exclusion for a preexisting condition. These provisions will benefit at least 25 million Americans annually, according to the General Accounting Office. In addition, the provisions will provide greater security for the 131 million Americans currently covered under group health plans.

The bill will also help small businesses provide better and less expensive coverage for their employees. Purchasing cooperatives will enable small groups and individuals to join together to negotiate better rates in the market. As a result, they can obtain the kind of clout in the marketplace currently available only to large employers.

The bill also provides great flexibility for States to meet the objective of access to affordable health care for individuals who leave their group health plans.

During the debate on health reform in the last Congress, even the opponents of comprehensive reform urged Congress to pass at least the reforms that everyone supported—portability of coverage, guaranteed availability of coverage, and limitations on exclusions for preexisting conditions. These are exactly the provisions included in this bill.

Senator PHIL GRAMM, over 2 years ago said:

> We can fix the system and make it possible for people to change jobs without losing their health insurance. Every one of the proposals that has been made to reform health care—every single bill—has a provision that would make it possible for people to change jobs without losing their insurance.

Majority Leader DOLE, in his statement on the floor of the Senate in August 1994 said this:

> We will be back . . . And you can bet that health care will be near the top of our agenda. . . . There are a lot of plans and some have similarities. Many of us think we ought to take all the common parts of these plans, put them together and pass that bill.

Here is our chance. This is the bill.

The Health Insurance Reform Act is a modest, responsible, bipartisan solution to many of the most obvious abuses in the health insurance marketplace today. The bill was approved by the Senate Labor and Human Resources Committee last August by a unanimous vote of 16 to 0. It is similar to proposals made by President Clinton in his recent balanced budget plan.

The measures it includes are also virtually identical to provisions of legislation offered by Senator DOLE in the last Congress—legislation supported by virtually every Republican Member. Sponsors range from the most conservative Members of the Senate to the most liberal—because these reforms

represent simple justice. They are not issues of ideology or partisanship.

Support for the bill by outside groups is equally broad. Almost 200 groups have expressed their support. These include business associations like the chamber of commercve, National Small Business United, the National Association of Manufacturers, the ERISA Industry Committee, and the Association of Private Pension and Welfare Plans. The AFL–CIO has endorsed the program, so that on this issue business and labor are united. The program is also supported by the National Governors' Association and the National Association of State Insurance Commissioners, who believe the legislation represents an appropriate balance between Federal and State responsibilities.

Responsible insurance companies support this bill, including the insurance companies in the Alliance for Managed Care, the American Association of Health Plans, Phoenix Life Insurance Co., the Blue Cross/Blue Shield Association, and other insurance companies. Blue Cross and Blue Shield are the largest carriers in the individual insurance market. The American Association of Health Plans has millions of individual subscribers. These responsible companies know that the insurance system is broken and needs to be fixed.

The Independent Insurance Agents of America—the largest association of agents in the country—sees the tragedies created by the current system every day. They support this bill.

Doctors, hospitals, and other health providers see those tragedies as well, and they support the legislation. It has been endorsed by the American Medical Association, the American Hospital Association, and over 44 medical specialty societies. This bill also enjoys the support of a number of the consumer groups that understand the need for legislation so well, including the Consortium for Citizens with Disabilities, and Consumers Union.

In fact, the only opposition to this legislation comes from those who profit from the abuses in the current system.

In his State of the Union Address last January, President Clinton challenged Congress to pass this bill. Now that the legislation has been brought to the floor of the Senate, I believe it will pass overwhelmingly—unless some in the Senate insist on following the Republican majority in the House of Representatives by addressing controversial and harmful provisions like medical savings accounts, federalization of multiple employer welfare arrangements, Federal caps on malpractice awards, repeal of MediGap rules protecting senior citizens against profiteers, or provisions making it more difficult to combat the waste, fraud and abuse in the current Medicare and Medicaid Programs. Almost all of the 200 groups that support the legislation have urged the Senate to pass a clean bill, without these controversial amendments.

These objectionable provisions of the House bill may serve the special interests, but they have no place in this legislation. Their adoption will almost certainly kill this bill, and destroy the hopes of millions of Americans for the kind of modest but effective reform that leaders of both parties have supported in the past.

Medical savings accounts, which are included in a major amendment to be offered later in this debate are particularly objectionable. They are opposed by virtually every credible health policy expert. They attract the healthy and wealthy, and add up to an unjustified $1.8 billion Federal giveaway to those who need it the least. They are a gift to the insurance companies with the worst record of abusive practices—a poorly disguised reward for millions of dollars of campaign contributions. And by pulling the healthiest individuals out of the conventional insurance market, they will raise premiums for everyone else, including those who need coverage the most.

In fact, the Congressional Budget Office concluded that, ''In the long run, the existence of any type of catastrophic plus MSA option that would be attractive to a large number of people could threaten the existence of standard health insurance.''

Members of the Senate who are serious about insurance reform should vote against all controversial amendments—including medical savings accounts. Senator KASSEBAUM and I have agreed that we will vigorously oppose all such amendments—even those that we might support under other circumstances. The Democratic leader, and many other Senators of both parties have joined us in this pledge. This is a test of the Senate's seriousness and ability to put the interest of the American people ahead of the special interests.

This legislation is not comprehensive health reform. It will not solve all the problems in the current system. But it is a constructive step forward—a step that will help millions of Americans. I urge its adoption.

Mr. President, if we are looking for just a shorthand explanation of what the legislation achieves, effectively, it is the Health Insurance Reform Act, the health insurance bill of rights. It guarantees that your insurance cannot be taken away because you, first, lose your job; second, change your job; third, become sick; or, fourth, start your own business. It protects against unfair preexisting conditions exclusion which affect millions of American citizens who virtually have no control over those preexisting conditions. In an important way it increases the purchasing power of small businesses so that they will be able to provide health insurance to the millions of Americans who work in small businesses and have no coverage at this time.

This is a modest bill, an important bill. It deserves overwhelming passage. It deserves, most importantly, to become law. Every day that we delay the legislation, there are other fellow citizens in this country that continue to be unable to get the kind of protections that they need and that they deserve. Hopefully, we will have overwhelming bipartisan vote on this legislation.

Mr. President, I see a number of our colleagues that will be speaking. I just hope that those that do have amendments—we hope there are not many of those—will make their amendments available to us at the earliest possible time so we can have a chance to review those amendments and to see what disposal we can make of them.

PRIVILEGE OF THE FLOOR

Mr. KENNEDY. Mr. President, I ask unanimous consent that members of the staff, four fellows, Lauren Ewers, Susan Castleberry, Sara Thom, and Anna Marie Murphy, be granted privileges of the floor during the debate on health insurance reform.

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

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that Anne Rufo and Kevin McShane be extended floor privileges during the duration of the debate.

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

Mrs. KASSEBAUM. Mr. President, I want to express my appreciation to Senator KENNEDY for his thoughtful statement. He is one who has been involved in health care issues for many, many years and cares deeply about it. He would, I am sure, like to have expanded this bill much further. But we worked hard to construct, as he mentioned, something that we felt could be passed and could be approved by the widest number in both the U.S. Senate and the House of Representatives. So I have greatly appreciated his leadership in the Labor and Human Resources Committee, as we have worked hard and constructively on both sides of the aisle in the committee, as well as on the floor, to bring this to fruition today.

One who has been a great asset in working with us is the Senator from Tennessee, who is waiting to speak. Not only has he been an exceptional legislator on this issue, he comes to it also with an expertise that the rest of us do not have—as a renowned cardiologist. So we have valued his willingness to be very engaged in this issue.

I have greatly appreciated his help on the Labor and Human Resources Committee as the ranking member. Senator KENNEDY and I have worked together to achieve this bill we are presenting today.

I yield the floor.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, I rise to congratulate Senators KASSEBAUM and KENNEDY for introducing what I consider to be a fair, balanced, focused, and excellent bill that will be to the

benefit of over 25 million Americans. I welcome this opportunity to focus today on the Health Insurance Reform Act.

The bill before us provides protection for some 25 million Americans, who, each year—it is a rolling number—are at risk for becoming uninsured. Too many Americans today have to live each day with that fear of the loss of health insurance for preexisting illness—for example, if they have heart disease or if they have a stroke—and for the lack of insurance portability when they move from one job to another job.

I commend Senator KASSEBAUM for her leadership in crafting this legislation because it truly is balanced, bipartisan, and focused. There has been much misinformation and misunderstanding of what the provisions in this bill truly accomplish. Its objectives are very well-defined, very specific.

I reject the notion that this bill, in any way, resembles, as has been alleged, or is similar to President Clinton's very large, massive, failed health care plan. This bill is very different and should not be confused with the President's. This bill contains the very provisions which had broad, very bipartisan support throughout the entire health care debate.

The bill before us today proves that we can move forward incrementally, rationally, step by step, to fix the problems in our health care system today—without a massive Federal Government takeover of the entire delivery system.

I am a physician, and as we talk about this bill and as we look at the provisions of this bill, I see those faces of hundreds—in fact, even thousands—of patients who I have had the opportunity to serve in the past. Too many of those faces, when I picture them, are faces of terror, of fear, that one day they will lose the insurance they have, which they have purchased and that they have been a player in purchasing, historically, that they will lose it, and that it will be taken away simply because they want to change jobs or leave a group plan, leave an insurance plan to go out and set up their own business.

As the only physician in this body, I do feel a very special responsibility to speak out loudly, clearly, and forcefully in support of those very practical solutions and patient protection when the Senate considers matters dealing with these challenging issues of health care. Each time I make a decision in this body regarding health care legislation, I apply some very stringent tests that go back to my experience as a physician delivering care to individuals, one on one, who need that care, who depend on that care for their quality of life and for their well-being.

In my practice as a heart and lung transplant surgeon, I shared daily the obstacles that patients face. They tell you about that every day in your office. For example, after a patient receives a new heart, has a heart transplant, and after they are ready to return to the work force and productive lives, there is a huge barrier there today, a barrier that, once we remove it with this bill, will allow that individual to live a more productive life, a life more fulfilling, a better quality of life. When I give a person a new heart today, the next day they start asking questions because they are petrified that they are not going to be able to go back to their old job, to go back and get insurance if they decide to change jobs.

They get trapped in a current situation for the rest of their lives because of this lack of portability of insurance coverage. The cost of their care, by no fault of their own, restricts their freedom of movement within the workplace.

I cannot help but to think back to last July during our Labor and Human Resources Committee when a man from Oklahoma, Tom Hall, testified before us. He reminded me so directly of the hundreds of patients who have told me this same story. He was denied individual coverage because of what we call a preexisting heart condition. But it was denied by the same insurer that he had insurance with for the last 30 years. It was denied because he wanted to go out and start his own company. The insurance company who he had worked with for 30 years—the same person, the same condition—when he wanted to go out and start his own company, initially denied that insurance. Eventually, yes, he got that insurance. But, remember, he had a heart condition. He got that insurance, but it did not cover his heart condition.

Well, this bill will address that. It passed the Labor Committee unanimously and is currently supported by well over half of the U.S. Senate. It limits exclusions for preexisting medical conditions, it guarantees renewability of health coverage, and it reduces this concept of job-lock—being locked in a job—by making health insurance coverage portable from one job to another. In other words, when this bill becomes law, people like Tom Hall will no longer be locked into jobs or prevented from starting their own businesses for fear of losing their health coverage.

As a doctor, there is nothing worse than having a patient tell me that he or she cannot afford health care due to denial of coverage by an insurance company. Tragically, over 1 million working Americans have lost health insurance over the last 2 years. Over 80 million Americans have preexisting conditions of some sort that could make it difficult, if not impossible, for them to maintain coverage when they change jobs. Many of these people are willing to pay the insurance premiums. In many cases, those insurance premiums could be costly. But they cannot find coverage at any price.

As a physician and as someone who is a real advocate of the free market system, I find this unacceptable, unconscionable. People who are willing to play by the rules—and again, this bill addresses people who currently have insurance coverage, who have paid in, or had their employer pay in, and have coverage. These are people who have played by the rules in the system. These people should not be denied the opportunity to lead productive lives.

I applaud Majority Leader DOLE, who has a long record of support for health care reform, for bringing this bill to the Senate floor. It is important to debate, and it is important for us to take this step and vote on this legislation.

Before I entered the public service as U.S. Senator a year and a half ago, the Senate had already debated and even passed provisions almost identical to this bill—debated and passed. Unfortunately, as the scope of many of these bills grew larger and larger, the support for the overall bill dwindled. As a result, we are here today still debating those long-awaited insurance reforms.

In closing, while this bill is not a cure-all—and we should not pretend it to be a cure-all, but it is a good first step—it is incremental, it is straightforward, it is rationale, it is focused, and it is direct. The bill will correct many of those imperfections in the market that we have today for health insurance.

I am confident that this Congress will be the one—this Congress will be the one—to deliver these much-needed reforms.

I thank the President. I yield the floor.

Mr. ROCKEFELLER addressed the Chair.

The PRESIDING OFFICER. The Senator from West Virginia.

PRIVILEGE OF THE FLOOR

Mr. ROCKEFELLER. Mr. President, I ask unanimous consent that Greg Jones, a legislative fellow in my office, be allowed privileges of the Senate floor.

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

Mr. ROCKEFELLER. Mr. President, I want to congratulate the Senator from Tennessee for the remarks just made. There is really an extraordinary synergy between Senator KASSEBAUM and Senator KENNEDY which has produced this legislation. It is interesting.

I was home last week in my State, and I was talking about this bill. As I talked, a lot of the feelings that a lot of us had 2 or 3 years ago began to come back. When the larger comprehensive health legislation failed, it was just pulled to the ground by Harry and Louise, special interests, and other things, there may be a feeling out there in the land that, well, since that did not pass, I guess things must be going better. Of course, that is not true. Things are really worse. The system is in worse condition than it was at that time, and people, I think, increasingly know that.

I think what we have to do is wait for a renewed demand, a broader demand, a broader anger on the part of the American people so that they will speak to

us with more clarity than happened in the last go-around and we can respond. But in the meantime, Senator KASSEBAUM and Senator KENNEDY saw an opportunity to take certain very specific and important parts of this problem and solve them, and they did so in a way which was so successful and so agreeable that the vote was unanimous from that committee. The Labor and Human Resources Committee has a reputation for having a good deal of bipartisanship. But it is also a committee where there are sharp differences of views and, therefore, the unanimity of the vote I think is a very, very good sign for the Health Insurance Reform Act of 1995.

I think that we have to be fully aware that people in this country desperately want and thoroughly deserve the security that health insurance will not disappear the way it does now. The Senator from Tennessee was talking about how he could see that fear in people's faces. I am not a physician, but I hear that constantly in my State of West Virginia. When it disappears, it disappears cruelly. It disappears without warning. It disappears often because people are simply just laid off because of downsizing or because of other economic factors. It always affects, it seems, millions of hard-working men and women, people who are playing by the rules every day. I think today is our chance to really do something. I think we can do our job for the West Virginians, for the South Dakotans, the Kansans, and other Americans everywhere who are out there doing their job but still fear the loss of health insurance.

Health insurance is a little bit like air. Sometimes you take it for granted. All of a sudden it is not there. You panic very quickly, and I think a lot more Americans are doing that. Some people, in fact, are estimating—a lot of people are—that by the year 2000, which is really only 3-plus years off, that 50 percent of Americans who work for a living—not 50 percent of Americans but 50 percent of Americans who work for a living—will not have health insurance.

So, this problem just continues to get worse and worse. Yet, the Labor and Human Resources Committee has made a substantial improvement if we are able to pass this bill and if we can do it without controversial amendments. I will have more to say about that as the day goes along.

I have, frankly, waited for this day for a long, long time, and I am filled with a sense of gratitude and a sense of relief that we are finally, as a body, going to do something which is meaningful. If everything really goes well, we may do this by the end of the night or tomorrow night. But the point is we really have a chance to do this.

I do not know of a great deal of criticism about this bill on the part of my colleagues. Relatively few people on the outside are criticizing it, and, therefore, I have a good feeling about it.

The so-called Kassebaum-Kennedy bill, the Health Insurance Reform Act, would establish some of the most fundamental and far-reaching changes in health insurance since the creation, in fact, of Medicare and Medicaid in 1965. I, therefore, again salute the two Senators, the chairman and the ranking member, for their really inspiring bipartisan partnership in crafting and advancing this very important legislation. I think we all remember, as I indicated—it seems like a long time ago, but it really was not—that there was a mighty debate in this body about guaranteeing health insurance for every man, woman, and child in this country. I believe that must still be the goal and the vision for America. I believe that as strongly as I did at the time. I believe in that even more strongly as I watch what is happening to more and more people as they lose their health insurance even though they are working.

Mr. President, that comprehensive effort at that time to reform our country's health care system was stopped. But, again, the problems of losing health insurance continue. That is why in a sense we have won, through the good work of Senator KASSEBAUM and Senator KENNEDY, we have won another chance to enact something which is really meaningful in the way of health care reform. The people of our States are still writing, calling, visiting, and asking for help. I am going to do whatever I can to make sure that we do not let this opportunity pass us by—that we will not fail on this and that we will make a real difference in people's day-to-day lives.

That is why we simply have to also exercise restraint and not kill this bill with extra baggage. It is tempting, but it cannot happen. Amendments, whether they are well-intentioned or not, which are controversial will have the effect of bringing this bill down, and we all know that. We have to be very careful as we go through this exercise that we do not accept controversial amendments.

I think this bill is going to solve some really horrible problems for real people. So why would we accept controversial amendments which we might otherwise support, as the Senator from Massachusetts said, when it could pull down the chance to do something really good for a lot of people?

During debate on comprehensive health care reform several years ago, many of my colleagues—especially those on the other side of the aisle—said repeatedly that we should only enact those health reforms on which there is a strong bipartisan consensus and support. Well, here we have it. Here we have that piece of legislation. That is the precise description of this bill, S. 1028, which is before us today. It was so carefully crafted by the chairman and the ranking member; it came out of the committee by unanimous vote; it is a bill which should be sent to the President for his signature, and I am certain, although one never knows, that he would sign it.

Loading up this bill with extraneous provisions which will please certain special interests but only delay enactment of health reform just does not make any sense at all. So, Mr. President, I intend to join the floor managers of this bill and Minority Leader DASCHLE in opposing any controversial amendment that will delay enactment of this bill—any controversial amendment, even if it means voting against amendments that, as I have indicated and so have others, have merit on their own and I would fight to enact in other terms and other circumstances. We cannot be distracted from the basic purposes of this bill, which are terribly important.

Almost 40 million Americans lack basic health coverage today. It is going up about a million plus every year, Mr. President. It has been doing that regularly, and it will continue to do that, perhaps at an accelerating rate. One cannot be sure. Most of the people who are not lucky enough to have health insurance, with cards in their wallets or back pockets, are in fact the people we revere and honor in this body, and that is they are the hard-working, middle-class families who are victims of layoffs and downsizing or just plain profit gouging.

This country offers the best health care in the world. Nobody has ever denied that. It is terribly true. Unfortunately, that health care continues to be beyond the reach of too many of our fellow citizens who do not deserve that lot in a country that is as outstanding and great as ours.

As both Senator KASSEBAUM and Senator KENNEDY said, this bill before us today will not solve all of the problems in the health care marketplace. I think it was Senator KASSEBAUM who said that the so-called guarantee issue, or guaranteed coverage, for that matter, for every man, woman and child in this country has not diminished. The bill is not going to solve it.

I still believe it is a fundamental right for each and every one of us, not just for those who can afford it or are healthy enough to keep insurance companies profitable. But again, the machinery of our health care system is breaking down, and this bill helps substantially. If we cannot therefore enact a complete overhaul, if we are not going to be able to do that in this session, we must enact the individual fixes and the individual reforms that will at least keep the engine of this system running.

Evidence of this need for an overhaul of our health care system is everywhere. It is found in the emergency rooms of our public hospitals, collapsing under the demand of the growing millions who need medical treatment but cannot pay for it. It is found in our schools where far too many children go without immunization and preventive care. It is found in the rooms of our nursing homes with so many residents

being uprooted from their homes and neighborhoods because of their inability to afford community-based alternatives. They are forced onto Medicaid. They are institutionalized because their savings have been exhausted, and on and on.

Mr. President, individuals and families go uninsured for several reasons. Often health insurance coverage is simply not available, or what is available is not affordable. The effect is the same. Health insurance often lapses after a worker is laid off and COBRA extensions that affect certain larger industries have expired.

Entrepreneurs who leave their jobs to start their own businesses, which is what we glory in America—IBM used to have it all and then people started going out and creating all kinds of other things. That is what we do in America. We are a country of entrepreneurs. Entrepreneurs who have to leave their jobs or want to leave their jobs to start their own companies because they think they have a better idea are sometimes unable to convert their group health insurance policies to an individual health plan, and, even more tragic, insurance coverage is often terminated by an insurer just when that insurance policy is needed the most, when an individual or a family member experiences a really serious, devastating illness or disability.

How reliable is a guarantee, so to speak, of health coverage when the health plan issuer acts in its own self-interest or cuts the safety line by either terminating a policy or increasing the premiums beyond the ability of the individual to pay, thus, in effect, accomplishing the same end—cutting that person off.

The Health Insurance Reform Act of 1995 makes significant strides to address each of these two problems, and that is why it is such a good bill and needs to be passed. The Health Insurance Reform Act will strengthen the safety net for millions of Americans by improving portability and security of private health insurance, especially in the small group and the individual insurance markets. I support this bill because I personally have heard the stories of hundreds of West Virginians who have fallen between the cracks of our health care system.

Mr. President, I wish to just give three personal examples that I know of and then end with a statement from the White House.

Mr. President, I want to start—and these are all people who would be helped by this bill, and the examples are so many—with one Norma Schoppert, who lives in Piedmont, WV—not large, near the top of our State. Several years ago, she developed diabetes. Lots of people do. When her husband was working, Mrs. Schoppert was covered by the health plan offered by his employer. That is understandable. But then he retired in 1991 and became eligible for Medicare. When that happened, she was able to extend her own health insurance coverage for 3 years because of the COBRA provisions that affected his health insurance, and thus she was able to pay monthly premiums of $354 and continue full health insurance coverage under COBRA for 3 years. But that only lasted from 1991 to 1994, those 3 years.

Mrs. Schoppert was offered an individual policy when her COBRA extension expired at a monthly premium, Mr. President, of $1,800. So you understand the effect, $354 in the COBRA extension, $1,800 without it. In effect, obviously, she could not pay that. She could not afford to pay this amount, so she has now no medical coverage at all. And unless the system is reformed, she will have to go without insurance until she qualifies for Medicare, which is still 3 years away.

Now, Mr. President, that means, as the Senator from Tennessee indicated, 3 more years of anxiety, 3 more years of fear, worrying about the risk of losing everything that she and her husband worked all of their lives to build. And we say that sentence so easily; it just rolls off our tongue. But these are gigantic tragedies in the lives of real people.

Second example. Juanita Taylor of Elkins, WV. Just a few years ago, she was a hard-working employee at Davis & Elkins, which is the local private college, but then she developed multiple sclerosis. She kept right on working, struggling to overcome the advancing weakness that her illness caused her. When she was, in fact, really too weak to meet the demands of her job, she lost her job and eventually the health insurance that had provided.

Her neighbors and her friends pitched in to help her pay for a wheelchair, so that she could stay connected and involved with her community, so that her morale would be better.

Those friends and neighbors told me that she was forced to pay out-of-pocket costs of $1,000 per treatment to help slow the advance of her multiple sclerosis. How many people can pay $1,000 per treatment? Although she now has Medicare, her medical expenses ate up all of her savings. Juanita Taylor courageously faced and fought a ravaging disease, only to be victimized by a system that cared more about how much money she had in her pocket than it did, quite honestly, about her health condition.

But the final story, and the saddest one of all, it seems to me, comes from Falling Waters, WV, which is in Berkeley County. In 1990, Walter McPeak and his wife, Karen, were granted custody of Mr. McPeak's two sons, Anthony and Thomas. They wanted these boys. Both the boys have severe hemophilia and hepatitis, as well as the social and the emotional difficulties that come from living in constant fear that even the slightest injury could result in terrible trauma or instant death.

At the time the boys came to live with them, both Walter and Karen McPeak were employed in high-paying management jobs. Together they earned a little over $80,000. But their employer's health plan would not issue coverage for Anthony or for Thomas. Their need for special clotting factors and other treatments means medical costs of several thousands of dollars each week.

So it was not long before the McPeak family had used up all of their savings. They had to sell their house and then they sold their first car, and then they sold their second car, but still the costs climbed and there was no help in sight. When they tried to apply for Medicaid—which you can imagine they did not want to have to do—because Medicaid would have helped pay for their sons' treatments, they were told that their family income was too high for the boys to be eligible for SSI, which would automatically make them eligible for Medicaid.

So, what choice did Walter and Karen McPeak have to make? In order to qualify the boys for SSI, which was their moral and parental responsibility, they gave up their management jobs, both of them, over $80,000 a year, and took minimum wage, unskilled jobs so their income would not exceed allowable limits for them to qualify for SSI and hence Medicaid.

This is a tragedy and this is a travesty. It should never happen in America. Anthony and Thomas got health insurance; yes, they did. But the McPeaks lost their savings, their home, their car, their jobs, probably a good deal of self-esteem—although not on a moral basis; and their employers, of course, lost two highly skilled managers. So we must pass health insurance reform in the form of this bill.

The bill we are considering is not a perfect solution and nobody has made that claim. But it will go a long way toward ensuring that working Americans and their families are able to keep the health insurance that they have, if they lose or if they change jobs. This legislation will mean that families like the McPeak's, who have children with special needs, will have the protection and have the security of insurance coverage. And it will mean that talented and hard-working individuals with new and creative ideas, entrepreneurs, will be free to go out and start their own businesses, because of this reform bill, without the fear of losing their health insurance.

Again, I thank and congratulate Senators KASSEBAUM and KENNEDY for their enormous leadership that gives us this historic—and it is historic—chance to do something that Americans deserve and want so badly. I conclude with a statement of administration policy. This is just for the edification of the membership.

I read from the administration's latest statement of administrative policy:

> Certain provisions included in the House-passed bill are so controversial and so potentially damaging to the health care system that they jeopardize enactment of the insurance reform that Americans want signed

into law this year. Specifically, the inclusion of amendments that, one, provide for medical savings accounts, MSA's; two, deregulate multiple employer welfare arrangements—MEWA's; three, impose federally defined caps on punitive and noneconomic medical malpractice awards; four, undermine Medicare fraud and abuse efforts; and, five, weaken the ban on the sale of duplicative insurance policies to the Medicare beneficiaries, would call into question the seriousness of the commitment of the Senate to health insurance reform this year.

The administration views such provisions as an effort to undermine a bipartisan consensus on health reform. If such amendments are adopted, they would create a grave risk to the passage and enactment of this bipartisan legislation.

Mr. President, I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I thank my friend and colleague from West Virginia for an excellent presentation on the current legislation and also for his really extraordinary leadership on the whole health care issue. As he mentioned, he was right in the vanguard of leaders when we debated the more comprehensive program over a year ago. I think he is tireless, as a member of the Finance Committee, in pursuing good health care policy. So I thank him for his comments. I am very hopeful he will be involved during the course of debate on this measure, because he brings great interest and knowledge to his comments.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I second those observations. Senator ROCKEFELLER has cared for a long time, as well, about a wide breadth of health issues, particularly as regards to children. I ask unanimous consent that the Senator from New Mexico [Mr. DOMENICI] be added as the 66th cosponsor of the bill before us.

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

Mrs. KASSEBAUM. The next speaker is the leader of the Republican health care task force. Senator BENNETT has been a very, very strong and constructive Member of the Senate, working with health care issues. I have certainly valued his advice and support in this endeavor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Mr. President, I thank the Senator from Kansas for her kind and generous words. It has been an interesting odyssey for me to get involved in the health care issue. It came up in the 1992 campaign, when I ran for the Senate in the first instance. I must confess, the first time the question came up I was pretty much stumped for any kind of an answer as to what we ought to do on health care. I do not like being stumped for an answer, so I have plunged into this issue ever since I have been in the Senate, and the more I get into it, the more certain things become clear.

One of the things that is very clear is that we need insurance reform now. It is something we can do now. And we should be careful not to attempt a complete overhaul of the system just to get insurance reform. That was one of the errors, in my view, that was made strategically by the President of the then majority party in the last Congress.

I always said, and repeat again, that the President deserves credit for having raised this issue. It is such a thorny issue that the instinct of most politicians is to flee from it. I learned in the days when I was working with the Congress, before I came here, that all you needed to do in order to defeat a bill was, not convince Congress that it was a bad bill, all you had to do was convince them that it was a controversial bill and they would flee from the controversy. So I salute the President and have always done so, since coming to the Senate, for his courage in raising the issue.

But in the last Congress, I seriously departed from the President because of his insistence that the entire system had to be fixed at once with a single bill and a single Congress. I thought that was the height of arrogance and, ultimately, it proved to be impossible.

I remind people that the Clinton health care plan was not voted down in the 103d Congress. It simply died, collapsed of its own weight, and a vote was never taken on it because it could never be put together in such fashion that it was ready for a vote.

So I commend the Senator from Kansas and the Senator from Massachusetts in their willingness to say, ''Let's step aside from the attempt to do everything in a single bill. Let's pick out the most pressing problems and see if we can address those.''

Those of us who tried to put forth this strategy in the last Congress were attacked as incrementalists, and we were denounced as being insufficiently compassionate and concerned. I do not know anybody in this body who is more compassionate and more concerned than the Senator from Kansas. I stand now to say that the incremental approach that we proposed in the 103d Congress is now bearing fruit in the 104th, primarily due to her leadership and her compassion and her concern. So I am delighted to be a cosponsor of the bill and to participate in this debate.

I do have to make a few general observations, however, before I get into talking about this bill, so that people who have heard me on health care in the past will know that I have not abandoned those observations.

I believe that we have the system that we have in the country today primarily because of the tax laws in this country. We have a system that is distorted, for a whole series of reasons. Not to go through the whole litany but to, again, lay down certain principles so that I am not accused of abandoning them, we have not one health care system in this country but two.

The first one is the delivery system, and it is run by doctors and nurses and hospital administrators and researchers and research hospitals and foundations and all of the rest of it, and it is dedicated to delivering the finest health care medical result for our citizens as possibly can be.

The second system is the payment system, and it is run by insurance companies and adjustors and, to a very large extent, the Federal Government. Forty percent of the health care bills in this country are paid by the Federal Government.

The payment system, to a certain extent and certainly to a larger extent than is proper, in my view, distorts the delivery system. Delivery system decisions are made on the basis of payment system decisions, and that is where we get into all of the difficulty, in my view.

If we could devise a way that the delivery system goes forward with the focus primarily on producing the best medical result for the patient, undistorted by the payment system, we would have the ultimate circumstance.

If I may give us an example—I realize it is not perfect, but it is one we ought to look at—I have been in Shriners hospitals. The Shriners raise every dollar that they spend for health care, which means that they do not interface with a single insurance company or a single Government bureaucrat. They simply raise the money to pay the bill for the kids, and they make the decision as to what will be done in a Shriners hospital solely and entirely on the question of medical need.

Here is the result of not having to deal with insurance companies or the Government at the Shriners Hospital in Salt Lake City: The cost per day, per-bed night, or whatever the appropriate medical term is, in the Shriners Hospital in Salt Lake City is $95. What could we do in medical costs if the per-night cost in a hospital were $95 for every 24-hour period?

The administrative costs of running the Shriners hospital system are 4 percent, which means that 96 percent of every dollar they raise to take care of the medical needs of these kids goes to the kids and only 4 percent goes to administration.

That is what happens when you do not have to deal with an insurance company or with the Government bureaucrat. That is the goal for which we should aspire somewhere out there to clean up the enormous costs and complexity of the system in which we are engaged.

I think the answer to that lies in restructuring our tax laws in the way we deal with health insurance. That is a speech I have given before; it is not a speech I will give today, but I lay that down because I do not want anyone who is listening to me to think that for one moment I have abandoned that as my ultimate goal: To get to the circumstance where we clear up the enormous complexities that now beset the whole health care issue.

That having been said then, Mr. President, let me address S. 1028 and my support for it. As I said at the outset, I believe in the incremental approach. I believe that when you are dealing with a trillion dollars' worth of economic activity, trying to fix it all at once with a single piece of legislation is a major mistake, and I think we learned that lesson in the 103d Congress.

The most pressing issue for most Americans is the question of job lock, the question of insurance through the employer keeping people tied to a particular employer or to a particular job.

During the campaign, whenever this came up, I had a little exercise I would go through, and it never failed to produce exactly the same result. As people would turn to me and say, ''What is the biggest problem with health insurance,'' I would answer with a question. I would say, ''How many of you here know of someone—either yourself, a member of your family, or friend—who is locked in a job he or she hates because he or she is afraid to lose health insurance?''

I would just sit back and watch the hands go up, and they would always go up in sufficient number around the room to make my point: That portability of health insurance is, for most Americans concerned with this issue, the No. 1 challenge, and portability of health insurance is at the core of S. 1028.

If we can make it possible for people to ultimately control their own destiny and not be under the control of their employer, then we have solved the problem for many, many Americans.

I am not one who subscribes to the statistics about the tremendous number of uninsured. I point out that for most of the uninsured, they are just passing through that category. I give this example.

In my own family, I have a son who, when he turned 24, went off the family policy. The insurance company says he should be through with school at age 24. I said, ''I agree with you he should be through with school at age 24, but he's not, so what do we do?''

Well, I called him up and said, ''Jim, go down to the student health center and sign up for the student health policy at the University of Southern California.''

He said, ''Sure, dad, I'll take care of that.''

Those of you who have children know that it took about 6 months for him to finally get around to taking care of that. During that 6-month period, he was one of those statistics of the uninsured. He had gone off my policy because he was too old to be a dependent and he had not gotten around to signing up with the other, and so he ended up in that statistical pool of the uninsured.

Frankly, it is not my son, Jim, we are worried about here. It is the people who, in that statistical pool, have a real problem.

I raise that only because I think it is unfair to use the huge statistical number of 37 or 40 million or whatever it may be, to try to highlight the problem that is really severe and significant for roughly a third or even a quarter of that number. But the people who are in that quarter, the 10 million, whatever, have real problems, and this bill addresses those problems.

We should understand that this terror of losing health insurance that has caused job lock can become more than just a personal problem for the individual involved. It can have consequences throughout the entire economy.

The Senator from West Virginia spoke about the entrepreneurs who leave a secure business to go start another one. I have been one of those entrepreneurs and had the experience of walking out of a secure company where I had health insurance, being told, ''OK, you have COBRA coverage for 18 months, and in that 18-month period, good luck in lining up some other kind of health insurance.''

I was able to line up another kind of health insurance for me, but discovered a very difficult problem. My secretary, who left with me when I left the company to start my own activity, was also covered by COBRA, and in that COBRA period while we were putting together a health insurance plan for our little tiny company—just the two of us; we were the only two employees—she came into my office one day and said she had to see a doctor, she was not feeling well. She came back from the appointment and said, ''I have a brain tumor. It is operable. It can be handled, but the problem of dealing with it is going to take a timeframe longer than the 18 months of COBRA. What are we going to do?''

I will not bore the Senate with the details. We were able to solve the problem. We were able, through the State of Utah and some of the things that it does on health insurance, to find an insurance pool that would accept her. But I saw firsthand how difficult that can be. People who are normal and healthy and have no problems at all in the 18-month period of COBRA are suddenly faced with this kind of circumstance.

So that is why I have joined in cosponsoring S. 1028. It is focused on a single problem. It is not an attempt to solve all of the issues simultaneously and thereby get gummed up in all of the challenges that face our health insurance and health care problems. It deals with the most pressing problem for most Americans who fall in this category. It does so in such a way that it does not close the door to the kinds of solutions I want to see down the road. It does not close the door to the kind of tax reform that I think will ultimately bring us the ultimate health care solution.

So, for those who say, ''Well, Senator BENNETT, you have been a voice for the entrepreneurial approach, the market approach, and don't endorse anything until you can restructure everything,'' I say, we have not got that luxury. We have to deal with the problem of job lock, the problem of portability of health insurance as quickly as we can, even as we have these other discussions for the solution a long way down the road.

Again, Mr. President, I congratulate the Senator from Kansas for her leadership and her tenacity. I say, as I have said before, that the loss of her membership in this body will be keenly felt. She brings an aura of civility and intelligence, combined with a tenacity and a sense of steel in her back that sometimes her pleasant exterior will cause people to misjudge. We have been honored with her service in the Senate. I think this will be a monument to her service in the Senate. I am delighted to be one of those who raises a voice in support of that concept. Mr. President, I yield the floor.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER (Mr. FRIST). The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I would like to express appreciation to the Senator from Utah, who gave such a very thoughtful opening statement, I think, by example, showing concretely why the provisions of this bill are important. I know that the majority leader, the senior Senator from Kansas, has also over the years been cognizant of the very things that Senator BENNETT, as the leader of the Republican health care task force, spoke so eloquently and sincerely about. I am very appreciative.

Mr. DOLE. Mr. President, I understand there are a number of my colleagues who wish to make opening statements. I just want to indicate that I am prepared to offer the so-called tax amendment. We are trying to get some agreement that is acceptable on both sides as far as a motion to strike one provision of that. So I ask unanimous consent that, following opening statements, I be recognized to offer the amendment.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. First of all, I would like to thank the distinguished Senator from Vermont for permitting me to go ahead of him. I know he has been waiting. I assured him my statement would be brief, so I am going to be held to that.

Mr. President, I would like to take this opportunity to reaffirm my support for the Kassebaum-Kennedy health reform legislation. The sponsors of this legislation have worked for a number of years to enact reforms in the private insurance market. I applaud them for their considerable efforts in bringing this legislation to the floor.

It is interesting to note this legislation is quite similar to that which Senator Durenberger first presented in

the Finance Committee, as I recall, or perhaps in the Labor Committee several years ago. Although he has left the Senate, I think he would be pleased to know we are making progress with the legislation he was so involved with.

In the wake of attempts in recent years to completely overhaul our health care system, this legislation has been characterized, as the distinguished Senator from Utah noted, as incremental. It has been criticized as even meager. But I urge my colleagues, as the Senator from Utah noted, not to underestimate the importance of this legislation.

One of the major failings of our health care system in this country is the difficulty thousands of Americans face each year when they change jobs or look for new jobs. But they find they cannot change jobs because they will no longer be eligible for health insurance. This is what is known in the trade as ''job lock.'' This problem for many Americans would be addressed under the Kassebaum-Kennedy bill. Insurers would be required to offer coverage, with no preexisting condition exclusions, for those moving from one group plan to another or from a group plan to an individual plan.

I expect, Mr. President, we will see many amendments to this proposal, many of which I have supported in the past. Though laudable, these additional provisions could jeopardize the more immediate and important goal of enacting insurance market reforms. Those of us who worked to enact health care reform 2 years ago know all too well the consequences of attempting to do too much with respect to health care reform. We failed to enact comprehensive health care reform in 1994. You try to do too much and you end up getting nothing. We have been through that experience, Mr. President, not only with the health care measure that we tried in 1994, but in other efforts in the past.

In the last 2 years, over a million Americans lost their health insurance coverage. Although this proposal, the Kassebaum-Kennedy proposal, does not include many of the health reforms which I advocated 2 years ago, I strongly support its enactment as a sound first step toward reform and improvement in our Nation's health care system.

So I congratulate the two principal cosponsors of this legislation and am delighted to be listed as a cosponsor myself. I thank the Chair.

Mrs. KASSEBAUM. I thank the Senator from Rhode Island. He, too, has been a long-time worker in the vineyards of health care, a staunch leader in the last Congress to find some answers and to bring people together to present health care reform. I value his support in helping us work through the language in this bill.

Mr. JEFFORDS addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

PRIVILEGE OF THE FLOOR

Mr. JEFFORDS. Mr. President, first, I ask unanimous consent that Theresa Stathas, a fellow in my office, be granted the privilege of the floor for the duration of the consideration of S. 1028.

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

Mr. JEFFORDS. Mr. President, I rise today in support of the Kassebaum-Kennedy bill. Before I do that, I want to express my deep appreciation for the efforts that were put in, in 1994, by Senator CHAFEE, in trying to reach a consensus on what we can do to move health care forward. We worked long and hard, many of us, and the issues which we are involved with today in S. 1028 were some of those which gave us the greatest concern.

I also want to thank Senator BENNETT for his work with the Republican task force on health care. His work has been invaluable to us as we move forward to try and find, again, the kind of consensus that is necessary to get us good health care reform. What a refreshing experience it is to have Senator Frist with us, who has given us the invaluable knowledge of a practicing physician, who kept us from going too far astray in our efforts. It is wonderful that we have this kind of a coalition. Senator ROCKEFELLER, who I have worked with, also, is so helpful in the health care reform area.

I am beginning to feel confident that we will do something constructive here in health care reform, and hopefully it will happen in the next few days. Of course, my chairman and my ranking member, Senator KENNEDY, who both have shown outstanding leadership in getting our committee to come out 16 to 0 on a bill, this is a miracle in itself. I am deeply appreciative of all their efforts.

I rise in support of the Kassebaum-Kennedy Health Insurance Reform Act. If we send this legislation to the President, the 104th Congress will be remembered in history for taking the first steps toward real market-based health care reform. Market reform is not as easy as it may sound, for the simple reason you must take into consideration the State's responsibility for regulating insurance versus the Federal responsibility for regulating ERISA, employee benefit plans.

That word, ERISA, is one that troubles many. The reason it troubles people is because there is not much there. We have the authority and the responsibility to provide good health care conditions for the self-funded plans, but we have exempted the self-funded plans from State regulations. That is why we are here today and why this is an important move forward.

Finding the right balance between insurance regulation and employee benefits, while trying to incrementally reform the market, is something like mastering the Rubic's cube. Just when you think you have all the sides lined up, you find out one square is out of place. Last August, the Labor and Human Resources Committee lined up that Rubic's cube and it all seemed right with the world.

As I mentioned, in a unanimous 16 to 0 vote, the committee voted favorably on S. 1028, the Health Insurance Reform Act of 1995. I must commend the chairman and the ranking member for that incredible feat. It is not an easy task putting together a health care reform bill that every member of the committee can vote for, but it happened. The Health Insurance Reform Act makes great strides in addressing many of the problems in the insured market and also begins to level the playing field in the self-funded ERISA market by apply the same national rules to both segments of the marketplace.

Chairman KASSEBAUM's approach from the beginning was to build a bill around two areas of consensus—portability and elimination of discriminatory treatment of preexisting condition rules. The Kassebaum-Kennedy bill provides Americans the security of knowing that their health insurance will be portable from job to job and that all people who have insurance today will be able to purchase affordable insurance tomorrow even if they get sick. That is a critical phrase—even if they get sick, or change or lose their jobs.

This is accomplished by converting the rules in today's insurance market which reward excluding people into rules where health plans can take all comers. There is a tendency to want to exclude sick people, naturally. You make more money if that happens. This will step in and say, ''Hey, no.'' S. 1028 provides much-needed improvements at the national level, but at the same time allows States the flexibility they need to move ahead in their own reform efforts.

As we attempt to make coverage more widely available, we must also not lose sight of affordability, particularly in a market where employers and individuals are not mandated to purchase insurance. We must be very careful as we reform the insurance market, because if we are not, reforms that we hope will reduce costs and improve access may do just the opposite.

How is this possible? Today, over 92 percent of the people who have private health coverage are part of a group—92 percent are part of a group. Most of these people get it through their employer under an ERISA health benefit plan. The key concern regarding ERISA is the risk segmentation that occurs in the private market due to the preemption clause. ERISA preemption effectively blocks States from regulating most employer-based health plans. ERISA preempts States from being in this area.

Although many employers still purchase health coverage from a State-regulated health insurer that is subject to State insurance regulation, employer plans that cover 44 million people have elected to self-fund and avoid

the State insurance laws. These laws deal with financial solvency, market conduct, benefit coverage, and premium taxes. States impose taxes on insurers for general revenues, as well as for financing specific programs like State guaranty funds and high-risk pools.

Preemption made a lot of sense 20 years ago when the multistate employers and unions were looking for a way to offer uniform benefits to employees throughout the country. Most of the plans were offered through insurers. Most of the plans were offered through insurers. As States started to weigh down the insured market with mandated benefits, employers saw self-funding as a means of flexibility and plan design.

These are two reasons why employers have left the insured marketplace. In a preliminary report I just received from GAO, the estimated additional costs of these mandated benefits range from a high in Maryland of 22 percent additional cost and low in Iowa of 5 percent.

Mr. President, I ask unanimous consent that excerpts of the GAO preliminary estimate be printed in the RECORD.

There being no objection, the material was ordered to be printed in the Record, as follows:

GENERAL ACCOUNTING OFFICE,
Washington, DC, April 15, 1996.

Hon. JAMES M. JEFFORDS,
U.S. Senate.
Washington, DC.

DEAR SENATOR JEFFORDS: The Congress is considering proposals intended to enhance the availability of health insurance. This debate has led to specific questions about the state regulation of health plans, including mandated benefit laws. In particular, you asked us to provide information on—

1. state requirements affecting fully insured health plans and how they compare with federal requirements affecting self-funded health plans,

2. the number of states that have enacted particular mandated benefit laws,

3. estimates of the costs of mandated benefits in particular states, and

4. the extent to which commonly mandated benefits are provided by self-funded health plans that are exempt from state laws.

This letter provides interim information based on our ongoing work for you on the factors affecting the costs of state health insurance regulation. As part of this effort, we interviewed officials from the National Association of Insurance Commissioners (NAIC); several state insurance commissions; and national organizations representing actuaries, health insurers, and self-funded employers. We reviewed documents and used data provided by these groups as well as available studies on mandated benefits. In addition, we included and updated information from previous GAO reports on state insurance regulation and the Employee Retirement Income Security Act of 1974 (ERISA). Our review was conducted between January and March 1996 in accordance with generally accepted government auditing standards. We expect to issue a report to you later this year that will provide a more detailed analysis of the factors affecting the costs of state health insurance regulation.

RESULTS IN BRIEF

We found that states have an average of 18 mandated benefits that health insurers must cover but the number of mandated benefits varies from a low of 6 in Idaho to a high of 39 in Maryland. However, assessing the costs of mandated benefits is difficult because their impact varies depending on state laws and employer practices. Published studies provide a range of cost estimates. For example, a recent study found that Virginia's mandated benefits accounted for about 12 percent of claims costs; earlier studies estimated that mandated benefits in Maryland cost 22 percent of claims and in Iowa cost 5 percent of claims. In general, cost estimates are higher in states with more mandated benefits and in states that mandate more costly benefits, such as mental health services and substance abuse treatment. We also found that self-funded health plans often offer similar benefits, even though they are exempt from state-mandated benefit laws. For example, a survey by KPMG Peat Marwick found that a large percentage of self-funded health plans offer benefits similar to those mandated for health insurers in many states.

REGULATORY FRAMEWORK DEPENDS ON WHETHER A HEALTH PLAN IS FULLY INSURED OR SELF-FUNDED

While states are able to regulate health insurance, state regulation does not directly affect everyone with private health coverage. ERISA preempts states from directly regulating employer provision of health plans. This results in a very different regulatory framework depending on whether an employer purchases its health care coverage from an insurer that the state regulates or self-funds its health plan is not directly affected by state regulation.[1]

States focus their regulation on the financial soundness of insurers and their market conduct, including benefit coverage. In addition, states impose taxes on insurers for general revenues as well as for financing specific programs. While federal requirements include fiduciary and other responsibilities, in many other areas no federal requirements exist for self-funded health plans that are comparable to state requirements for health insurers. In particular, self-funded health plans are exempt from state laws that mandate insurers to include coverage for specific benefits. Table 1 companies the requirements that fully insured and self-funded health plans must meet.

TABLE 1.—COMPARISON OF RELEVANT STATE AND FEDERAL PROVISIONS AFFECTING FULLY INSURED AND SELF-FUNDED HEALTH PLANS

	State insurance regulations affecting fully insured health plans	ERISA provisions affecting self-funded health plans[1]
Financial requirements:		
Licensing	States license insurance companies and the agents who sell insurance to ensure that companies are financially sound and reputable and that agents are qualified.	No comparable requirements.
Financial solvency	States set standards for and monitor financial operations of insurers to determine whether they have adequate reserves to pay policyholders' claims. States restrict how insurers invest their funds.	No solvency requirements but fiduciary duty to act in a prudent manner solely in the interests of plan participants and beneficiaries.
Rate reviews	States review and approve rates to ensure that they are both reasonable for consumers and sufficient to maintain the solvency of insurance companies.	No comparable requirements.
	Some states regulate insurer rating practices in the small group market to determine the factors insurers may use in setting premiums[2].	No comparable requirements.
Market conduct requirements:		
Plan benefit coverage and description	States review and approve insurance policies to make sure that they are not vague or misleading and to ensure that they meet state requirements, such as mandatory benefit provisions.	Disclosure requirements to provide summary plan description to participants and the Department of Labor. No requirements to provide specific benefits.
Consumer protections and complaints	States monitor insurers' actions to make sure that they are not engaging in unfair business practices or otherwise taking advantage of consumers by investigating their complaints, answering questions, and conducting educational programs.	Plan must reconsider denied claims at participant's request. States have no authority to pursue consumer complaints regarding self-funded plans. Department of Labor has responsibility for complaints regarding self-funded health plans.
Small group reforms	Most states require insurers selling to small employers to accept and renew employees who want health insurance coverage, establish short waiting periods for preexisting conditions, and require portability of coverage even when an individual changes jobs or insurers[2].	States are preempted from applying small group reforms to self-funded health plans.
Tax requirements:		
Premium taxes	States assess premium taxes on insurers	States are preempted from assessing premium taxes on self-funded health plans.
Guaranty funds	States assess insurers to finance guaranty funds that provide financial protections to enrollees who have outstanding medical claims in the case of an insurer insolvency.	States are preempted from requiring self-funded health plans to participate in guaranty funds.
High-risk pools	Some states assess insurers to finance losses in high-risk pools that provide health coverage for individuals who otherwise had been denied health coverage due to a medical condition.	States are preempted from requiring self-funded health plans to participate in high-risk pools.

[1] ERISA requirements apply to all private employer and union health plans, including fully insured and self-funded health plans. See Employer-Based Health Plans (GAO/HEHS–95–167, July 25, 1995). While states are preempted from regulating self-funded health plans directly, some states regulate third-parties that provide administrative services for self-funded health plans and stop-loss insurance carriers that reimburse self-funded health plans for claims that exceed a predetermined threshold.

[2] For a listing of states that have enacted these reforms, see Health Insurance Regulation: Variation in Recent State Small employer Health Insurance Reforms (GAO/HEHS–95–161FS, June 12, 1995).

NUMBER AND TYPE OF MANDATED BENEFITS ADOPTED BY STATES VARY

On average, states have enacted laws mandating about 18 specific benefits. As shown in figure 1, 15 states have over 20 mandated benefits while 9 states have 10 or fewer mandates. Maryland (39), Minnesota (34), and California (33) are the states with the highest number of mandated benefits. In contrast, Idaho has only 6 mandated benefits; Alabama, Delaware, Vermont, and Wyoming each have 8 mandated benefits.[2]

States most frequently mandate coverage for preventive treatments like mammograms and well-child care or for treatment of mental illness or alcohol and drug abuse. (See table 2.) In addition, states often require coverage for some types of providers like optometrists and chiropractors. States typically mandate that insurers cover specific benefits in all plans sold, whereas some states merely mandate that each insurer make this service available in at least one plan that it offers. In some cases, the mandates are limited to particular types of plans such as health

maintenance organizations or group insurance plans.

TABLE 2.—COMMONLY MANDATED BENEFITS

	Number of States		
	Cover	Offer	Total
Treatment-related:			
Mammography screening	42	4	46
Alcoholism treatment	23	16	39
Mental illness	15	16	31
Well-child care	21	4	25
Drug abuse treatment	13	10	23
Pap smear	17	0	17
Infertility treatment/in vitro fertilization	12	2	14
Temporomandibular joint disorders	11	3	14
Off-label drug use	13	0	13
Maternity care	11	2	13
Breast reconstruction following mastectomy	9	2	11
Provider-related:			
Optometrists	46	1	47
Chiropractors	43	3	46
Psychologists	42	0	42
Podiatrists	38	0	38
Social workers	26	0	26
Osteopaths	21	0	21
Nurse midwives	15	0	15
Physical therapists	14	0	14
Nurse practitioners	13	1	14

Source: NAIC, Compendium of State Laws on Insurance Topics: Mandated Benefits (Kansas City, Missouri: NAIC, 1995).

STUDIES VARY IN THEIR ESTIMATES OF THE COSTS OF MANDATED BENEFITS

Studies conducted in several states between 1987 and 1993 provide varying estimates of the costs associated with mandated benefits. (See table 3.) Among the most recent, the Virginia State Corporation Commission has required insurers to report cost and utilization information annually for each of the mandated benefits in the state. Overall, the commission reports that Virginia's mandated benefits accounted for about 12 percent of group health insurance claims in 1993. An earlier study in Maryland, the state with the most mandated benefits, estimated that mandated benefits represent 22 percent of average claims costs in 1988. At the other extreme, a 1987 study in Iowa estimated that the potential costs of introducing several commonly mandated benefits would be about 5 percent of claims costs.

TABLE 3.—STUDIES OF THE COSTS OF MANDATED BENEFITS IN SELECTED STATES

State	Year	Percent of total claims costs
Maryland	1988	22.0
Massachusetts	1990	18.0
Virginia	1993	12.2
Oregon	1989	8.1
Wisconsin[1]	1989	7.9
Iowa[2]	1987	5.4

[1] Includes six mandated benefits: alcohol and other drug abuse treatment, chiropractic care, diabetes care, home health care, skilled nursing facility care, and kidney disease treatment.

[2] The study in Iowa examined potential costs of six commonly mandated benefits, including mental health, alcohol and drug abuse, podiatrists, optometrists, registered nurses, and physical therapists. Iowa has not adopted all of these mandates; according to the Blue Cross and Blue Shield Association, Iowa's current mandates are mammography screening, well-child care, chiropractors, dentists, registered nurses, optometrists, and diabetic education.

To some extent, the differences in the cost estimates reported by the various studies are related to the number of mandated benefits included in each state. For example, the studies that showed the highest estimated costs were for Maryland and Massachusetts, states that have more mandated benefits than most states. Thus, these cost estimates cannot be generalized to other states.

While the studies report varying cumulative costs in different states, they generally agree that several specific mandated benefits account for a large share of the additional costs. In particular, mental health and substance abuse are often cited as the most costly mandated benefits whereas other commonly mandated benefits, such as mammography screening, account for fewer than 1 percent of costs. Furthermore, in some cases, mandated benefits covering services offered by some alternative types of providers, such as nurse midwives, may reduce costs because they substitute for more costly forms of care. However, some provider mandated benefits may also increase the demand for services, thereby increasing costs. For example, while chiropractic services may be a less expensive alternative for some treatments, mandating their coverage may also lead to increased use.

One limitation of most studies on mandated benefits is that they have examined the impact of mandated benefits on claims costs, which does not necessarily capture the actual effect on employers' costs. In particular, multistate employers note that varying state-mandated benefits result in additional administrative cost. Employers that purchase health insurance must modify their plans to meet these differences in state-mandated benefits. Furthermore, employers are concerned that mandated benefits limit their flexibility in designing the most cost-effective health benefit plan to best meet the needs of their employees.

SELF-FUNDED HEALTH PLANS OFTEN COVER BENEFITS COMMONLY MANDATED BY STATES

The actual cost impact of mandated benefits to employers also depends on whether the employer offers a comprehensive or limited health plan, which in turn is often related to the size of the employer. Many of the commonly mandated benefits are often offered by employers, even those who self-fund and are not subject to the state mandates. In general, large employers are more likely to self-fund their health plans and also tend to offer more comprehensive benefits than small employers. For small employers, who typically purchase fully insured health plans and are less likely to offer health coverage at all, mandates may impose claims costs for benefits that they otherwise might not have covered.

Studies have shown that self-funded health plans typically offer many of the benefits that are commonly mandated by states for fully insured health plans. For example, as shown in figure 2, a KPMG Peat Marwick survey of employer benefits among all firm sizes indicates that self-funded health plans are more likely to offer well-child care outpatient alcohol treatment, outpatient drug treatment, mental health benefits, and chiropractic care than fully insured health plans. This survey also reports similar patterns for other benefits that are not typically mandated, including prescription drugs, adult physicals, and dental benefits.[3] Similarly, a survey of Wisconsin insurers also found that: ''self-funded health plans provide at least as many of the managed benefits as insured health plans and in some cases provide more generous coverage.''

This result may partially be due to the tendency of large employers to both self-fund and offer more comprehensive benefits.

Although self-funded plans often offer the same types of benefits as are commonly mandated by states for insurers, they may include features that differ from the requirements of state mandates. For example, state mandates generally specify a minimum number of days of care that insurers must cover for inpatient mental health care. One employer association indicated that many employers prefer designing more flexible mental health benefits; for example, requiring case management rather than specifying a limited number of days of care. Thus, even though 97 percent of self-funded plans offer inpatient mental health care services, all these plans would not meet the state requirement for fully insured health plans.

Assessing the cost differences between self-funded and fully insured health plans resulting from mandated benefits is difficult. To the extent that self-funded health plans offer benefits that are similar to state-mandated benefits, they do not have lower claims costs due to their exemption from state-mandated benefit laws. For less commonly offered benefits, such as in vitro fertilization, self-funded employers would face additional claims costs if they were required to meet the state mandates.

Please contact me at (202) 512–7119 or Michael Gutowski, Assistant Director, at (202) 512–7128 if you or your staff have any questions. Other major contributions to this letter are John Dicken and Carmen Rivera-Lowitt.

Sincerely yours,

JONATHAN RATNER,
Associate Director,
Health Systems Issues.

FOOTNOTES

[1] ERISA preemption effectively blocks states from regulating most employer-based health plans, but it permits states to regulate health insurers. The majority of employers purchase health coverage from a third-party insurer that is subject to state insurance regulation. However, for plans covering about 44 million people in 1993 the employer chose to self-fund and retain at least some financial risk for its health plan. Because these self-funded health plans are not deemed to be insurance, ERISA preempts them from insurance regulation and premium taxation. For a fuller discussion of the regulatory differences, see Employer Based Health Plans (GAO/HEHS-95–167, July 25, 1995).

[2] The calculation of the number of mandated benefits includes requirements that insurers provide or continue coverage for specific populations, such as dependent students, as a mandated benefit. Thus, the number of mandated benefits per state includes these requirements as well as treatment-related and provider-related mandated benefits. See Blue Cross and Blue Shield Association, State Legislative Health Care and Insurance Issuers: 1995 Survey of Plans (Washington, D.C.: Blue Cross and Blue Shield Association, 1995) for a list of mandated benefits for each state.

[3] The data in figure 2 represent the percentage of covered workers in conventional health plans. KPMG Peat Marwick reports similar findings for workers in preferred provider organizations and point-of-service plans that are either self-funded or fully insured. KPMG Peat Marwick is currently examining to what extent these differences in the rates of benefits coverage among self-funded and fully insured health plans can be explained by differences in firm size and premium levels.

Mr. JEFFORDS. Because the employer frequently pays a significant portion of the premium, a large majority of the eligible employee—both young and old, sick and healthy—choose to enroll in an employer-sponsored plan. Since so many people participate in group plans, the average per employee price of coverage stays relatively low and remains affordable for each employee, since the insurance risk is spread over a large pool of people.

The individual market, on the other hand, contrasts in many ways from the group market. For instance, those who buy individual health insurance pay the entire premium out of their own pockets, whereas, in most cases, a business picks up most of the tab. If an individual buys it, it is out of his own pocket. Not only do the people receive no subsidy from the employer, they also do not receive the same tax advantages afforded to employer-sponsored health plans. This is a critical difference. Therefore, costs to the individual is a major concern. When individuals leave a group coverage situation

and decide not to purchase in the individual market, it is because they cannot afford it or because they are healthy and have decided they do not need the coverage and do not want to pay the amount of money they would have to pay.

The individual market is so price sensitive, as prices go up, healthy and less costly people leave the market, causing the prices to continue to spiral upward. This vicious cycle makes it inevitable that individual coverage will become less affordable for hundreds of thousands, if not millions, of Americans.

What is the solution? We must encourage purchasing cooperatives in the individual and small group market. Group purchasing is the first tool to bring down costs of individuals. The key concern regarding ERISA is the risk of segmentation.

I was very pleased when Senators KASSEBAUM and KENNEDY included in the health plan purchasing coalition section my own bill which I offered with Senator NUNN, S. 1062. I believe that the key to making health insurance more affordable for individuals and small employers is properly designed voluntary group purchasing arrangements.

Employer group purchasing is not in the concept. Many employers have been pooling funds and contracting with entrepreneurs to offer health benefits to their employees at reduced rates for many years through something defined as multiple employer welfare arrangements, referred to as MEWA's, under ERISA. A MEWA is an arrangement where two or more employers group together to purchase health benefits. The more that group together, the lower the per employee cost or employer cost.

While a number of MEWA's form important gaps in our health care system, some MEWA administrators have taken advantage of the confusion as to who bears responsibility for regulatory oversight, the Feds or the States. It is very, very confusing. They have been able to create and run ponzi schemes, designed to take premium payments with no intention of covering any major health claims. My esteemed cosponsor of S. 1062, Senator NUNN, led the effort to uncover the corruption of fraudulent MEWA's when he chaired the Senate Permanent Committee on Investigations. He was instrumental in drafting the section of the bill that addresses MEWA reform. It is important. I bring it up, also, as I will mention later, because of what is in the House bill.

The bill Senator NUNN and I introduced makes clear, once and for all, that the States are responsible for regulating all MEWA's. Therefore, the number of States that have moved forward in this area will no longer have to be involved in costly litigation, using precious State resources, to prove they are regulated.

I must say, I am very concerned about the way the House bill handles the group purchasing in the small group market. First, continuing to segment the market by creating different rules for insured and self-insured MEWA's is a mistake.

Second, giving the Department of Labor the additional responsibility of now being the insurance regulator for all self-insured MEWA's takes away a current State responsibility and hands it over to the Federal Government. This seems totally inconsistent with the philosophy and fiscal reality of less Federal Government and more responsibility for the States. I think we should be careful when we are looking at this in the conference committee.

Requiring purchasing cooperatives to offer only fully insured products, as in the case of S. 1028, is a much better solution. Although the group purchasing section of the Kassebaum-Kennedy bill is good, I hope we will be able to improve upon it in conference with the House. I hope we can take the lead from Governor Whitman accomplished in New Jersey. She saw the need to look at the impact overburdened State-mandated benefits laws can have in a small group market and developed a variety of distinct benefit packages that small employers can choose to purchase for their employees. This strikes me as a critical step at expanding health care coverage.

Fixing what is broken in our current health insurance system should be what is accomplished in this year of incremental reform. Although I believe the Kassebaum-Kennedy bill is a good bill, I believe it can be a great one. That is the main reason Senator SIMON and I plan to offer an amendment that would raise lifetime limits, caps, to $10 million. We want to ensure that this bill lives up to its basic promise. What good does it do to pass a law that prevents insurers from excluding individuals with preexisting conditions if you let employers set lifetime caps at $50,000—which is probably 1 day or 1 week for those people—to meet the needs of those conditions?

It is critically important, in my mind, that we make sure that we make this remain a good bill and that we pass a good bill. I will mention that I offered this amendment in committee, and they said at that time that we wanted to come out with a 16 to 0 bill. This was the step that people have to understand—that I would not offer this in committee, but I said I would offer it on the floor. There was some concern raised about having amendments to this bill. But I point out that this is important to the bill in order to make it work.

This is not an extraneous amendment, unrelated to the purpose of the bill. If we do not prevent insurers from reducing lifetime caps, then we have the very likely situation where they will reduce the caps if they have to take sick people in. If we do that, we will have lost the great benefit of what we are trying to do today.

Let me talk about the lifetime cap amendment. In a letter I received from the American Academy of Actuaries addressing my amendment, they stated:

> . . . this amendment is unlike State mandates that require coverage of specific medical services. This is a Federal mandate that appears to greatly increase the security provided plan participants by raising their potential benefits to $10 million.

This is also important. CBO has estimated that premiums would only increase by 0.16 of a percent, while at the same time reducing Federal and State expenditures in the Medicaid Program. So what we would do is to prevent the horrendous situation we have now.

How do you take care of the sick people in this country that have an insurance policy that has a lifetime cap? What happens? You reach the cap and then you have to, under the present situation, drain all your resources until you are poor. And then you apply for Medicaid, and you are eligible for Medicaid. I want to point out that I think that is a terrible way to handle things.

I also point out that other information that we have received from reputable organizations has backed us up in the fact that this is a de minimus cost to most employers, and it is a huge benefit to the Federal budget. The National Taxpayers Union has said that the net savings could be as much as $2 billion in Federal savings and $3 billion in State and local savings by just passing this amendment, at a very minimal cost to employers.

As U.S. Senators, we have the peace of mind in knowing that our health insurance will be there if a catastrophic illness or injury strikes one of our families. In our plan, there is no cap. Anything can be covered. In a large number of HMO's, there are no lifetime caps, and in some other group policies there are no lifetime caps. So I want to focus your attention on that. Hopefully, in the time before I offer the amendment, you will learn more about this and agree with us.

For now, I would like to, once again, commend both Senators Kassebaum and Kennedy for bringing this bill to the floor of the Senate. I urge my colleagues to vote for its passage. I am hopeful that when we finally do get to my amendment, you will keep in mind that what we will do will be almost an unmentionable expense to most employers, but will save people from incredible experiences of having to go through bankruptcy in order to get health care coverage, and also will allow us to reduce the cost of Medicaid to State, local, and Federal Government.

Mr. President, I yield the floor.

Mr. KERREY addressed the Chair.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

PRIVILEGE OF THE FLOOR

Mr. KERREY. Mr. President, I ask unanimous consent that Karen Davenport, a fellow in my office, be allowed privileges of the Senate floor during our debate and consideration of S. 1028.

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

Mr. KERREY. Mr. President, I rise to support the Kassebaum-Kennedy bill, S. 1028. I believe it is a long-overdue change. As the Senator from Rhode Island and others have said already, it is regarded by some as very incremental. I regard it as one of those very important pieces of legislation.

Earlier, we enacted a piece of legislation, ironically, that Senator KASSEBAUM actually took the lead on last year, which consolidated the job training programs and gave the States a lot more flexibility in designing their own programs. I said at the time that I thought this law was the second most important thing we could take up this year because we know, with certainty, that it is going to effect some 20 million people. It does not cost the taxpayers any money. It does make a change of the law, the Federal law and will alter the way the market works. But it is not the first time that we have interfered with the health care market.

One of the most expensive interferences that we have with the health care market is that we allow health insurance to be deducted with offsets against FICA by employers, as well. It is a very important deduction, but it also must be seen by citizens as an interference with the market because it is for upper income people in particular. For people like myself, if I am buying private health insurance, it provides me with a substantial subsidy.

It has been a very important way to allow people who otherwise would not be able to purchase health insurance to buy it. So it is not as if this kind of action is without precedent. There is no doubt that close to 21 million Americans will be positively affected by this. They will be able to purchase with their own money health insurance, and still in many cases it is going to be quite high. But nonetheless they are going to have an opportunity to buy it. They are not going to be denied the opportunity to purchase. It does not obliterate the high-risk pool States like Nebraska. We started one when I was Governor. It does not affect States that worked on this for years to try to provide some way to have all of us share a bit of the risk.

This bill, as I see it, is designed to accommodate or rather radically change the economy where we are seeing a lot of downsizing, particularly in larger corporations. You have individuals that are covered by group policies from those corporations. They will find themselves very quickly running out of their benefits and having to purchase individual policies. And very often they find themselves faced with the inability to make the purchase. This law will basically say we are all going to share the risk of that in the marketplace so that these individuals can make the purchase. As has already been pointed out, nearly 25 percent of all working Americans who have private sector jobs have job lock as a result of the lack of portability and the lack of ability to be able to purchase with preexisting conditions. Nearly 3.8 million American workers lost their jobs in March. It is a rather substantial paradox that it has become a fact of life that even at a time when the economy continues to grow, even as we have a recovery underway, that we have layoffs that are close to the same number that were occurring during the last recession that we experienced in the early 1990's. Thus, this change in the law accommodates rather substantial change in our economy.

One of the things that a lot of us who are older—I am 52—sometimes fail to recognize is that the cost of health care as it has gone up has changed the way people in the market, working people and particularly younger people, face health care expenditures. For example, when my babies were born 20 and 19 years ago I was able to pay cash for them. I did not insure against the risk of having a baby because it was a relatively modest amount of money. You paid for it out of pocket. It was not considered to be a big deal. Today you need to be insured because the normal delivery is expensive. But almost any extended stay in the hospital can put a young family in a great deal of financial distress.

That is just one of many, many examples that one could cite; a very relevant example because it is a rather common experience. There are 4 million live births a year in the United States, and an awful lot of those births are in families that are uninsured. This will make it more likely that those families will have insurance and have coverage.

It certainly will not get us to where I would like to see us; and, that is, at a point where every single American and legal resident knows with certainty that they have insurance. I hope this is a first step.

I will support Senator KASSEBAUM's and Senator KENNEDY's request to vote against all amendments. I believe that this bill needs to go across in an amendment-free fashion. I do not know if I ever stated what Senator KASSEBAUM is going to support. But I believe this bill is too important for me to be supporting, as Senator JEFFORDS earlier indicated, an amendment that I would under normal circumstances support. I will vote against that amendment because I believe the bill needs to be clean and clear. It came out of the Labor Committee with unanimous support. We have an opportunity to help 21 million Americans. I think it is very important, in spite of my respect for the Senator from Vermont and admiration for him personally, as well as my normal inclination to vote for that amendment. I believe an amendment-free strategy is the right one to adopt.

Mr. President, one of the things that I think we need to do as we move toward universal coverage—and I hope that is the goal—we spend $400 billion a year in Federal direct spending in tax benefits for health care. We spend a sufficient amount. If we would change the way eligibility occurs, one of the things we have to do in order to be able to get there is we all have to face the true cost of health care and very often we do not. Somebody else is paying for it. The insurance company is paying for it—the Government. So we really do not worry about whether or not the bill is high or the bill is low. The more that we can face that cost directly and understand that, if we do not have the resources to pay for it—it is paid for out of an insurance pool, paid for with Medicaid or Medicare, somebody else is essentially paying our bills—the more that we can face that fact the more likely it is that we will move quickly to a point where, if you are an American or legal resident, you will know for certainty that you have health insurance.

This morning June O'Neill, the Director of the Congressional Budget Office, appeared before the Senate Budget Committee and laid down a rather stark warning; that is, even if the President's budget or the Republican budget were adopted, we still have not controlled the growth of entitlement programs. I say that to colleagues because I think once we get beyond the Presidential election we are going face in 1997 a really rather difficult fact. And I believe June O'Neill laid it out for us this morning; that is, we have commitments on the mandatory side that are going to make it difficult for us to fund education, to fund transportation, to fund defense, to fund space, to fund law enforcement, and to fund all sorts of other things that are going on. Unfortunately, very often that occurs because people believe that they have a right to something, that they have a benefit that actually is paid up, the money is all there, and it is set aside for them—no problems, do not worry about it—when in fact that is not the case.

It gets back, it seems to me, to a problem that we have whether it is the tax deductibility, or whether it is Medicare part B. There is sort of a sense that somebody else is paying for it. Why should I have to worry about it? As a consequence, we just are not engaged personally as we ought to be in trying to control the cost of health care, and as a result, it seems to me, it is difficult for us to take the next step.

So again I want to say how much I really appreciate very much and applaud the determination of the Senator from Kansas, and the Senator from Massachusetts. They and the Labor Committee voted this out unanimously, and 21 million Americans will be affected positively. Taxpayers will not be on the hook for this thing. It has been measured. It will cost no more than 2 percent in premiums across the country and with reasonable changes in the law given what is happening out in the marketplace.

I hope this body will pass it as quickly as possible and get it on to the President for his signature.

I yield the floor.

Mr. JEFFORDS. Mr. President, I want to comment briefly on the comments of the Senator from Nebraska about my amendment. I point out that, unlike all of the other amendments, this one is very relevant to this bill and will improve the bill. It is not extraneous to it. If we do not keep track of what the lifetime caps are, then this bill will be a mockery because, if we require the insurers to take sick people on, one way of getting out of that is to reduce the lifetime caps so that as soon as they come in they are out the other end. It was offered in committee with the understanding that it would be brought forward at this time.

I just wanted to bring that to the Senator's attention and hope that I will make an exception to his decision in that regard.

Mr. President, I yield to the Senator from Iowa.

Mr. GRASSLEY addressed the Chair.

The PRESIDING OFFICER (Mr. SANTORUM). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I am very glad that this debate is taking place before this body. Having had an opportunity on two separate occasions to push concepts similar to what is in this legislation to accomplish the same goal in maybe not exactly the same way, I am glad that we are here today and that there is a bipartisan effort to get this legislation passed. I think being truly bipartisan is a continuation on these issues of guaranteeing some health insurance to people who can afford it—things that we have tried to accomplish before in a bipartisan fashion.

I respect Secretary of Treasury Bentsen because when he was chairman of the Senate Finance Committee he had proposals which I think were bipartisan with the ranking Republican at that time included in H.R. 11, a major tax bill. And those health insurance provisions went through without any debate on the floor of this body because they were accepted as things that should be done. To see that happen was good. Obviously, President Bush vetoed that bill because he did not like the tax provisions that were in it.

Then, if you remember the next step, there was a fairly bipartisan effort to make these provisions part of basic law. It was during the health care reform debate of 1993 and 1994. They were relatively noncontroversial provisions of much more controversial efforts by the Clinton administration to have the Government totally dominant in the delivery of health care in America and do it through a provision that we called employer mandates, meaning every employer, large or small, would have to provide health insurance to their employees.

Of course, that came down to total defeat in 1994 because the middle class and the small business people of America woke up to a couple of things: First, that small-business America could not afford an employer mandate because they could not pass it on to their consumers like big corporations can do; second, middle-class, taxpaying people saw their rates going up, or if their rates did not go up the services that they received from the health care industry and from the health insurance industry would have gone down.

You remember that was part of a big effort we had in 1993 and 1994 where we were going to insure everybody. Obviously, when there is 13 or 14 percent of the people who do not get insurance and a large percentage of them that cannot afford it, somebody is going to pay. There is no doubt about it. There is no free lunch in our system of doing business in America.

The middle class saw this problem, that we were trying to reduce the coverage, affordability and quality of health care to middle class working America as we were trying to solve the problems of the 13 or 14 percent of the American people who did not have any health insurance. Of course, it only took about 3 or 4 months until working, taxpaying American citizens found out what Congress was proposing to do, and they turned against the Clinton health care proposal.

Then that message really did sink in to the President of the United States because after the November election in 1994, when the Republicans took over the Congress, the President said he was not going to attempt to have that complete overhaul of the American health care provisions he incorporated in his 1993 and 1994 proposals, and that if he was going to do anything it was going to be done incrementally.

So you have a President, thankfully, waking up to the realities of what grassroots America wants, particularly what middle class America wants, they liked their health care plans and wanted to keep them from being diluted. You have the President waking up to that reality, on the one hand, and then you have Republicans who had accepted these noncontroversial parts of the President's health care provisions, the noncontroversial parts, being debated in this Chamber today, which bring together the bipartisan efforts that are going to make this legislation very successful.

So I just wanted to give that background before I express my words of support for and cosponsorship of this very important piece of legislation, because the American people for the last 6 or 7 years, as expressed by this history I just gave you, believe it is high time Congress passed legislation which provides basic health insurance protections for individuals and small businesses. The Kassebaum bill is our opportunity to respond to these concerns.

This bill would assure greater portability of health insurance for individuals. It would limit the ability of insurers to deny health insurance coverage because an individual has a preexisting condition. It would require insurers to offer health insurance to individuals who have lost jobs and seek such insurance. And it would require insurers to issue health coverage to individuals who want to purchase insurance for their employees on a group basis.

The bill defers to health insurance reforms passed by the States. This is very important for my State of Iowa, because in my State we have enacted a very good health insurance reform law. It went into effect on April 1 just past.

Enactment of the Kassebaum bill should not disrupt the reforms that are going on in my State. So, in my State, Iowans would continue to receive health insurance under the terms of the Iowa reforms.

I thank Senator KASSEBAUM and her very capable staff for working with me and my staff and with some of the Iowans who helped put together the Iowa reforms. The modifications Senator KASSEBAUM will offer to her bill would help make sure that Iowa and similar State reforms would not be disrupted when this bill is enacted. As a consequence of these changes, Iowa, and probably several other States should be able to carry out their own reforms without undue interference from the Federal level.

For States which have not implemented their own reforms, this bill would then reform both the group and the individual health insurance markets in those particular States. As I said earlier, these reforms would respond to some of the most pressing problems encountered by small businesses and individuals when they need health insurance.

For the group market, this bill would require insurers who offer group health plan coverage to offer such coverage to all groups that apply. This would prohibit insurers from denying health insurance coverage to employers whose work force the insurer believes is not healthy enough to insure.

Next, the Kassebaum bill would require insurers to offer coverage to all individuals in a group without regard to their health status. This would prohibit insurers then from denying coverage for an individual member of a group plan based on that individual's health status. This legislation would require insurers to renew group health plans at the option of the employer. Renewal may not be denied for reasons of health status of those in the plan. Thus, an insurer would not be able to refuse to renew a health insurance plan to a group based on changes in the health profile of the individual.

This legislation would limit an insurer's ability to deny coverage for preexisting conditions to 12 months. This waiting period would be reduced by 1 month for every month during which an individual was continuously covered under a prior health plan. Thus, Mr. President, an individual who had maintained continuous coverage for 12 months could not be denied coverage because of preexisting conditions.

I think it is simple to say, Mr. President—as far as I can tell—the provisions I have just outlined in this bill, the provisions which apply to the group health insurance market only, are relatively unopposed.

This bill would also reform the individual market. This bill would guarantee the availability of health insurance coverage for individuals leaving group coverage, who want to get individual insurance coverage, as long as they have been covered under their previous group plan for 18 months.

If those individuals were eligible for coverage under current Federal law, and we call that law by the acronym COBRA, these individuals must have exhausted that coverage before they can be guaranteed coverage in the individual market. But that is the only requirement that keeps these individuals from getting insurance.

This legislation would require that health plan insurers renew individual policies at the discretion of the individual, similar to group policies being renewed at the discretion of the employer providing the group policy. Now, without a doubt, there has been a lot of concern expressed about this provision, and it continues to be expressed. It continues to be expressed by insurers who operate primarily in the individual market.

I might say to these companies that I am talking about here, that have this concern—and I am not going to say that this concern is not legitimate—but, as far as practical matters are concerned, I want to remind these companies that if we were to have passed the Clinton health reform plan of 1993, there would not have been any individual market out there. These companies would have been out of business. A lot of the companies in my State that do a majority of group coverage still have a vast minority of their business in the individual market. That portion of their market would have been wiped out. I hope these companies that have some concern about this provision I am speaking about here realize that they have a lot of friends in this body that believe in the free market and do not want to hurt individual insurance coverage. A lot of Americans want individual insurance coverage, not necessarily because it is better than group, but because that may be the only way they can have it and get the type of health care that they want. These companies have that business today because we stopped the Clinton health care reform plan that would have wiped out individual insurance coverage for health care.

Now, what do these companies fear? They fear that the group to individual provisions in the Kassebaum bill would have the ultimate effect of greatly raising premiums in the individual market and hence, I suppose, cutting out a lot of their business because some people might drop it. The marketplace kind of dictates as the price goes up you sell less of something. So these insurers feel the numbers of insured are going to go up. Some of them would say the numbers would increase greatly. But going up greatly, compared to not having any of this business had these reforms been adopted in 1993, is the difference between night and day, as far as I can tell.

It is the case that the bill would not forbid health insurers from rating individuals and charging them a higher premium if such rating indicates that they are greater health risks than any other individuals. I would think that would help this problem for these individual policy companies to some extent. But as far as we can tell from analysis done by the independent actuaries, the premium price increases caused by the bill should be very modest.

The analysis done by the health insurers' association, the Health Insurance Association of America, wants us to believe that the premiums would increase in the neighborhood of 15 percent. But in making my decision to support the Kassebaum bill vis-a-vis this problem I am just describing, I took into consideration the analyses done by independent actuaries such as the American Academy of Actuaries, and Hay Huggins, which was done under contract with the Congressional Research Service at the request of Senator KASSEBAUM, and even the nonpartisan Congressional Budget Office. All these found that any premium increases attributable to the enactment of this legislation should be very modest, in the range of 1 to 5 percent. The Congressional Budget Office estimates that this increase would be no more than 2 percent as a result of the group to individual portability provisions. If this bill is enacted, it should help provide some peace of mind for a lot of people.

But we should make it clear to the public what this bill would not do. As a lot of people have said here already, it would not solve the problems of those people who cannot afford to have health care insurance. But that is what the term ''incremental'' meant. When President Clinton, after the November 1994 election, when the Republicans gained control of Congress, was asked about health care reform, he indicated he had learned a lesson from the debate of 1993 and 1994, and he was going to promote the incremental approach. Basically that means we should provide a marketplace out there so people who want and can afford health insurance are going to be able to buy it.

We are going to be able to get a better handle on what the cost is out there, for those who cannot afford insurance. Maybe we can help those people without screwing up the best health care system in the world, which would have been done with the effective Government takeover of health care, if the Clinton health care proposal had gone through in 1993.

But peace of mind for this percentage of people that can afford it is only one goal. That peace of mind should not be enough for everybody to buy into this, because there are some shortcomings that we have to admit to the American people. This bill would not completely eliminate the denial of coverage for every preexisting condition. It would not require employers to offer insurance to their employees. It would not provide portability between different individual policies. And it would not necessarily mean that currently uninsured individuals would have to be sold a health insurance policy.

It is for these reasons that I support the addition to the bill of provisions which would increase the tax deductibility of health care costs for the self-employed. That is not only to pick up a hole that is in this bill but to also bring some equity to the difference between the deductibility at 30 percent of health insurance for self-employed and the 100-percent deductibility for health insurance for employees of corporations. In my State of Iowa, that is like saying that the farmers of my State are denied equity when they can only deduct 30 percent of their health insurance from their income tax, where John Deere, for its workers, can deduct 100 percent of the cost of insurance for that corporation.

I support the addition of medical savings accounts. Both the tax deductibility of health care costs for the self-employed and MSA's, together, at a minimum should make health insurance more affordable, improve portability, as well as providing a greater degree of tax fairness. In any case, if enacted, the bill would be a step forward. The majority of those who are paying attention to our debate since it began several years ago very much want to see Senator KASSEBAUM's bill enacted. We have been promising these reforms, as I indicated at the opening of my remarks, since the Bentsen bill passed this body in 1992, without any debate—indicating, then, that it was the best thing to do. It was a good thing to do. It was a bipartisan thing to do.

So most of us have been saying since that date in 1992, or years before that, we could easily enact such reforms as those that are in this bill. Remember, then, what incremental health reform is. Incremental reforms were what most Republicans were saying was the way to go and we have the President of the United States, in November 1994, saying the same thing. Now we have before us a bill that will deliver incremental health insurance reform if it is enacted. We should pass it.

We have before us a bill that will deliver these incremental health insurance reforms if this bill is enacted—and it will be enacted—and we should pass it. Thank you.

Ms. MIKULSKI addressed the Chair.

The PRESIDING OFFICER. The Senator from Maryland.

Ms. MIKULSKI. Thank you, Mr. President.

I rise to voice my very strong support for this health insurance reform.

This is a tremendous opportunity today to provide greater access to health care for millions of Americans and their families. The Kassebaum-Kennedy health insurance bill, of which I am a cosponsor, is an excellent step in that direction.

This bill will be a great relief for most working Americans. They will not have to worry about losing their insurance if they change jobs. Insurance companies will not be able to deny coverage or make it prohibitively expensive for a preexisting condition.

What this means, Mr. President, is that this bill is a safety net for working Americans and their families. This legislation will make health insurance portable and affordable, and it will give a benefit package that is both reliable and renewable.

I was disappointed that we were not able to enact comprehensive health insurance reform. After that debate came to a close, I pledged to continue the fight to reform health care. This is an important step in that direction, and Senator KASSEBAUM and Senator KENNEDY should be thanked for their great effort in bringing us this far.

Many Americans have medical histories of preexisting conditions that make it difficult for them to get insurance coverage. They stay locked in their jobs and unable to move to improve their standard of living because they fear they will not be able to get insurance coverage. This legislation will end job lock. This legislation will end the penalty for having a preexisting condition, like diabetes. People who work in small business, especially many women, will now be able to get health insurance.

The bill before us today goes a long way toward eliminating the barriers to coverage. For 81 million Americans who have preexisting medical conditions, insurance companies can no longer exclude them from coverage.

Millions of Americans will be able to be secure in the knowledge that if they change or lose their jobs, they will not lose their health insurance. And for those entrepreneurs who start and work in small business, this legislation will provide increasing purchasing power for them and their families.

I am pleased that the bill has the potential to help millions of women and their families. This legislation will help women who start a new job with an employer who provides health insurance. A woman will not be denied insurance for herself and/or family if there is a preexisting condition. Like when she is pregnant, she will be able to get immediate coverage for the pregnancy, even if she is already pregnant. Her newborn or adopted child will receive health insurance coverage as well.

This bill will stop the terrible practice of denying women insurance if they are victims of domestic violence. I think that is crucial. This bill will stop that horrible practice of denying women health insurance if they are victims of domestic violence.

There is much more that I would like to be able to do to make insurance coverage affordable, accessible, portable and undeniable. I would like to see coverage for long-term care, and I would like to see a comprehensive benefit package for women and children, but this is a very important step. We have a tremendous opportunity to improve the lives of many Americans, and I am pleased to support this bill.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. SHELBY). The Senator from Wyoming.

Mr. THOMAS. Mr. President, I rise in support of the Kassebaum bill. I suppose most of us today and on through the night will be saying much the same thing. We have not all said it yet, so we will have to keep doing it. But this is a bill that is very important to us, and we ought to comment on it.

It provides, I think, long-awaited reforms. We have all worked on health care for a very long time. I have had a particular interest in rural health care in that the delivery systems in rural States are necessarily quite different than they are in other States.

This is an incremental move, and I am for that. The portability is important so that people are not afraid to change jobs. Certainly, not prohibiting preexisting conditions and allowing small businesses to form purchasing cooperatives are terribly important. So these are practical and affordable reforms that we need—really relief from trying to change the whole system. I think Congress will meet this challenge.

The Health Insurance Reform Act helps each and every American, more than any other bill that has passed this year. Wyoming ranchers and farmers and owners of small businesses and folks in the mineral industry will no longer be excluded from care they deserve. S. 1028 is compassionate, and I challenge President Clinton to sign this bill for the sake of all Americans.

There has been a major shift in the debate, of course, over the last couple of years. It is historical when you look at how far we have come since we initially discussed health care reform. No longer are we considering the Clinton approach to a Government-run system. That was rejected by Americans, and I think properly so. Instead, we are going to move incrementally into some commonsense reforms. There will be some changes, and there have been some changes suggested by the managers, moving closer to the House proposal, in terms of high-risk pools.

In 1991, my State of Wyoming responded to the health care concerns of individuals with serious illnesses establishing a State insurance pool, a high-risk pool allowing States to continue these measures, rather than be forced to enact other individual insurance reforms. I think this is very helpful to rural States like Wyoming.

Moving incrementally does not mean keeping every worthwhile proposal off the table, however. I think we should promote solutions that expand health care choices and, most of all, in the final analysis, do something about cost. When you talk about health care, what do you usually end up talking about? Cost. Availability, of course, then cost.

I happen to favor medical savings accounts. I think this gives the kind of discipline to health care costs that individuals give when they are responsible for making some of the decisions.

Self-employed deductibility is fair and equitable, and we should have done it long, long ago. Eighty percent of that is good. Administrative simplification, of course. And I believe when we talk about costs, we ought to concern ourselves with malpractice reform. I do not think there is any question but what there are substantial costs there.

Mr. President, I have been dismayed that the President is threatening to veto health insurance reform over some of these provisions. I believe the veto flies in the face of what the American people want.

As part of the changes that have occurred in Washington last fall, I am committed to bringing quality health care to rural America, some equity to rural America, and that is why I have an amendment to offer that corrects the formula used to set payments for rates under managed care plans that participate under Medicare. We will see increasing numbers of managed care plans, and more and more people in Medicare going into them.

The formula is not fair, the formula is not equitable, and we need to make some adjustments. To give an example, the payments made in rural areas of South Dakota are $177 a month. Payments for similar services in New York are $678 a month based on historical utilization. That needs to be changed. That is unfair. When we have a program like Medicare that is treated somewhat uniformly, that is a 367-percent gap, and we can change that, and I think we should.

The longer these disparities exist, the longer rural seniors will be left with less health care choices.

So I am in support of this bill. I think it could be stronger. I hope it is. But I am supporting it. I think we should have this bill. Access to health insurance is, of course, a little comforting for those who need it.

Mr. INHOFE. Will the Senator yield?

Mr. THOMAS. Yes, I yield.

Mr. INHOFE. I recall the Senator bringing up and discussing some of these things that need to be done within our health care system. I remember so well back when we had the proposal by the President to have Government take over a system that has been run well but needed some improvements, we committed ourselves at that time to incremental improvements.

I think the bill that is before us today is good. But I also think that the amendments that will be offered, some of the provisions of which the Senator

has talked about, are going to make it better. The MSA element of this bill I think is very significant. You know, this is the only product or service anywhere in America where it has built in a factor to pay more. I do not know of anyone in America, that once they pay their deductible on a health policy, watches what they spend as much as if they were paying their own money. This is human nature.

I am hoping that this bill that is a good bill, can be made a much better bill and we can come through and take care of some of the things that the Senator is talking about. I am particularly interested in some items that are not going in there. I would like medical malpractice reform but I also realize that would be a very heavy thing that would cause it to go down and perhaps cause a veto. I think with these very moderate and modest reforms that the Senator is talking about, I think it will be a better bill, better bill for our health delivery system in America. I applaud the Senator for bringing these up and discussing them.

Mr. THOMAS. I thank my colleague. Before I sit down, I do want to compliment the Senator from Kansas. This is the product of a great deal of work and great deal of leadership and something that we do need to do. I want to say, however, in closing, that I think we have made some real progress in the last couple years in the industry, in the private sector. And even though I think there are some problems that we will have to deal with as we go about it, managed care has been helpful, managed care has done something to control prices.

I think more and more people are becoming aware of their responsibility with regard to payments. I think it is true that third-party payers have been part of the problem of costs. We can work that out. So in any event, I rise in support of the basic bill. It guarantees coverage of the type of insurance particularly important today, and I compliment the Senator for it. I yield the floor.

Mr. BREAUX addressed the Chair.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. I thank the Presiding Officer.

Let me start by saying what I would imagine has already been said a number of times; that is, to compliment the junior Senator from the State of Kansas, Senator KASSEBAUM, and the senior Senator from the State of Massachusetts, Senator KENNEDY, for bringing together a unique, I think in these times, coalition of Members to support a major, major legislative effort in one of the most important areas that this Congress could be dealing with, and that is the health care of the citizens of this country.

This body is going to miss the Senator from Kansas for her wisdom and her balance and her willingness to work in a bipartisan fashion to accommodate the various interests of the Members of this body. It has been a real pleasure to work with her in the so-called Chafee-Breaux Group where we have been trying to come together to come up with a balanced budget. I commend her for her efforts in that regard, but particularly in bringing this Kassebaum-Kennedy bill to the floor; and, of course, for the years of tireless service by the senior Senator from Massachusetts, because he has really been dedicated over the years in trying to come up with health care legislation that really serves the needs of the people of this country.

Let me start by saying that this indeed is a large coalition. It is a large coalition—65 Members of Congress in the Senate alone have endorsed and have agreed to cosponsor this legislation. So that in itself is very rare in today's atmosphere of high partisanship that we see more and more, unfortunately. So anytime you can get a coalition of 65 cosponsors of a major piece of legislation indeed that is very, very good news.

Let me also say that while the coalition is large, the coalition is very fragile. It is very fragile because it does not do as much as what many Members would like to see it do. And there are still things that this legislation does not do that it should address. It probably does more than some people would like to see done with requirements from a Federal level that certain things be required when you sell health insurance in this country.

But the real accomplishment of the two Senators in bringing this legislation today to the floor of the Senate is the fact that it is a large coalition, it is a bipartisan coalition. It does, I think, accomplish some very important things that need to be done in the area of health insurance for the people of America.

In my own State of Louisiana there are nearly a million people who are uninsured, a million people who do not have enough money to buy a private insurance policy or who earn more than they are allowed to earn and qualify for Medicaid, the Federal-State health insurance program. So a million people walk around my State every day—go to work in most cases every day—but do not know how they are going to treat their children, their spouses, if they should get seriously ill other than through the charity of others or the charity of the hospital systems in my State of Louisiana.

Many people do not have insurance for reasons that are corrected by this legislation. For instance, there are many people who had insurance but when they got sick and needed it the most, it was canceled. How many of us as Members know a family or perhaps a member of our own families that have had health insurance, but then when they need it the most, when they get sick, after the illness is over, they get a little note in the mail from an insurance company that says, ''Well, we're going to cancel your insurance''? And the only reason they really give is because you got sick. That was what they bought insurance for in the first place. If you get sick you have insurance. It takes care of the hospital and the doctor bills.

But today, unfortunately, in this society we have people who get sick and then have their insurance canceled just when they need it the most. So they do not have it today. This legislation, for the first time, says that you are not going to be able to cancel someone's health insurance because they got sick—sort of a logical thing I think we should have done a long time ago. But this legislation does accomplish that.

The second point is, people, in my State and other States, that have tried to buy health insurance, and, sometimes, because they have had a preexisting condition, they are prohibited from buying a health insurance policy. I do not think that is basically fair. Health insurance shares the risks. There are a lot of sick people that are in the insurance pool. There are a lot of well people in the insurance pool. On balance, the insurance companies make money and people get health insurance.

That is how the system is supposed to work. So this legislation addresses the problem of people who have had preexisting conditions and brings them in a fair fashion into the system in a way that I think makes a great deal of sense.

The other problem of all those people who do not have health insurance in my State and, again, in the other 49 States is because they have had to change a job. And we all know in this mobile society as people change jobs because of downsizing, or because of changes in technology, they are able to get a better job through education and training, they could move on to another field, the problem is that many people will not change jobs, will not get a better job even if it means better economic conditions for themselves and their families. Guess why? Because they will lose their health insurance.

So we have a situation referred to as ''job lock'' where our people would like to move on to better jobs—or maybe even forced to change to a new job because of downsizing—and cannot do so because they lose their health insurance, which is one of the most important things that the job market can provide. But if you cannot be guaranteed that coverage you have today will be with you tomorrow when you are in a different job, well then, people say, ''I'm just going to stay right here.'' Or if they get laid off and they have to move to another job, they do so perhaps without any insurance because they are uninsurable when they move into the new position.

So what we have today through the Kassebaum-Kennedy legislation is a major, major health reform package which I enthusiastically am a cosponsor of and congratulate the people who have brought this monumental piece of

legislation to us. It will, when it passes, and President Clinton signs it, be, I think, a shining example of what Congress can do when we are willing to work in a bipartisan fashion to accomplish something as monumental as this legislation does.

I know the majority leader has a package of amendments that he is going to present at a later time. I as an individual Senator and a member of the Finance Committee looked over a lot of the suggestions in the proposed amendments that he has submitted. You know, a lot of them are good ideas. They have not yet worked their way through the committee. That gives me a little concern about how these new ideas are going to be paid for. Our staffs are now, as we speak, looking at the legislation and the series of amendments. I think, by and large, most of them are pretty good—80 percent tax deductibility for self-employed people who buy insurance. All the people around the country that are self-employed, now, can only deduct about 30 percent of their premiums. With this amendment, you would be able to deduct 80 percent of your health insurance premiums. I think that is pretty darn good, just like a company that contributes to a policy can deduct 100 percent of their contributions. So we should do something for the self-employed people in this country. That amendment does that.

Penalty-free IRA, individual retirement accounts, withdrawals for large medical expenses and for the unemployed to pay their health insurance premiums. That is a good idea. We have talked about that. I think this should be bipartisan in that amendment. I think that is good.

My point, as I reach to a conclusion here, is that we have a large coalition, but it is a fragile coalition. I suggest that if people come up with amendments that are very controversial, that there is not a consensus on, or that we have not had hearings on, or amendments that have not been reported out, like this bill has, by a full committee of the Senate, that we will run into problems, and we will miss what I think is a golden opportunity to, in fact, create legislation which makes a lot of sense for all Americans.

One of the amendments I will just mention is a so-called medical savings account. This is a classic example of ''if it sounds too good to be true, it probably is.'' I think that when you look at this concept—and I found after looking at it—that it, in fact, is too good to be true and causes problems that greatly outweigh the benefits. It is not to say that medical savings accounts do not have some benefits; they do. But I do not think that we are certain enough about those benefits as opposed to the negative problems that will occur to automatically accept this provision without a great deal of discussion.

I hope when that amendment is offered we will be able to strike out that section of the proposed Dole amendment and proceed to pass this legislation, hopefully with the other amendments that the majority leader is prepared to offer.

Let me tell you why I think medical savings accounts are a bad idea. I say, first of all, at one time I thought they were a great idea. At one time I introduced legislation to create medical savings accounts. Boy—they sound terrific. I asked my staff—''What is the problem?'' At the time, we—like many others—did not have the full picture to understand the problems. Few had analyzed the effects of medical savings accounts.

The problem was that while it is really terrific for healthy people, it is not so terrific, in fact, potentially very bad, for people who are not healthy. If you take, for example, young people—I have four children who are relatively young and very healthy, thank goodness—a medical savings account is very attractive for them. Their employer can contribute money to an account, and they would use that account to pay for their initial medical bills during the course of the year. If they did not have to use it at all, they get to keep the money. What a great deal if you are 20, 25 years old and very healthy.

So, in the past, we had only looked at how it affected one group of people—healthy, basically young people. A terrific idea for them. What we failed to look at is how it affected other people who buy insurance because they may get sick—generally, more elderly people, and people who do get sick during the course of their life. If they have a very high deductible policy, as high as $3,000 for a family, they have a problem, because they will incur medical expenses during the year. If they have to pay for it out of their pocket, it is a really serious problem for them. Again, it is not a problem for people who are young and never have to go to the doctor during the course of the year.

Incentives for the medical savings account have a tendency to suck out all the healthy people from the insurance pool, put them into a medical savings account where they will not be using a lot of medical health care, but leaving behind people who do get sick, who do have to go to the doctor and do have to go to a hospital during the course of a year. If the only people remaining in an insurance pool are people who have to use doctors and hospitals, the risk becomes so great because of the loss of healthy people, that their premiums would rise so high that insurance would soon be unaffordable for them as well.

My fear is that while a medical savings account takes care of one group of people, it causes far greater problems than are justified for everybody else, which is the vast majority of the remaining people in this country.

I think at the appropriate time we should set aside the medical savings account, with an amendment if we have to, look at the other amendments that Senator DOLE has offered, and I think most of them, from my personal observation, are good. I think we should accept them. But certainly not the medical savings account at this time.

Let me conclude, once again, saying to Senator KENNEDY and Senator KASSEBAUM, my congratulations to you for bringing to the Senate a real opportunity to do real health care reform in 1996. We hope that the Senate and the House would ultimately pass this legislation, and the President should sign it.

Mr. FEINGOLD. Mr. President, I rise in support of this bipartisan health insurance reform bill, a measure that I was pleased to cosponsor. There are a number of reasons to support this legislation introduced by my good friends, the Senator from Kansas and the Senator from Massachusetts.

Let me focus my remarks on ways in which this measure should provide some meaningful help for one group in particular. That is our Nation's small businesses.

From existing companies trying to maintain health care coverage to individuals who are trying to start a small business, this bill addresses several problems confronting smaller firms trying to provide health insurance for their employees.

First, Mr. President, and I want to emphasize this, the measure addresses the barriers often posed by preexisting conditions. An estimated 81 million Americans have some kind of preexisting medical condition that could, unfortunately, affect their insurability. The legislation limits the ability of insurers to impose exclusions for preexisting conditions.

In addition, the bill requires insurers to sell and renew group health policies for all employers who want coverage for their employees, and it prohibits group health plans from excluding any employee based on health status.

Now, Mr. President, this can be especially helpful to our small businesses. The problem of getting insurance does not just affect individuals with preexisting conditions. Whole industries have been denied coverage by certain insurers because they are not to employ people who are more likely than others to get sick.

A study by the Congressional Research Service found that several insurers routinely denied coverage to dozens of different types of businesses ranging from some of the following: auto dealers, barber shops, beauty parlors, hotels, lodges, and restaurants. Mr. President, even businesses and individuals that have health insurance cannot be sure of maintaining their coverage if illness strikes.

Insurers can, therefore, collect premiums for years and then just suddenly refuse to renew coverage in individuals or employees who begin to incur large health care costs. So, requiring insurers to renew policies can certainly help address that problem. This bill finally helps move us down this road.

Mr. President, the bill also guarantees renewability of individual policies and prohibits insurers from denying insurance to those moving from group coverage to individual coverage. We know that the inability to retain health care coverage once somebody leaves a job can trap many people in the jobs they wish to leave. This is often referred to as ''job lock,'' a problem, according to one survey, that may touch one quarter of all American workers—individuals that stay in jobs they would otherwise leave, because they fear losing their health care coverage.

Mr. President, this job-lock effect has an impact on small business, as well. Unless you inherit wealth, or maybe win the lottery, the chances are pretty good that anyone who wants to start a small business will be somebody's employee—at least as they make the decision to become a small business person. If you or a member of your family have any kind of preexisting condition, you may be faced with this job lock. The inability to get health insurance prevents those individuals from leaving their existing jobs to start their new business.

Mr. President, I think this barrier has a major impact on our economy by discouraging new business startups. We all know that small business is the real foundation of our economy. We have an insurance practice that discourages people from taking their good ideas and starting new businesses that will employ many more people. That is a real, real restraint on the growth of our economy.

Mr. President, finally, I want to commend the authors of this measure for the provisions that help make it easier for small businesses to form private, voluntary coalitions to purchase health insurance, and to also negotiate with providers in health plans.

While the economic power of big businesses has enabled many larger firms to contain health care costs and improve the quality of health care for their employees, small businesses continue to see health care costs climb.

The Senate Labor and Human Resources Committee reported that while health care costs for large employers declined 1.9 percent in 1994, small employers saw an average increase of 6.5 percent. This is a very large discrepancy, and one that really discourages small business at the same time that larger businesses are benefited.

By providing small employers and individuals with the kind of economic leverage in the marketplace that is currently enjoyed by large employers, these provisions should help bring the costs of health insurance down for small businesses and individuals.

Mr. President, as you know, there are over 50 cosponsors of this measure, pretty evenly divided between Democrats and Republicans. Of course, this is an indication of the broad desire for health insurance reform. But it is also an indication of the care taken by Senator KASSEBAUM and Senator KENNEDY in crafting a measure that, finally, has a real good chance of becoming law, at a time of very heightened political sensitivities on this issue.

Before any measure is enacted, it has to navigate the choppy waters of each body, a conference committee, going back to each body again, and, finally, receive Presidential approval.

That is no mean feat at any time, but it is especially difficult in the political environment of a Presidential election year.

If this bill becomes law, as I hope it will, its enactment would be in no small part due to the legislative skills of the Senator from Kansas and the Senator from Massachusetts, and, I might add, to the fondness and respect many of us in this body have for both of them.

Mr. President, I congratulate my friends, and I yield the floor.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

PRIVILEGE OF THE FLOOR

Mr. WELLSTONE. Mr. President, first of all, I ask unanimous consent that Dr. Maimon Cohen, a fellow on my staff, have the privilege of the floor during the pendency of this legislation.

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

Mr. WELLSTONE. Mr. President, I think every Senator who came to the floor has thanked both Senator KASSEBAUM and Senator KENNEDY for their fine work. I wish to join in that. I also say to the Senator from Kansas, who is chair of the Labor and Human Resources Committee, that along with everyone else, I will miss her. I think she has been a great Senator for Kansas and for the benefit the country. I mean that sincerely.

Mr. President, I think this is a very important piece of legislation for a number of different reasons. I would like to start out talking about that. I am going to be relatively brief, I say to other colleagues, who may want to come down to the floor for opening statements.

I think this is important because, first of all, we will not be able to have any kind of regulation if we do not do it at the Federal level because of ERISA exemption—in other words, preemption. In other words, so many citizens in our States are insured by self-insured plans, and really it is impossible for States—and Minnesota has run into this—to pass reforms that, in fact, will help people and cover everyone because self-insured plans are exempt from that coverage. We ran into this the other day when we marked up an important piece of legislation that I hope will come to the floor, where we said, look, you really do not want to have a family be put in the situation where a mother with a newborn is told, after 24 hours, regardless of circumstances, ''You are out.'' I mean, that is something that people in the country do not think is fair.

But the fact of the matter is that even though my State of Minnesota has passed such a piece of legislation, saying, no, that is not fair, there has to be a mother and a doctor and the family in consultation making decisions about what is good for that mother, about 40 percent of the citizens in Minnesota would not be covered because they are in a self-insured plan.

This is an extremely important piece of legislation. I hope it is not so weighted down with killer amendments that it does not pass. This is a bipartisan effort, and I think we ought to take this step for one reason more than any other; it is just a matter of elementary fairness. I have not seen polls on this, but I think the Senator from Kansas and the Senator from Massachusetts, and all the rest of us that are cosponsors, would go forward regardless, but I just bet that 99 percent of the country would agree with the proposition that if you have paid your premium on time, just because you now have a bout with breast cancer, or some other kind of illness, it would be outrageous to all of a sudden find yourself without coverage, or you should leave one job and go to another job and not be able to obtain coverage.

Most all Americans just find that to be an outrageous proposition. My wife, Sheila, has been my teacher when it comes to domestic violence issues. And with the support of both the Senators from Kansas and Massachusetts in markup, we have a provision in here that we think is important dealing with issues of family violence. I wish these issues were not out there. But we want to make sure battered women are not battered again. If a woman is beaten up and comes to a hospital with her children and reports that, which is what she should do, and which is the first step in being able to leave a very dangerous home—and, unfortunately, homes are not always the safest places in the world—she would not find herself without coverage for that condition.

So this is really a piece of legislation that is a matter of basic fairness. I know GAO has estimated that some 25 million Americans could benefit. I also want to make the point that most of the uninsured in our country are uninsured because they cannot afford coverage, not because they are denied coverage.

So, in other words, we have a piece of legislation that deals with accessibility and with portability. For those of you listening to the debate, that means you can go from one job to another and not lose your coverage or be locked out because of a preexisting condition. We are not still dealing with affordability. In Minnesota, there are 400,000 Minnesotans without insurance coverage, and 91,000 of them are children. In the main, that is not because of preexisting conditions, it is because the families cannot afford the coverage. Nationwide, the uninsured now number 40 million people.

I hope that we will get to the point, again, in this Congress when, in fact, we make sure that every citizen in our country has at least as good a health care coverage as we have as Senators and Representatives. This piece of legislation does not do all that, but it is an important step forward.

One other concern I have, Mr. President—and I just want to make this point—you cannot do everything in one piece of legislation. I am out here to support it. I worry a little bit that what might happen is that the insurance companies might say, ''OK, when you shift from job to job, or you move from one job and now you want to set up your own small business, or whatever, we will not deny you coverage because of a preexisting condition, but we will raise your premium to $8,800 a year or $9,000 a year,'' in which case, my fear is that it will become the functional equivalent of preexisting condition discrimination. Let us hope we have the cooperation of the insurance industry. But I just flag that as a potential problem.

Last point, Mr. President. I have been doing a lot of work with my colleague from New Mexico, Senator DOMENICI. A couple of years ago, we started a working group on mental health. Both of us, and other Senators, feel very strongly about this issue. We are working on an amendment that I think is real important. It is an amendment that would provide equitable health care coverage for mental illness and substance abuse services. In other words, what we want to make sure of is that we, once and for all, put a stop to the discrimination that all too often takes place in the health care field. We are simply talking about parity—parity in coverage for physical and mental health and substance abuse services, and not different co-pay requirements, not arbitrary caps on visits with physicians or other health care providers. I have to say that I believe this amendment, which we have worked very hard on, is an extremely important amendment.

I believe that Senators, regardless of political party—Senator DOMENICI and I certainly do not agree on all issues, but we have been immersed in this issue for several years now. We have seen all of the ways in which people, who are struggling with these health care problems, fall between the cracks. We have seen the discrimination. And this amendment, which will really focus on the importance of parity, which will make sure there is no discrimination in this area, I think, is extremely important.

I will have data to bring to the floor. I will talk about some of the insurance plans right now that do not discriminate and will talk about why this part is so important. I will talk about the differences it can make for women and men being able to work, to live lives of dignity, and to contribute to the community.

But I do look forward at some point in time as we move along with this piece of legislation to bringing this amendment to the floor with my colleague, Senator DOMENICI. Mr. President, I do not know that there has been another Senator who has been a stronger voice in this area for those citizens who are struggling with mental illness. The same thing can be said for his wife Nancy. For Sheila and I, this has emerged as a professional and a personal friendship. I look forward to being able to proudly bring this amendment out to the floor with my colleague and good friend, Senator DOMENICI, and I hope in the spirit of what I think is bipartisanship that we will be able to get good, strong support.

I yield the floor.

Mrs. KASSEBAUM. Mr. President, may I respond for a moment to the Senator from Minnesota, who is a valued member of the Labor and Human Resources Committee?

When he mentioned the rate increase possibly coming if we do not cap any of the premiums, I would just say also that we do not preempt States from doing community weighting or a cap, if a State so desires. That is one of the flexibilities that I believe is important. It is one of the reasons we have the strong support of the State insurance commissioners. That flexibility which has been built into this also has strong support from the National Governors' Association.

Mr. WELLSTONE. Mr. President, I never argue or disagree with the chairman of my committee. I think it is a point well taken. I do hope at the State level we will have in fact that oversight and that accountability.

Mr. WYDEN addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon is recognized.

Mr. WYDEN. Mr. President, thank you very much.

Mr. President, I take the floor today to speak on behalf of this extremely important bill. In doing so, I want to commend the chair, Senator KASSEBAUM, and also Senator KENNEDY for what I think is exactly the kind of spirit of bipartisan effort that is needed to produce an important health bill.

The reason this legislation is very important is it will provide a new path for upward mobility in American life. I have seen again and again in my home State—this goes back to the days when I was director of the Grey Panthers, a senior citizens group at home—I have seen citizens cut off from economic opportunity because this bill was not law. You could have, for example, a young person just starting their career in Oregon. They are working hard. They are committed, doing well in the marketplace, playing by the rules, and showing the kind of discipline to get ahead in the work force. But they, in effect, end up being cut off because they have a medical problem. So, if they hear about a better job across town, another economic opportunity where they can make a better wage, they lose out simply because today's insurance system does not work all that well unless you are healthy and wealthy.

With this legislation, it is going to be possible to make the health insurance system work for all Americans so that all Americans can get access to health insurance and get it when they need it most, which is when they have serious medical problems.

I would like to give special thanks to the chair, Senator KASSEBAUM, and to Senator KENNEDY for their efforts to work with those of us from Oregon. Oregon has been one of the States, as the Chair knows, that has consistently been out in front in terms of health reform. We have done it with the Oregon Health Plan, for example, innovative in terms of senior programs, and we have been on the cutting edge with insurance reform as well. There is a very special State effort supported by Republicans and Democrats alike at home. We have initiated a number of important insurance reforms at the State level that we felt had to be protected. Through the good offices of the chair, Senator KASSEBAUM, and Senator KENNEDY that has been possible.

I have been notified in writing that the Oregon insurance reforms that have been initiated on a bipartisan basis are working well according to the insurance industry, and consumer groups alike are protected under this legislation.

Finally, Mr. President, let me add that no one should be mistaken about how much more is left to do in the area of health reform. If I had my way, for example, a very important, albeit modest, change that we would add to this legislation would be to open up the national practitioner data base to the public so that the citizens of this country could get access to the disciplinary record where the medical profession has disciplined one of their colleagues. I wrote this law as a Member of the House of Representatives—again, a statute that has bipartisan support. Today in that data bank lay thousands and thousands of names of physicians who have been disciplined formally by their colleagues, and the American people cannot find out about it.

Senator BOXER has done yeoman work on this issue. A number of our colleagues on both sides of the floor have approached me on this. If I had my way, we would be on the floor today including this important change that would be of benefit to consumers.

But as a number of our colleagues have noted, it is not possible to get all the way to health reform in America. It is not possible today to get all of the work done that needs to be done to protect consumers and to insure universal coverage. But I think it is quite clear that a major step forward is being taken as a result of the bipartisan work done by Senator KASSEBAUM and Senator KENNEDY.

I urge my colleagues to support this legislation and then, as it goes to conference, to reject the number of anticonsumer provisions that were added in the House. For example, in the House—it seems, again, incredible

to see this kind of anticonsumer retreat—the House wants to roll back the protections for older people who buy policies to supplement their Medicare care. The late Senator Heinz of Pennsylvania and others fought for years for this legislation. The House wants to roll it back. The House wants to roll back the fight against fraud and waste.

So, I hope today that the Senate will vote for this important bipartisan legislation—it is an important step forward—and then to reject the legislation in conference coming from the House.

Mr. President, I ask unanimous consent that my letter to Senator KENNEDY on the Oregon reform proposal and his reply to me be printed in the RECORD.

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

U.S. SENATE,
Washington, DC, March 29, 1996.

Hon. EDWARD M. KENNEDY,
Ranking Member, Committee on Labor and Human Resources, Russell Senate Office Building, Washington, DC.

DEAR SENATOR KENNEDY: The development of S. 1028, the ''Health Insurance Reform Act of 1995,'' certainly is one of the current Congress' most important advances in assuring access to quality health care. I look forward to the debate of this significant legislation on the floor of the Senate.

I am, however, concerned that our efforts to extend health insurance coverage and end ''job-lock'' not impede significant advances made by individual states in the health insurance reform arena. One such effort is coming to culmination in my home state of Oregon, and I write to you today to inquire if the Oregon reform proposal likely would be subject to a favorable exemption ruling by the Secretary under the language of Section 112 of your legislation. The section's flexibility in this regard will be an important element in my consideration of the overall legislation.

Embodied by Oregon State Senate Bill 152, our group-to-individual portability plan was designed by a working group of state insurance officials, insurance carrier representatives and health insurance agents. This enacted state law will extend affordable health insurance coverage by mandating that all state-regulated group insurance carriers offer portability plans to persons leaving groups after having had six months of continuous insurance coverage.

This plan also demands that carriers offer a choice between both a moderately priced insurance package based on the average of the State's most popular HMO plans, and a lower-priced, catastrophic coverage option.

Finally, group carriers that have individual products can offer them as their portability products as long as they offer both the prevailing (HMO average-best) and low-cost options.

The Oregon insurance reform program, due to go into effect October 1, 1996, with portability plans on the market by January 1, 1997, has other encouraging elements as well. For your information, I attach a copy of a March 22, 1996, letter to me by two members of the working group which produced the plan. Should you have any questions regarding this letter, please don't hesitate to contact me, or Steve Jenning of my staff at 224–1084.

Thank you for your consideration of this matter. I look forward to working with you on this issue, and on other important health matters.

Sincerely,

RON WYDEN,
U.S. Senator.

U.S. SENATE, COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC, April 18, 1996.

Hon. RON WYDEN;
U.S. Senate,
Washington, DC.

DEAR RON: Based on my understanding of the Oregon plan, it would clearly meet the requirements for an alternative State mechanism under the State flexibility mechanism of the Kennedy-Kassebaum bill. My understanding is that your program offers a program for all individuals leaving insured group coverage that allows them to remain in a pool with employed persons remaining in the entire insured market. For those individuals leaving self-insured coverage, access to an open high risk pool meeting the standards of the bill is guaranteed.

Yours sincerely,

EDWARD M. KENNEDY.

Mr. WYDEN. Mr. President, I yield the floor.

Mr. DEWINE addressed the Chair.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Mr. President, I would like to say a few words in support of the pending legislation.

Our distinguished colleagues, the Senator from Kansas and the Senator from Massachusetts, I believe, have crafted a sensible piece of legislation that really represents the broadest possible consensus on health reform that we can achieve at this point.

Back in 1994 when I was a candidate for the U.S. Senate, the President was trying to get Congress to enact a health reform bill. That was a health reform bill that went substantially further than the national consensus on health care would allow. For better or for worse, the American people made a decision. They made a decision and determined that they would not support a bill that threatened a large expansion of Federal involvement in health care. They made the decision that that simply was not good.

During that debate when I was running for the Senate, I said that the failure to enact the President's plan did not mean that we would have to give up on health care reform. And we should not. In fact, what we should do, as I said at the time we should do, is to try to get a consensus, that there were things that we could agree on, there were things that Democrats and Republicans could agree on, liberals and conservatives. We ought to agree on those things. We ought to put that into legislation, and we ought to pass it. I think what we have in front of us today is just that. It is that bipartisan consensus. It is a consensus of what we can agree on.

There was, going back 2 years ago, a broad agreement on several aspects of this health care reform—disagreement on some areas but agreement on others. One of the areas where there clearly was agreement was on the problem of portability, or the challenge of portability or the need for portability. Basically, there was agreement on the issue of letting people who have preexisting conditions get health insurance. That was very important. Let small businesses form purchasing pools so their employees could get a better price for health insurance. There was and is agreement on that.

These are basic mainstream principles. I am happy to say that they are embodied in the legislation that we have before us today.

The Kassebaum-Kennedy legislation would create major positive changes in the health insurance market, and it would do so without imposing new mandates on employers or creating new Government bureaucracies. It would give workers the flexibility to change jobs without losing their health insurance coverage. It would protect families from losing their health insurance if a family member loses his or her job.

Mr. President, according to the General Accounting Office, the bill would provide health care security to 25 million additional Americans. This is genuinely a far-reaching health reform that I believe does in fact preserve the bipartisan support it is receiving in the Chamber. I am glad today to be able to add my voice in support of this legislation.

Let me, if I could, turn very, very briefly to another issue, and I had intended to speak and still intend to speak sometime today or tomorrow or early next week at length on this, but I wish to take a minute right now to call my colleagues' attention to this and also the American people.

Next week is National Organ Donor Awareness Week. I again will speak at length about this in the future. But the basic facts are that we lose people every day in this country, 7, 8, 9, 10 people, people who medical science, medical capabilities could save, but we lose these people, their families lose them, because they are on a waiting list, a waiting list to get an organ donor transplant.

They die because, frankly, there simply are not enough organ donations made in this country every day. The reason that there are not enough is very simple. It is that too many families, when faced with life's most horrible tragedy, and that is the loss of a loved one, do not really know what to do when they are asked whether or not they will donate their loved one's organ or organs.

I encourage my colleagues and families across the country to talk about this issue because I am convinced that the vast majority of American people are caring, loving people who want to help other people when they can and who, if they think about this for any period of time at all, will conclude that if, heaven forbid, something traumatic would happen to them and they would be killed, they would want their organs to be donated to somebody else, so somebody else could see, so somebody

else could live, so somebody else could carry on a productive life.

As I said, I will speak more about this at length later. I see my colleague from North Dakota is present and ready to speak. I am not going to hold him up at this point. But I just again call my colleagues' attention to this. National Organ Donor Awareness Week is next week. It is one of the rare times in public office or in public debate in this country where, when we talk about an issue, we can help solve it. It does not cost any money to do it. It is just a question of getting people to be more aware of the tragedy that occurs every single day to someone who could be saved, when someone who could remain with their family and be productive and live a good life dies because other individuals, not knowing really what to do, make a decision not to allow their loved one's organs to be donated.

So, Mr. President, I appreciate the Chair's indulgence and my colleagues' indulgence, and I will today or tomorrow be talking further at length about this important issue.

I thank the Chair.

Mrs. KASSEBAUM. Mr. President, I should like to recognize first the valuable work that the Senator from Ohio has done on the Labor and Human Resources Committee. Senator DEWINE has worked hard to help us get this put together. He was worked hard on all the other health issues that have come before the committee, and as he mentioned is a major leader along with Senator FRIST on the organ donation issue. So I appreciate his assistance with the legislation.

Mr. DORGAN addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I too commend the Senator from Ohio. I know he has done a great deal of work on the issue of organ donation—work that I support very strongly. I hope we will advance public understanding and knowledge about organ donation, not only in this legislation but in other pieces of legislation as we move forward.

I did want to say as I begin—and I will be very brief since there are others in the Chamber who wish to speak—I cannot think of two more able Senators to bring a piece of legislation like this to the floor than Senator KASSEBAUM and Senator KENNEDY. This Senate will be diminished when Senator KASSEBAUM leaves, but she has done outstanding work on this legislation and she and Senator KENNEDY deserves to be complimented for bringing this to the floor. In my judgment, the approach we've taken to this legislation—finding the issues that we all agree on—is the kind of thing we should be doing routinely. I did not support the Clinton health care plan. I did not cosponsor the Clinton health care plan because I believed then that it was too bureaucratic. But he was asking the right questions. We needed to address health care for two reasons. One, to provide broader access to health care. And two, to try to do something about the escalating costs of health care.

I happen to think the proposal that he made was too bureaucratic. It would have not advanced the solution in both of those areas that I think was appropriate. But that does not mean we do not have problems in both areas that we must address. This piece of legislation addresses one of those. It addresses the issue of access to health care.

Again, this is exactly what we should be doing when we have a disagreement, a substantial disagreement about a major policy issue. What we ought to do in those instances is find where is there an area of agreement, and that is what happened with this legislation.

This legislation addresses the issue of access. It brings together those varying viewpoints in the Senate into one bill on which we can all agree that, yes, this advances the issue of access to health care. That is why I am pleased to have been a cosponsor of the legislation and am pleased today to speak in favor of it.

The health care system in this country is a remarkable system. You do not see very many Americans who get sick and decide to get on an airplane and go to some other country for health care. That would be a very unusual thing to see. What you see instead is people getting on an airplane or getting on some other means of transportation and coming to America to get health care because we have a wonderful system of health care.

But we have two problems. One, not everyone has access to it, and, two, its cost is escalating. It has diminished a little bit in recent years, but it has been escalating double and triple the rate of inflation every year for many years, and that prices health care out of the reach of too many of our American citizens.

All of us understand that our health care system is a system that offers miracles to many Americans—new hips, new knees, cataract surgery, even heart transplants. The list is endless.

I would suggest that anyone who wonders about where all of this comes from might go out to the National Institutes of Health. Take a look at something they have out there called the ''Healing Garden,'' where they do research on a range of plants and all kinds of other things that produce all of these wonderful new medicines. They do research on a whole range of health care issues and develop new surgical techniques and new approaches.

We have invested a substantial amount of money that has produced enormous rewards for our society. And with all of those miracles and all of this wonderful medicine, the two remaining questions are, one, how do we provide to people more access to this wonderful system, and, two, how do we bring the cost down so it does not rise out of the reach of too many American people?

This bill addresses that issue of access—not for everybody, but it does it in a way that pulls together those things that we agree on. This includes dealing with the limits on exclusions for preexisting conditions. This bill is a very modest approach that solves part of that problem, a major part of that problem, for many of the American people.

A whole lot of people are locked in their jobs because of this issue of preexisting conditions. They are unable to move, because if they move they cannot carry that insurance with them and no other insurance carrier will pick them up because they have had a preexisting condition. This piece of legislation deals with that in the right way.

This legislation says to insurance companies: if someone has been a good customer of yours, buying your policy for years, you cannot drop coverage simply because that person gets sick. This piece of legislation also addresses the issue of portability, and does it in exactly the right way.

So I am pleased that we are here on the floor with this piece of legislation. It is exactly the kind of thing we ought to do. Instead of continually talking about what we cannot agree on, we should find the areas where we can agree to begin moving toward a solution to a problem. That is exactly what this piece of legislation does.

Let me end where I began, by complimenting the Senator from Kansas, Senator KASSEBAUM. This body will be diminished by your leaving at the end of this year, but you will have left your mark here in many, many ways. You and Senator KENNEDY will have left an indelible mark, if we can pass this legislation, by advancing this issue of access to a wonderful health care system to millions and millions of additional Americans who ought not be left out of the system.

So I compliment Senator KASSEBAUM and Senator KENNEDY for their diligent work and I hope we can do exactly the same thing on other issues in the coming weeks. If we disagree, let us figure out where we disagree, but then let us find the center. We ought to come to the floor to move toward solving problems, rather than being so intractable in our own camps and deciding we simply cannot solve problems.

I look forward to casting a final vote, an aye vote on this legislation. I hope it does not get too loaded down as it moves along. I hope the Senate will act with some haste to try to move this to a conference.

I yield the floor.

The PRESIDING OFFICER (Mr. CAMPBELL). The Senator from Idaho, [Mr. CRAIG], is recognized.

Mr. CRAIG. Mr. President, I come to the floor this afternoon in support of the intent of S. 1028. Let me join my other colleagues in thanking the Senator from Kansas for her work in getting this kind of health care reform legislation to the floor, and also the

Senator from Massachusetts for the work that he has done in this area.

Health care in some form has been on the congressional agenda for several years. It is an important issue, and I hope by the end of this process we will have a health care insurance reform proposal that will make health care insurance more accessible and more affordable.

The purpose of S. 1028, the Health Insurance Reform Act of 1995, is to increase access to health care insurance, improve the portability of benefits, give people greater security, and increase the purchasing power of individuals as well as small employers. The bill does this through a series of insurance market reforms. For example, the bill would reduce the duration of exclusions for preexisting conditions by crediting enrollees for maintaining continuous coverage through a previous employer. Another important component would be the portability of coverage from a group plan into the individual insurance market.

The bill also includes a proposal that would create new State-based health insurance purchasing cooperatives, or HIPC's, based on a program that was included in the Clinton-Mitchell health care reform bill. These HIPC's are intended to give small businesses and individuals greater purchasing power in negotiating more favorable rates.

Many Idahoans complain that they are locked into their current jobs because they fear losing their health care insurance. Several of my colleagues have been on the floor in the last few hours, giving examples of this kind of very real problem that Americans face. In some instances, entrepreneurs avoid starting their own businesses because they are unsure that they would be able to provide health care insurance for their families in the way that they were covered under their current employer. This is a problem that has existed in this country in an increasing way over the last decade, and it simply needs to get corrected. This legislation offers that correction.

Another problem commonly raised is that individuals who have had major illnesses or preexisting conditions cannot obtain coverage if they change jobs. In other words, once you have a medical record, insurance companies, by that record, can disallow you coverage for that problem under a new insurance policy. These kinds of fears are real. Real life examples are given, and they are faced by individuals and families every day. The security issue I mentioned, as part of the intent of this bill, is a very important component of health care insurance reform.

We must all be mindful that health insurance reform will have an impact on the marketplace. These kinds of reforms that are being proposed in this legislation are not without cost. As we cause the insurance market to change, the marketplace will price itself differently. In our effort to improve access to health care coverage we need to be extremely cautious and ensure that there is a minimal impact on the cost, or the increased costs of insurance, especially in the individual market.

One thing we can do is to address the issue of cost in this bill. A number of valuable provisions for addressing these consumer concerns were included in the Balanced Budget Act. However, that was vetoed by the President, so they are not yet available to correspond with this legislation when it becomes law.

Therefore, Mr. President, while I agree on the intent of S. 1028, to improve access, I do have concern about the issue, of affordability. In order to fully address access to health care coverage we must look at affordability. While we create potential flexibility in the marketplace, if we drive the cost beyond the reach of the individual, the family or the employer, then what have we solved? What old problems have we only changed into new ones?

In order to fully address access to health care coverage, we must look at the whole issue of affordability. There are several key amendments that I think are going to be offered by the leader which will help us a great deal in solving this potential problem, such as increasing tax deductions and implementing medical savings accounts, or MSA's, as the public has grown to know them. MSA's should be a part of this bill. That amendment will be offered. I certainly hope the Senate will respond as they should to the question of affordability, rounding out this legislation by addressing the cost component.

Title III of this legislation, S. 1028, includes a sense of the committee language that MSA's should be enacted. If they should be enacted—and that is what the committee says and what the legislation says—then why do we not do it? Let me read what the sense of the committee is.

> It is the sense of the committee on Labor and Human Resources of the Senate that the establishment of medical savings accounts, including those defined in . . . the Public Health Service Act . . . should be encouraged as part of any health insurance reform legislation passed by the Senate, through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, such accounts.

That is what the legislation says. That is what the law would say. But, if we do not add an amendment to it, it is fine rhetoric but it does not address the needs of the American people. And it does not, in my opinion, create the component of affordability that this Senate must be responsive to, if we are to bring about this kind of insurance reform.

I said the language is supportive, but it does not change anything. Instead of using this bill to speak to the issue, we should be using it as an opportunity to give consumers this valuable tool to finance health care costs.

MSA's work much like individual retirement accounts, something that the consuming public of this country knows about and likes. They are often coupled with a catastrophic health care policy, but some models have been conducted in combination with managed care plans. A limited amount can be deposited annually, usually equaling the amount of the high deductible. At the end of the year, the unused amount is rolled into the next year, allowing for savings to accrue.

If an individual does experience a catastrophic illness, savings can be used to meet the annual deductible, as well as cover any copayment that may be included as part of the catastrophic plan.

MSA's are portable because they belong to the individual. If we are reforming health care insurance, why do we not create a vehicle that provides increased opportunity for individuals to possess health insurance?

Regardless of your employment status, your MSA's stay with you. So, the job-lock question is less likely to occur. In addition, savings you accrue can then be taken with you and used to pay for insurance premiums if you are between jobs. If you want to start your own business and step away from an employer who provides insurance, the MSA stays with you. You can buy your own insurance with it.

It certainly creates tremendous choice and flexibility for the individual and families, and that is what we are concerned about here, the freedom of the individual and families to make sure they can provide for themselves. Health care insurance coverage and MSA's can play a tremendous role in doing just that.

Because MSA's have a higher deductible and lower premiums, they are a workable alternative for small employers who currently cannot afford to provide insurance as a benefit. So they even offer the small employer greater opportunity to provide health insurance benefits to his or her employees.

A catastrophic policy and a deposit in an MSA for the annual deductible are lower in cost than any other type of insurance coverage. In addition to the lowering of cost to the employer providing insurance, MSA's provide the beneficiary greater flexibility in how those health care dollars are spent and limit out-of-pocket exposure.

Finally, because savings can accrue, this is an opportunity to save over an individual's lifetime for those hefty, late-in-life health care costs such as long-term care. That is real health care reform. That is real health care insurance reform.

The cost of long-term care is a big problem that Senators have tried to deal with on this floor and that certainly the seniors of our country have faced themselves for a long time. Many of us at our age in life, who have parents who are nearing a time when they may need long-term care, all of a sudden begin to factor some of those financial costs into our own budget, if we are capable of doing so, in caring for the elderly of our family.

MSA's could help solve this problem in a generational way if this Senate and this Congress would simply quit talking about the value of them and allow them to become available to all Americans.

Mr. President, I have been frustrated by some of the references about MSA's, that they are an extreme idea that will help only the healthy and the wealthy. It could not be further from the truth. Rather, I argue that MSA's are a commonsense response to the current problems of our health care system, incorporating individual choice and responsibility. The American people understand that and I think the American people are ready to use this health care insurance tool in a way that works to their benefit.

The history of this issue has been one of bipartisan support. In both the House of Representatives and the Senate, MSA bills have been cosponsored and supported by Republicans and Democrats alike.

I have a copy of an old ''Dear Colleague'' letter on a bipartisan bill, S. 2873, the Medical Cost Containment Act of 1992. Mr. President, I ask unanimous consent that the letter be printed in the RECORD.

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

U.S. SENATE,
Washington, DC, September 8, 1992.

DEAR COLLEAGUE: The United States is faced with a crisis in health care on two fronts: access and cost control. So far, most of the proposals before Congress attempt to deal with access but do not adequately address the more important factor—cost control. We have introduced legislation that will begin to get medical spending under control by giving individual consumers a larger stake in spending decisions.

We have introduced a bill, the Medical Cost Containment Act of 1992 (S. 2873), which would allow employers to provide their employees with an annual allowance in a ''Medical Care Savings Account'' to pay for routine health care needs. This allowance would not be subject to income tax if used for qualified medical expenses. Any money not spent out of a given year's allowance could be kept by the employee in an account for future medical needs during times of unemployment or for long term care. In order to protect employees and their families from catastrophic health care expenses above the amount in the Medical Care Savings Account, an employer would be required to purchase a high-deductible catastrophic insurance policy.

Unlike many standard third party health care coverage plans, Medical Care Savings Accounts would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their ''own'' money. That is, money that they would otherwise be able to save in their account for future needs.

Once a Medical Care Savings Account is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. Recent studies show that at least 50% of the uninsured are uninsured for four months or less.

Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventive care services. With Medical Care Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services.

We feel that, while the Medical Care Savings Account concept does not provide the total solution to the crisis in health care access, it does begin to address the critical aspects of increasing costs and utilization by consumers.

We hope that you will join us as cosponsors of this legislation. If you have any questions please contact us or have your staff contact Laird Burnett of Senator Breaux's staff.

Sincerely,

JOHN BREAUX.
DAVID BOREN.
TOM DASCHLE.
RICHARD LUGAR.
DAN COATS.
SAM NUNN.

Mr. CRAIG. Mr. President, this letter outlines many of the beneficial aspects of MSA's, or medical savings accounts, in addition. I found it quite interesting that as part of his pension simplification proposal, President Clinton would allow withdrawals from individual retirement accounts for catastrophic health care insurance needs. That is a great idea. But that is an MSA. Whether Bill Clinton knew it or not, by his endorsement of this approach, he has, in effect, endorsed medical savings accounts, and I applaud him for doing so.

Since the healthy-and-wealthy assertions have been made, I want to take a moment to address this issue, because it is phony, phony, phony.

Anyone who has experienced chronic health problems or a catastrophic illness realizes how difficult it is to cover out-of-pocket expenses. If that health care problem is not covered by insurance, you get no assistance in helping finance the cost incurred. We have people who have minimal coverage and are making limited incomes, and they cannot afford the out-of-pocket costs to get across the deductible threshold to get the benefits of their insurance, in many instances. For families and individuals on fixed incomes, this is especially problematic.

I had a constituent who expressed to me a frustration that even though she had great health care insurance, it did not provide comprehensive dental benefits. She needed to get a tooth capped, which would cost her at least $500 out of pocket. Her alternative was that she should live with the discomfort until more serious problems occurred with the tooth that would be covered by her insurance.

Her frustration was that this was the only health care problem she had experienced in the last 2 years and the only cost incurred other than her annual physical and dental checkup. She had not met her deductible, but would have to find $500 in her monthly budget to pay for capping a tooth or go take out a loan, if she could qualify, to cap a tooth and then spread that cost over several months. If my constituent had an MSA, the $500 would have been covered by funds in her account.

Medical savings accounts would also benefit individuals with chronic illnesses, such as diabetes. A few years ago, several individuals who live with diabetes complained to me that many of the health care costs they incurred are not covered by insurance. For example, the glucose testing strips, the syringes for insulin, dieticians or nutritional services, and the pharmaceuticals are not always fully covered by insurance but are necessary in order to avoid more expensive, catastrophic illnesses.

With a medical savings account, a diabetic could pay for these expenses from his or her MSA. In addition, if they did experience a catastrophic illness, they would be covered once their high deductible was met.

Mr. President, some will claim that MSA's will cause people to forgo needed health care treatment. This is simply not the case. I must say, while that allegation is made, there is no proof that MSA's would have that effect. Unlike most health care coverage plans, MSA's give consumers an incentive to stay healthy because the money you spend is your own. In addition, they provide access to funds for preventive health care services which may not be covered by insurance plans.

Let me respond to the other half of the argument that MSA's are just another tax break for the rich. Working families will benefit greatly from MSA's. The United Mine Workers of America have a provision similar to MSA's in their current contracts. Mine workers and other working families, in my opinion, do not meet the definition of those who claim this is just for the rich. I think those are hard-working people who want and need good health care coverage for their families. That is exactly why the United Mine Workers Union negotiated it with their employers, because it was something the employers could afford and it gave those working men and women greater opportunities for coverage.

I must say I grow saddened by the kind of rich demagoguery that is played on the floor of this Senate on a variety of issues when we try to expand the base and expand the opportunity for all Americans by giving tax incentives or tax breaks that allow them to do certain things beneficial to their well-being.

Mr. President, regardless of income, if you get an MSA and catastrophic plan from your employer, your employer will be making the same contribution to your account. In addition, MSA catastrophic plans are a less expensive option for an employer, especially small businesses, providing another affordable option for employers who currently do not provide insurance. That is what insurance reform should all be about; as I said, to create affordability and to expand the opportunity for access to this kind of coverage.

Finally, MSA's give lower income individuals an account to draw from for primary care and other preventive services that otherwise would be paid

out of pocket. The out-of-pocket issue to those less fortunate in our country is a very real issue, Mr. President. In other words, MSA's eliminate the upfront deductible required with most insurance policies and provide, in essence, by this very action, first-dollar coverage.

For example, with a traditional employer-provided insurance policy, a deductible must be reached before the insurance policy kicks in. A low-income parent with a sick child has to find funding out of his or her monthly budget to pay for the doctor or for any prescription. With an MSA, the worry is gone because the money has been placed by the employer in the MSA. Furthermore, if the problem is catastrophic, once the deductible is met from funds in the MSA account, the catastrophic policy provides the coverage.

In most cases, out-of-pocket exposure for individuals with MSA's is less than with other types of insurance coverage policies. In fact, low-income families have an opportunity to benefit from the savings that would accrue in an MSA over time.

Consider the following: Janet earns $13,000 a year. She is 20 years old and keeps her MSA through to age 60. If her employer deposits $1,800 a year in her medical savings account and she remains in good health and spends an average of $250 a year from her MSA, by the age of 60, assuming an 8 percent interest rate per year, Janet would have $433,661 in her medical savings account. Now, that is an optimum scenario.

Let me give a more likely one. Under the same scenario, with Janet experiencing more health problems, and let us say she is spending $1,000 a year from her medical savings account for health care, she would still accrue $223,000-plus in her medical savings account by the time she is 60. That is the opportunity that exists today if this Senate and this Congress will awaken to what the American consuming public wants.

Under a traditional fee-for-service HMO–PPO program, Janet would have health care coverage as long as she stayed with her employer. She would have to pay her annual deductible out of pocket and a copayment for service once she met that deductible. At age 60, if she retired, she would have no health care insurance and no medical savings account. That is the current law. Even this legislation does not really address that problem upon retirement, for those individuals who are not yet 65. Medical savings accounts do.

So, let us change S. 1028 from rhetoric to reality by amending it and putting medical savings accounts in it. While Janet may not be a real person, there are plenty of real Janets waiting to benefit from medical savings accounts.

Mr. President, my home State of Idaho was one of the first States to implement a statewide MSA program. Early reports and reactions to Idaho's program have been very, very favorable. Ada County, the largest metropolitan county in my State, was the first major employer in Idaho to offer the plan. It is saving the county a lot of money and providing greater flexibility for county employees. Passing a Federal MSA plan will enhance what is already a beneficial program in my home State of Idaho. It will allow our MSA program to be even more effectively used across the State. In short, Mr. President, passing a federal MSA plan will enhance what is already a beneficial program in Idaho.

Let me tell you about one of our county commissioners in Idaho who has been a great advocate of medical savings accounts and was instrumental in bringing that county on line with an MSA policy once the State legislature passed the law. Gary Glenn, an Ada County commissioner, participates in the optional MSA plan, as do about 20 percent of the Ada County employees.

Ada County's medical savings account plan saves taxpayers' dollars, maximizes patients' choices, and rewards responsible health care consumption. The benefits to Gary's six-member family are illustrated in these examples. The county's old indemnity program provided Gary's family typical coverage, $100 per person deductible, with a maximum of $300 per family, plus a 20-percent copay. The monthly premium was $494, of which Gary and his family paid $158 a month.

Under the new MSA, Gary's family has catastrophic coverage with a $2,000 per person deductible—the maximum per family, though, is $3,000—and 100 percent coverage or payment above that deductible. The new monthly premium is $194. Gary still pays $158, but the county pays $36 per month instead of $336.00 for the old indemnity plan. This is a dramatic reduction in the overall cost of insurance on a per month basis. This provides a savings of $3,600 per year. Out of the savings, the county will deposit $2,100 in Gary Glenn's medical savings account.

Under the old indemnity plan, Gary's family faced a much higher financial risk. In the worst case, they would be forced to pay $5,100 in deductibles and copays out of pocket and after taxes. Under the medical savings account, with a $3,000 deductible, no copayment, and $2,100 in his medical savings account, the most they would have to spend out of pocket in 1 year would be $900. That is important to remember. Instead of $5,100 out of pocket, they would spend $900. And the county is saving literally thousands of dollars as the employer.

In addition, by reducing Gary's out-of-pocket family risk by 82 percent and providing them with maximum flexibility in how they spend their health care dollars, any portion of the $2,100 deposit in their account—Gary Glenn's account now—is left to spend on health care, state income tax-free, or to carry forward and earn interest.

So under the Idaho medical savings account plan in Ada County, the taxpayers of that county and Gary's family are realizing real benefits. Mr. President, why cannot we be smart enough to provide that to all Americans—to give them at least the option, the choice? That is real insurance reform. That is real flexibility. That is real portability. MSA's are an idea whose time has come. We ought to do it. Today, though, in this bill we only offer the rhetoric. I hope the amendment that will be offered by the majority leader will pass and become a part of this important law.

Let me say in closing that S. 1028 is a good bill. What I have talked about is making it a better bill, a more complete reform of the health care system. Not the adjustments around the edges, but major reform in a way that fits 21st century Americans. It gives them the freedom of choice, access, the individual decisionmaking authority, the buying power they need, and it is effective for all levels of our society, the poor and the rich alike. That is what it should be about.

Mr. President, I ask unanimous consent that an editorial from the Idaho Statesman be printed in the RECORD. The headline says ''Congress Can Follow County Lead on Medical Savings Accounts.''

This editorial urges this Congress, this Senate, and the President himself to become modern, to become thinkers and not prohibitors, and add to this major reform package the concept of medical savings accounts. I hope we can accomplish that.

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

[From the Idaho Statesman, Apr. 1, 1996]

CONGRESS CAN FOLLOW COUNTY LEAD ON MEDICAL SAVINGS ACCOUNT

Ada County is leading the way in health-insurance reform by its use of medical savings accounts. Too bad many Democrats in Congress and President Clinton are among those most afraid to follow.

The U.S. House endorsed medical savings accounts Thursday as part of its legislative package on health care, but the outcome in the Senate is less certain, especially with Clinton's threat of a veto looming over the whole bill.

The nation loses if medical savings accounts are stripped out of the final legislation in a compromise.

As local experience shows, they can be an effective way to save insurance expenses and give consumers more control over decisions about their own health care.

Instead of traditional and expensive health-insurance policies, Ada County buys only catastrophic policies for the 20 percent of its work force signed up for the program. The savings are put into the accounts of participating individuals and can be used for routine medical expenses.

The measures in Congress works about the same.

Individuals could make tax-deductible contributions of up to $2,000 (or $4,000 for families) in a medical savings account and would be required to purchase a high-deductible health insurance policy for catastrophic illnesses.

The system saves money because workers have an incentive to shop around for medical care. Bargain hunters can motivate doctors and hospitals to compete, which in turn injects needed market forces into the health industry.

By eliminating the middle man—insurance companies—the accounts allow people more direct control of how, when and where they spend their medical dollars.

Sadly the issue of medical savings account has become embroiled in partisan politics in Congress. But reforming health care and giving consumers more options should not be a partisan issue.

It is simply a matter of giving consumers greater clout as the nation seeks an improved health-care industry.

Mr. KENNEDY. Mr. President, just for the information of the Senators, we have been on the legislation since 9:30 this morning, 5 hours, and we have not had amendments. In the earlier part of the day, I think both Senator KASSEBAUM and I were urging our colleagues to come over and make comments about it. We have been blessed with so many bipartisan comments on the legislation.

We are expecting an amendment by the majority leader momentarily to be put down, also a unanimous-consent agreement in the process of being circulated so we might be able to move toward the consideration, or we are going to find a situation as the evening time comes that Members will say, ''Why can we not attend to some of our other responsibilities in the evening?'' We want to try and accommodate everyone, but we are open for business. But the first business, we had hoped, would be the majority leader's amendment, and then to have a good debate on that. Part of the debate will be on the medical savings account, and we will address that issue in a more complete way at that time.

I just wanted to at least give some indication to our colleagues about where we are in the course of the debate.

Mr. SIMPSON. Mr. President, I certainly will not take 10 minutes.

I want to add my voice to the bipartisan chorus of support for S. 1028, the Health Insurance Reform Act. I am proud to say I was an early supporter of this one. I signed on as a cosponsor back on July 17, 1995, just 4 days after it was introduced by Senator KASSEBAUM.

I commend her and I commend Senator KENNEDY for their determined efforts to advance this legislation through the Senate in the politically charged atmosphere of an election year. She has created a bill that deserves the support of Republicans and Democrats alike.

The provisions of this bill have been well covered—portability, guaranteeing availability and renewability of coverage, preexisting medical conditions, and maintaining continuous health coverage, making it easier for small employers to voluntarily form purchasing cooperatives—and would bring about changes that a vast majority of us agree upon.

Even President Clinton, in a dramatic departure from his earlier proposal for a Government-run health care system, has now embraced health insurance reforms that are remarkably similar to those which President George Bush proposed back in 1992. Whatever one might be attempted to say about the irony of all of that, it clearly indicates that we now have a unique opportunity to correct the problems that pose the most serious threat to the health coverage of millions of Americans.

Though each of us can think of various ways in which we would like to expand upon the pending legislation, the reality is that the bipartisan appeal of the bill will be lost if we go too far in amending. I intend to be very cautious about amendments that are offered for the Senate's consideration, even in cases where I might support the amendment on its merits. I say this because I would rather pass legislation that actually becomes law, even if it is not as far reaching and perfect as I would like it to be, than to make a legal statement with legislation that ends up in the great scrap heap of unfinished business—and there will be plenty of that in this session of Congress, things that stood on principle and could not get into law because you did not have the votes to get them into law. Unfinished business—that stack.

When I hold town meetings in Wyoming—I do not know how many of us still do that; I do—the message I always come away with is that people are thirsty for action. They are not interested in excuses or rhetoric or political maneuvers from either party. No matter how clever or imaginative we are in explaining ourselves, they just do not buy it. They have had a bellyful of petty partisan squabbles. What they long for is to see a Congress identify areas of agreement, as Senators KASSEBAUM and KENNEDY have done with this legislation, and then act in the best interests of the American people, without agonizing who will win or who will lose, who will be the top dog, who will be the underdog when it is finished, or politically, how to simply portray Members of the other party in the worst possible light.

The pending bill would allow us to do something beneficial, I think, for millions of Americans who are at most risk of losing their health coverage. The General Accounting Office reports as many as 21 million Americans would benefit if preexisting-condition exclusions are waived for people who maintain continuous health coverage, and, furthermore, another 4 million would no longer experience job lock if portability of health insurance is insured.

I believe it is time to move forward, adopt these protections to the extent that more sweeping measures are needed to make health insurance more affordable, more accessible. I will help with that. I surely agree that there is much more we can do.

I worked with Senators CHAFEE and BREAUX on issues of a bipartisan nature. I think that is very important. Let us consider those items separately that might serve to bring this down and view them at another time in such a way that we do not jeopardize the enactment of the pending bill.

I think what we need, sometimes, is an old-fashioned trait known as self-restraint. Perhaps we could even adopt self-restraint as the theme for the next several hours as we consider the bill. It would surely be an appropriate manner in which to recognize Senator KASSEBAUM's tremendous leadership on this issue, and to preserve a thoughtful bill that will provide important health insurance protections to millions of Americans.

Finally, I note the senior Senator from North Dakota is not on the floor. I hope he will have an opportunity to address my remarks. I admire him. He is a friend. We have worked together. He has come forward and said that we should put aside our agendas, put aside our own causes, work in harmony and concert. I hear that, yet I also hear each and almost every day my good friend from North Dakota stirring up some issue in some way, usually with a partisan twist. I think that if we are going to do that, just note the pending business of the Senate on the calendar. The pending business of the Senate is the illegal immigration bill. It is not moving simply because the Senator from North Dakota wishes to place an amendment on it with regard to the balanced budget and Social Security.

I am not speaking in a partisan way. I have been here before. I remember my dear friend Senator John Heinz placed amendments on illegal immigration bills. Even my ranking member has done such heinous activity from time to time, the Senator from Massachusetts. I have seen him do that. I am not talking about partisanship. If we are going to do this—we have a bill that is stalled right now. We will see how long it will stall out. There are three amendments ready to be voted upon. Where it is all held up, that bill is held up for a single particular reason: Because of the Senator from North Dakota, because of an eternal amendment that he has with regard to Social Security, saying that no balanced budget can ever be done, and we do not do anything with Social Security, which is an extraordinary thing in itself because Social Security is going broke. The people that are telling us it is going broke are the trustees, the stewards of the system, who are saying the system will go broke in the year 2020.

So how do you keep ducking it, unless you are just carrying water for the AARP and the Committee for the Preservation of Social Security and Medicare and other 800-pound gorillas in that particular Social Security debate.

So I hope that we will proceed. I say to my friend from North Dakota—my friend and sometimes adversary—heed thine own advice. I will be waiting.

Ms. MOSELEY-BRAUN addressed the Chair.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Ms. MOSELEY-BRAUN. Mr. President, about 2 years ago, this Congress blocked attempts to act on comprehensive health care reform. While that year's effort to achieve the major reforms that are so needed and so long overdue did not succeed, the problems that led the President to make that proposal have not disappeared. Far from it.

There are over 40 million Americans without health insurance, and over 23 million of those are employed. Over a million working Americans have lost health care coverage over the past 2 years; 60 percent or more of all Americans currently worry about losing their current health insurance coverage.

Over the last few years, the rate of private health care cost increases has dropped substantially, but there are now increasing concerns about the quality of care. Public health care costs continue to increase at an unsustainable rate. The case for reform, therefore, is perhaps even more compelling now than it was 2 years ago when we first took up this issue.

I am, therefore, proud to be one of the cosponsors of S. 1028, the Health Insurance Reform Act. It is not the comprehensive reform that we looked at to begin with, but it is a good and important step in the right direction. Indeed, this may well be the first step on the road to reform that everyone can agree upon. I say to the Senator from Kansas and the Senator from Massachusetts that this legislation is brilliant in its simplicity, precisely because it cuts to the heart of the issues that concern the American people most about health care coverage.

Mr. President, in my view, there are four cornerstones of health care reform: Universal coverage, cost containment, maintaining the quality of care that we enjoy in this country, and retaining freedom of choice for the American people in terms of health care delivery and the providers of health care.

This bill moves us in the direction of universal coverage by keeping people insured who might otherwise not be. If there is any concern which everyone has regarding health insurance, it is the trap of preexisting conditions. All too often, individuals find themselves excluded from coverage because of a preexisting condition. In some cases, the individuals themselves are not even aware of the existence of that preexisting condition.

By limiting exclusions for preexisting conditions, by making health insurance coverage available for small businesses, and by ensuring portability and ending job lock, this legislation deals with the concerns of millions of Americans. It will help to make health insurance coverage more available for millions of Americans and for small businesses, help hold down health care costs for Americans, and further help to expand access to health care. That, in my opinion, is real reform, or a step in the right direction.

In my own State of Illinois, over 2 million people are currently without health insurance. This bill will make a critical difference in their lives and in the lives of similarly situated people all across our Nation.

Those who are now without insurance are far from the only beneficiaries of this legislation. For Americans who might want to leave their jobs and start their own businesses, or who might have to leave their jobs because of corporate restructuring, but who might have a preexisting condition or family medical history that would currently make it difficult or impossible for them to purchase an individual health policy, this bill will make a huge difference. It will guarantee their ability to access health insurance.

This bill will also guarantee that small businesses with only a few employees would not lose their group health care coverage because one of the people in the group develops a serious health problem, as is the case now. Moreover, it will make health insurance more affordable for those small groups, making it more likely that more small businesses will provide health insurance benefits for their employees.

Families with small children suffering from a serious health problem will no longer face the prospect of being unable to obtain health insurance if the child's parent changes jobs, ensuring that the child's parents are not themselves job locked because of the condition of a member of the family. It is tough enough for families to deal with serious health problems affecting one of their children without having to face the additional problem of losing access to health insurance if they are laid off or restructured out of their jobs or if they want to change jobs for a new, perhaps better paying job that could help their families in other ways.

Women who have had breast cancer or other diseases will no longer face higher premiums or loss of access to health insurance altogether if they change jobs once this bill becomes law. And young college graduates starting their first jobs would not be barred from access to health insurance simply because they suffer from a childhood ailment or a continuing disability from an unfortunate accident.

The Health Insurance Reform Act, therefore, represents a practical, caring set of reforms to deal with the real health care problems facing so many Americans, based on their everyday realities. It does not require Americans to radically change their behavior. It does not add another bureaucracy or a huge new paperwork system. It does not require new Federal spending or new taxes. It does not create any new unfunded mandate on State or local governments. At most, it will increase the costs for private health insurance companies by less than one-quarter of 1 percent.

This bill is about incremental reform, but real reform nonetheless. It will help virtually every working American, as well as millions of Americans who are temporarily out of the work force. The bill itself will work because it is based on what is actually going on in the world of real people who need health care.

Mr. President, it is worth thinking a moment about those everyday realities. Statistics tell us that the average American works at a job for about 4½ years. Over the course of a working career, therefore, an average working American could hold seven or more jobs. That fact alone makes it all too clear just how important it is for the American people to have portable health care coverage. That fact alone is a good indication of how necessary it is to end preexisting condition restrictions that result in Americans having to pay enormous sums for new health care policies, losing access to the one they had, or end up with no access to health insurance at all.

Eighty-one million Americans have preexisting conditions that could affect their insurability. More than half of all American workers are enrolled in health insurance plans that impose some form of preexisting condition exclusion. As I stated earlier, when you consider that most of us will change jobs several times in the course of a lifetime, the preexisting condition problem affects virtually every American family.

Mr. President, every American wants and needs health care security. It is as important to them as retirement security, an objective that should command absolute consensus in this country. That vision and importance of retirement security led to the creation of Social Security. That is why we provide tens of billions of dollars in annual tax incentives to companies to provide pension plans for their workers. That is why we support pension plans and retirement programs and savings.

Health care security is no less essential to the American people than retirement security, not only because you cannot enjoy retirement if you are in poor health, but because lack of access to affordable health care insurance can literally mean bankruptcy. Being able to roll over your insurance coverage, therefore, is just as important as being able to roll over pension savings. Maintaining health security deserves the same level of attention that we give to retirement security, and measures that protect and enhance that kind of health security deserve the same kind of consensus support.

Mr. President, the really good news is that so many of our colleagues—57, in fact—and so many different organizations, and the President, support this legislation. The American people support this. Facing the fear of loss of health insurance, facing the preexisting exclusion, those kinds of uncertainties will be resolved when we take this step in the direction of incremental reform.

This legislation has been carefully worked out. It represents a real compromise by both Democrats and Republicans who support it. I congratulate the chairman of the Labor and Human Resources Committee, Senator KASSEBAUM, and the ranking Democratic member, Senator KENNEDY, for their leadership and for all the hard work they have put into bringing this bill to this point. As I said earlier, it really is brilliant in its simplicity. I congratulate them for the bipartisan nature of this debate so far and for the efforts in bringing us together as representatives of the American people, whatever political party, bringing us together to get this badly needed legislation passed.

If there is one matter that commands consensus, it is what this bill addresses because it addresses it so brilliantly, in my opinion.

I urge Senators on both sides of the aisle to put aside partisan differences, put aside other good ideas, and let us move forward and pass this legislation so that it can be law and so we will have done the job the American people have every right to expect that we will do.

Thank you very much.

I yield the floor.

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas, [Mr. GRAMM], is recognized.

Mr. GRAMM. Mr. President, I want to talk about the bill that is before the Senate and the amendment that Senator DOLE will offer on behalf of himself and others. I will also cosponsor that amendment. I want to try to explain why it is essential that we have measures which will promote efficiency and cost savings if we are going to adopt this bill.

Let me say that making insurance portable and permanent is something that I support. But I think that, if we are going to be honest with ourselves, it is very hard to do this with a straight face, which is what has been done in virtually every speech that has been given on the floor of the Senate this morning. We are talking about 25 million Americans who are going to benefit from this bill. This is a number that has been established independently of the Senate. We all rejoice in it—25 million beneficiaries of this bill, which is supposedly just a technical amendment. Yet I would point out to my colleagues, if you look through this bill, it does not appropriate one penny. It does not provide one cent.

Now ask yourself, how are 25 million people going to benefit from this bill, through greater availability of health insurance and lower prices, if the Government and the Congress which passes this bill are not providing one single penny? Is it somehow magic that through Government edict we can bestow billions of dollars of benefits on our fellow citizens at no cost and no dislocation whatsoever? The answer to that is clearly no.

I would like to begin by making a prediction. That prediction is, if we adopt this bill as it is written, at the end of the first full year of its implementation, the cost of individual private health insurance policies will rise by a minimum of 10 percent. I also believe that this is a conservative estimate.

I believe that group policy rates will go up because we are going to produce, through this effort, several undesirable effects. I want to go through them to be absolutely sure that anybody who really wants to understand can do so, and because I think they make the argument for medical savings accounts and other reforms to try to offset the basic cost increase that is going to result from this bill as it is currently written.

First of all, this bill guarantees that if a person wants private health insurance, they can get it. There may be a delay in the availability of benefits, depending on where the person works and when they have private health insurance, but under this bill, anybody who wants private health insurance at any time, under some circumstances, can get it. Furthermore, when someone comes into a group plan, no matter what the state of their health, they cannot be charged more than any other member of that group and if somebody leaves a private employer, they must be offered an individual insurance policy.

What is the result of this going to be? It seems to me there are going to be positive as well as negative results. The entire debate so far has been about the positive result: 21 million people that do not have private health insurance will be able to get it, because we are saying by law that insurance companies must sell it to them. An estimated 4 million people who are locked into their job because they fear the loss of their health insurance if they move will benefit since they will be guaranteed the issuance of health insurance when they change jobs. These are the positive impacts of the proposed changes.

But it is generally true, in the real world we live in, that not all impacts of dramatic changes are positive; let me outline some of the negative impacts.

No. 1, we are going to end up, by guaranteeing availability, distorting health coverage. Young, healthy people, knowing that they are going to be able to qualify for private health insurance in some form—either through a group or as individuals—are going to have a greater incentive to not obtain the coverage that they have today.

Why do young workers who are basically healthy buy private health insurance right now? Some might buy it because they are risk averse. But many buy it because they want to guarantee that in the future, when they may not be as healthy, they will have locked in their coverage.

What this produces is a balanced distribution of people who are buying private health insurance—many people who are young and healthy and who are very modest users of health care as well as many people who are older and less healthy and who are heavy users of health care are all buying insurance. Since many young people buy private health insurance in order to lock in guaranteed health coverage in the future, to the degree that we mandate that insurance companies sell people health insurance no matter what the state of their health is, we eliminate one of the primary reasons that young people buy private health insurance. So the first negative impact of this bill is the creation of a new incentive for young people not to buy private health insurance.

Under this bill we also have some rather extreme provisions. Before I mention one of them, let me say that I understand, when you are talking about health care, that it is hard to have a rational debate because you are talking about sick people who we can all empathize with. But I think it is important that we understand what we are doing if we are going to have a real debate in the Senate because, after all, that is our job—to understand what the implications are and to try to see that we make a rational decision.

Under this bill, not only will young people with guaranteed ability at a later point to buy private health insurance have an incentive not to buy it today, but in designating a series of health benefits for which there is no waiting period, we create a special class of people who will buy health insurance when they know they are going to need it, such as in a pregnancy, and then cancel the policy after they receive the benefit—only to buy another policy when they are ready to use the benefit again.

It is very difficult to quantify this, but anyone who read the article in the April 5 issue of the Wall Street Journal knows this is happening in States which have done exactly what we are proposing to do.

So the first negative impact of this bill is that it eliminates one of the prime incentives for young, healthy people to buy private health insurance, and the second negative impact is that it distorts the risk pool in the process.

The third thing it is going to do, which is part of the positive impact, is that the 21 million people who are sick today and as a result of being high risk have opted not to pay the going market rate—or in some cases they simply have not been able to afford health insurance—the positive thing for them will be that they will now be able to buy health insurance. The fact that they will opt for coverage, while younger healthier people, knowing they can get it later, will opt not to get the coverage, however, will further distort the risk pool of insurance. What this will mean is that in America there will be more young, healthy people who do not opt for health insurance than we have today, and there will be more

older, less healthy people who do. Given the inherent cost of changing the mix of people who are buying private health insurance, the inevitable result of this is going to be that you drive up the cost of insurance premiums.

This is not just something that is theoretical, I know we have some study which says that costs are going to go up by some minuscule amount. I do not believe, however, that anybody who has looked at the experience of States like Washington could possibly believe this. I think what we are really looking at in this bill, independent of any other changes, is younger, healthier people dropping out and older, sicker people opting in. The net result of these shifts is going to be a substantial increase in insurance rates for those who have bought health insurance, for those who, in many cases, bought it when they were young and healthy in order to have a guarantee of insurability. The net result of this bill is going to be rising insurance costs.

Now, this bill, in fact, anticipates this result and sets up a series of powers to help the States try to deal with these potential impacts. At some later point I am going to debate and possibly offer an amendment dealing with a provision on page 40 that gives the Secretary of Health and Human Services the power to disallow a State program to deal with rising costs unless it implements a mechanism to spread the risk and to limit rate increases. I do not think we ought to be dictating to the States what they can and cannot do in order to deal with a problem that this bill is going to cause.

We have before us a bill that is going to help people, 25 million of them, and for these individuals it is going to be a godsend. But another 100 million people, who already have private health insurance and who are going to see their rates go up, are going to be losers from this reform. We are going to change behavior by inducing younger people to not buy into the system, and as a result rates will be raised. We are also going to bring sicker people into the system, and the final result is going to be a spike in insurance rates—just as has happened all over the country in States with similar programs.

We have now some 29 States that have gone about this in a different way by creating risk pools to help people who have a preexisting condition get health insurance. We are, in essence, going to kill that off this approach by mandating that the insurance policy be sold in the way we dictate at the Federal level.

There is a way to get the advantages to the 25 million people who will benefit from the bill and offset the cost to the 100 million who will lose from it. The way to do that is with fundamental reform which, it seems to me, can take two basic approaches. No. 1 is with medical savings accounts as will be offered by the majority leader. The idea behind the medical savings account is to change the Tax Code to allow an individual or a family to choose a high deductible insurance policy instead of a low deductible policy, and to put the savings from the resulting lower premiums into an account which is designated solely for the purpose of paying the policy's deductible. At the end of the year, if they do not spend that money on the deductible, they can roll it over for their retirement or take it out as income and pay taxes on it.

What that means is that for routine type care they are spending their own money. Medical savings accounts empower the individual consumer to be cost conscious and provide a mechanism that will save the concept of fee-for-service medicine so those who do not want to be members of an HMO or a prepaid system can opt to stay in fee-for-service medicine and yet have incentives to be cost conscious.

If we adopt the amendment of the distinguished majority leader, we will fundamentally change the health care market, and those savings will offset several times over the cost that is involved in driving up insurance rates for 100 million Americans to help the 25 million who will be beneficiaries of this program.

A second reform, which is not contained in the Dole amendment, deals with medical liability. We have some estimates which indicate that 20 percent of the cost of medical care in America comes from expenditures that are aimed at keeping people out of the courthouse instead of keeping people out of the hospital and out of the grave.

If we are going to make the changes envisioned in this bill, which in essence transfers costs to the people who have private health insurance—by raising their premiums—from people who do not have health insurance today, the way to offset that burden on people who have in essence done what we wanted them to do—bought private health insurance—is by allowing for medical savings accounts and dealing with medical liability.

If we do not make these two changes, my fear is that 2 years from today, insurance rates, especially on individual policies outside of group plans—because under this bill we guarantee the availability of a policy to somebody who leaves their group plan—I am concerned that without medical savings accounts or without medical liability reform, we are going to see insurance rates spike and we are going to see States try to hold them down with rationing mechanisms and price controls. I think they are going to fail, as they are failing in Washington State today, and I think we are going to be right here 2 years from now debating a health care bill again, and the demand will be made to do something about exploding costs. Yet we will have produced these exploding costs with this bill.

We have it in our power to help 25 million people and yet not hurt another 100 million people in order to pay for it. The way to do that is with a medical savings accounts and medical liability reform.

In and of itself, this bill simply transfers income and assets from one group of Americans to another, and in the whole you have 25 million winners but you have 100 million losers.

With reform, we can see that virtually every American family wins. If all we are doing is simply shifting risk, we are not dealing with the fundamental health care problem in America.

So I hope my colleagues will vote for the Dole amendment. I think it is very important. I totally reject the idea that this is a simple bill and that we ought not to load it up with other items. If we do not have fundamental savings, this bill is going to cause insurance rates to explode, and we are going to be right back here 2 years from now debating socialized medicine again. I have debated that once, I am not eager to do it again, but if it is required, I certainly will.

I yield the floor.

Mr. HELMS. Mr. President, more than 80 percent of Americans younger than 65 are covered by health insurance, but if one of them changes jobs, or is laid off, he or she may be denied health insurance because of a preexisting problem, or because his health insurance cannot move with him or her. A genuine fear therefore exists that the security of health insurance could very well be lost. In fact, opinion polls show that as many as one-third of employees fear that if they switch jobs they will be unable to obtain new health insurance.

The American people believe, and I agree, that they should be able to change jobs without losing their health insurance. Congress needs to insist that health insurance be made portable so that the fear of losing their health insurance should not plague the American people when they change or lose their jobs. This bill permits insured employees who leave one employer to be covered immediately upon taking another job that offers employees health insurance, regardless of their health status.

This bill does not establish community rating. Community rating is a grave threat to the insurance market. I have heard many cite the dismal failure of guaranteed issue in States such as New York. These States coupled guaranteed issue with price controls that kept premium prices equal for everyone regardless of age, health status, etc. This combination ensures collapse of the health insurance market. However, S. 1028 narrowly defines guaranteed issue in order to avoid the devastating effects of pushing healthy people out of the health insurance market.

There must be a limit to preexisting condition restrictions that now prevent many citizens from obtaining or holding onto health insurance. I am convinced, Mr. President, that small businesses should be encouraged to form

groups to build joint purchasing power when buying health insurance for their employees.

These provisions of the Kassebaum bill will be welcome and overdue improvements in the health insurance market, and I wholeheartedly support them.

However, Mr. President, in the debate on health insurance reform, perhaps the most innovative solution has been given the shortest shrift—the medical savings account. This solution—that will provide the greatest freedom—has been successfully used by many businesses to keep their health care costs down and employee satisfaction up. In a truly American way, medical savings accounts harness the free enterprise profit motive to promote sorely needed efficiencies in the health care economy. MSA's confer upon individuals an incentive, a reason, to spend their health care dollars wisely by turning part of the savings over to the employees, in effect rewarding efficiency.

Mr. President, many private businesses are already using cash incentives and medical savings accounts to reduce their health care costs while, at the same time, achieving great employee satisfaction with the health care afforded them.

One company cut its health care costs significantly. In 1992, Forbes magazine was spending $2.3 million per year for health insurance from CIGNA at an average cost of about $5,000 per employee. In order to encourage employees to be more cost conscious, Malcolm Forbes, Jr., decided to reward his employees with a bonus for not filing major-medical and dental claims.

Forbes explained the choice to its employees: If, during the year, an employee minimized the number of claims filed with the insurance company, Forbes agreed to pay that employee a bonus of up to $1,200. Employees enthusiastically embraced this plan; insurance claims dropped dramatically. As of 1994, while premiums for other CIGNA clients rose between 21 and 25 percent, Forbes' major-medical premiums fell 17.6 percent.

The obvious lesson learned from the Forbes example is that employees will control their health spending—if they are allowed to keep the savings. Of course, in the case of employees who are really sick, they file the necessary claims and receive bonuses in lesser amounts. Employees choosing to pay out-of-pocket for routine health expenses instead of filing claims, get the bonuses at the end of the year.

Consider, Mr. President, how this kind of commonsense incentive will change the public attitudes about health care costs. For example, one Forbes employee regularly needs four different prescriptions filled, but as a result of the Forbes bonus program, this employee now shops around for the best price. Before, he didn't care how much a prescription cost because insurance paid it. And when insurance pays, we all pay, in the form of higher insurance premiums and lower income.

Forbes is not the only company to benefit from an incentive-based program. Dominion Resources, a public utility holding company in Richmond, VA, has likewise developed an innovative method of reducing its health care expenses, a medical savings account.

An MSA works: The employer buys its employees a health insurance policy with a high deductible. This kind of policy has two attributes: First, it protects the insured against catastrophic health care expenses; and second, its premiums are less expensive.

The employer then establishes a special account for each employee to pay for routine medical treatment. What the employee does not spend from the account, he keeps. This incentive encouraged 75 percent of Dominion's employees to enroll in a high-deductible plan. And guess what—since 1990, Dominion's health care costs have risen less than 1 percent per year; premiums have not increased in 3 years.

Forbes and Dominion Resources are but two examples of private industry enterprise coming up with health care solutions that work. Incentive-based solutions work for the company and they work for the employee. As one economist, Gerald Musgrave, put it, "We have thousands of years of experience with how people handle their own money."

So, why not let Americans continue to handle their own health care dollars and help them realize their role in cost savings? Time and time again, Americans have shown that they can and will make cost-conscious health care decisions when given a sensible incentive to do so.

So, Mr. President, insurance can be made more accessible by assuring Americans that their policies will not be canceled because of an illness or when they are changing jobs. These are some obvious flaws in the market and I believe further progress can be made by addressing the Tax Code. But I am convinced that we're on the right track.

Mr. President, I ask unanimous consent that an April 17, 1996 Wall Street Journal article entitled "A Way Out of Soviet-Style Health Care" by Milton Friedman be printed in the RECORD.

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

[From the Wall Street Journal, Apr. 17, 1996]

A WAY OUT OF SOVIET-STYLE HEALTH CARE

(By Milton Friedman)

In a chapter in his novel "The Cancer Ward" titled "The Old Doctor," Alexander Solzhenitsyn compares "private medical practice" with "universal, free, public health service" through the words of an elderly physician whose practice predated 1918. A byproduct is an eloquent statement of the major advantages of medical savings accounts for the U.S. in 1996.

Mr. Solzhenitsyn himself had no personal experience on which to base his account and yet, in what I have long regarded as a striking example of creative imagination, his character presents an accurate and moving vision. The essence of that vision is the consensual relation between the patient and the physician. The patient was free to choose his physician, and the physician free to accept or reject the patient.

In Mr. Solzhenitsyn's words, "among all these persecutions [of the old doctor] the most persistent and stringent had been directed against the fact that Doctor Oreschenkov clung stubbornly to his right to conduct a private medical practice, although this was forbidden."

"EASIER TO FIND A WIFE"

In the words of Dr. Oreschenkov in conversation with Lyudmila Afanasyevna, a longtime patient and herself a physician in the cancer ward: "In general, the family doctor is the most comforting figure in our lives. But he has been cut down and foreshortened. . . . Sometimes it's easier to find a wife than to find a doctor nowadays who is prepared to give you as much time as you need and understands you completely, all of you."

Lyudmila Afanasyevna: "All right, but how many of these family doctors would be needed? They just can't be fitted into our system of universal, free, public health services."

Dr. Oreschenkov: "Universal and public—yes, they could. Free, no."

Lyudmila Afanasyevna: "But the fact that it is free is our greatest achievement."

Dr. Oreschenkov: "Is it such a great achievement? What do you mean by 'free'? The doctors don't work without pay. It's just that the patient doesn't pay them, they're paid out of the public budget. The public budget comes from these same patients. Treatment isn't free, it's just depersonalized. If the cost of it were left with the patient, he'd turn the ten rubles over and over in his hands. But when he really needed help he'd come to the doctor five times over. . . .

"Is it better the way it is now? You'd pay anything for careful and sympathetic attention from the doctor, but everywhere there's a schedule, a quota the doctors have to meet; next! . . . And what do patients come for? For a certificate to be absent from work, for sick leave, for certification for invalids' pensions; and the doctor's job is to catch the frauds. Doctor and patient as enemies—is that medicine?"

"Depersonalized," "doctor and patient as enemies"—those are the key phrases in the growing body of complaints about health maintenance organizations and other forms of managed care. In many managed care situations, the patient no longer regards the physician who serves him as "his" or "her" physician responsible primarily to the patient; and the physician no longer regards himself as primarily responsible to the patient. His first responsibility is to the managed care entity that hires him. He is not engaged in the kind of private medical practice that Dr. Oreschenkov valued so highly.

For the first 30 years of my life, until World War II, that kind of practice was the norm. Individuals were responsible for their own medical care. They could pay for it out-of-pocket or they could buy insurance. "Sliding scale" fees plus professional ethics assured that the poor got care. On entry to a hospital, the first question was "What's wrong?" not "What is your insurance?" It may be that some firms provided health care as a benefit to their workers, but if so it was the exception not the rule.

The first major change in those arrangements was a byproduct of wage and price controls during World War II. Employers, pressed to find more workers under wartime boom conditions but forbidden to offer higher money wages, started adding benefits in

kind to the money wage. Employer-provided medical care proved particularly popular. As something new, it was not covered by existing tax regulations, so employers treated it as exempt from withholding tax.

It took a few years before the Internal Revenue Service got around to issuing regulations requiring the cost of employer-provided medical care to be included in taxable wages. That aroused a howl of protest from employees who had come to take tax exemption for granted, and Congress responded by exempting employer-provided medical care from both the personal and the corporate income tax.

Because private expenditures on health care are not exempt from income tax, almost all employees now receive health care coverage from their employers, leading to problems of portability, third party payment and rising costs that have become increasingly serious. Of course, the cost of medical care comes out of wages, but out of before-tax rather than after-tax wages, so that the employee receives what he or she regards as a higher real wage for the same cost to the employer.

A second major change was the enactment of Medicare and Medicaid in 1965. These added another large slice of the population to those for whom medical care, though not completely ''free,'' thanks to deductibles and co-payments, was mostly paid by a third party, providing little incentive to economize on medical care. The resulting dramatic rise in expenditures on medical care led to the imposition of controls on both patients and suppliers of medical care in a futile attempt to hold down costs, further undermining the kind of private practice that Dr. Oreschenkov ''cherished most in his work.''

The best way to restore freedom of choice to both patient and physician and to control costs would be to eliminate the tax exemption of employer-provided medical care. However, that is clearly not feasible politically. The best alternative available is to extend the tax exemption to all expenditures on medical care, whether made by the patient directly or by employers, to establish a level playing field, in terms of the currently popular cliche.

Many individuals would then find it attractive to negotiate with their employer for a higher cash wage in place of employer-financed medical care. With part or all of the higher case wage, they could purchase an insurance policy with a very high deductible, i.e., a policy for medical catastrophes, which would be decidedly cheaper than the low-deductible policy their employer had been providing to them, and deposit all or part of the difference in a special ''medical savings account'' that could be drawn on only for medical purposes. Any amounts unused in a particular year could be allowed to accumulate without being subject to tax, or could be withdrawn with a tax penalty or for special purposes, as with current Individual Retirement Accounts—in effect, a medical IRA. Many employers would find it attractive to offer such an arrangement to their employees as an option.

Some enterprises already have managed to do so despite the tax penalty involved. MSAs have proved very popular with employees at all levels of income, and they've been cost-effective for employers. The employee has a strong incentive to economize, but also complete freedom to choose a physician, and the equivalent of first-dollar coverage. There are no out-of-pocket costs. Until the employee spends more than the total amount in the MSA. Such costs are then limited to the difference between the amount in the account and the deductible in the catastrophic policy. Moreover, the employee can use money in the MSA at his or her discretion for dental or vision care that is typically not covered under most health plans. No need to get ''authorization'' from a gatekeeper or an insurance company to visit a specialist or to have a medical procedure—until the catastrophic policy takes over.

LIMITING COMPETITION

The managed care industry has come to recognize that MSAs might threaten its growing control of American medicine by offering a more attractive alternative. As a result, the managed care industry has recently become a vigorous enemy of MSAs. Every believer in competition will recognize that opposition for what it is: a special interest using government to limit rather than expand competition.

Medical savings accounts are not a panacea. Many problems would remain for an industry that now absorbs about a seventh of the national product. However, I believe that they offer the closest approximation that is currently feasible to the private medical practice that Dr. Oreschenkov cherished.

Mr. BRYAN. Mr. President, today is remarkable. At long last—on the floor of the Senate—we are considering health care reform legislation that the American people both want and support. And at long last, it is legislation with significant bipartisan support.

I am proud to be a cosponsor of this bill. It will provide health care insurance protection for thousands of Nevadans, and millions of Americans. This incremental bill is our best opportunity to get working Americans the health care access they deserve.

We have been close to this point before. It seems like ancient history when I think back to cosponsoring former Senator Lloyd Bentsen's small business insurance health care reform. It too had incremental insurance coverage improvements that many in this body supported—yet once again, the final hurdle could not be overcome.

Many times—and over many years—Nevadans have shared with me their heart breaking stories. Families whose children have medical conditions that prevent the family from being able to purchase health insurance, because no insurer will take a child with a preexisting condition. Working individuals who develop chronic health conditions, and cannot leave their current employment for fear of not being able to get health insurance in their new job.

Health insurance is often denied for the very illnesses most likely to require medical care. Eighty-one million Americans have conditions that could subject them to such exclusions if they lose their current coverage, and sometimes these exclusions make them completely uninsurable.

People with preexisting conditions are penalized twice. First, they have a serious health care condition that requires medical care—a situation they did not choose. Second, they are at the mercy of insurers who decide whether they will have coverage, or be cut off.

For the person with a preexisting medical condition, who has been lucky enough to get health care insurance through his or her job, the secondary fear is keeping their job.

If the job is eliminated, it may mean no more health care insurance—ever. For the person who wants to better himself or herself by taking a new job, or starting a new business, it may mean no more health insurance—period. We can all imagine that fear.

These insurance company decisions affect working people who play by the rules. They pay their insurance premiums when they can get coverage. But they find themselves in untenable situations.

They are unable to have the most basic insurance of all—for themselves and their families—to not have to worry about health care coverage.

It is demeaning to all Americans if people cannot better themselves and their families' situations for fear of losing health care insurance. This legislation will free many working people from the stagnation of being unable to accept new job opportunities.

The Health Insurance Reform Act guarantees that private health insurance coverage will be available, renewable, and portable to working Americans.

This legislation will make it easier for individuals and employers to buy and keep health insurance, even when a family member or employee has a preexisting condition. This legislation makes health care coverage portable so workers would no longer be locked into jobs or prevented from starting their own business for fear of losing their health coverage.

Small businesses and self-employed individuals are particularly victimized under the current system, because they lack the bargaining power of larger corporations. This legislation addresses their problem by encouraging them to form private, voluntary coalitions for purposes of purchasing health plans and negotiating with providers. By forming these groups, the costs of health plans would be more competitive for small employers and individuals, as compared to large employers, by giving them more clout in the marketplace.

This bill is the foundation for incremental health reform. Although this insurance reform legislation will not solve all of the problems of the Nation's health care system, it will promote greater access and security for health coverage for all Americans. Private insurance carriers will compete based on quality, price and service, instead of by their ability to refuse coverage to those who need it the most.

We all know there will be attempts to add amendments to this legislation. Some of those amendments are going to be very hard to vote against.

But we must keep focused on what it is we are trying to accomplish here.

We have the opportunity to provide access to health care insurance for millions of Americans who each and every day face the uncertainty of whether they will have coverage.

We can do something to allay those fears.

Passing this bill is a big step to ensuring health care coverage is available to working Americans. Other steps are needed—but they need not be taken today.

Let us first take this big step, and get the job started. And from there, we can and will, work to ensure even better health care for all Americans.

Mrs. MURRAY. Mr. President, during the 103d Congress many of us worked very hard to try to enact comprehensive health care reform. Despite our efforts and what felt like endless debate, politics prevailed and we came up emptyhanded. Perhaps we were too optimistic to think we could accomplish such broad and sweeping reforms in 1993; but unfortunately health reform remains a critical high priority issue for every family in this country.

Well, political realities are still very real factors in determining the outcome of legislative initiatives here in Congress. And here we are again discussing health care reform, only in a much more limited and focused way.

I am encouraged that the dialogue is open once again, and that we are taking positive steps toward addressing the many health-related issues confronting people across our country.

If I had it my way, we would not just be talking about health insurance reform today. We would be doing more, especially for our most precious resource, children. We should be doing more, like: ensuring better pre- and post-natal care for women and their babies; boosting rates of immunization even higher for children across our nation; working even harder to reduce adolescent health problems like teen pregnancies, substance abuse and STD's; improving child nutrition programs and strengthening our overall national commitment to children and family health and well-being.

But, I recognize the realities of the 104th Congress, and realize that sometimes progress comes one step at a time. I am proud to be a cosponsor of S. 1028, the Health Insurance Reform Act. I believe this is a commonsense measure that will directly benefit working families across our country. I sincerely hope we can pass this bill and send it to the President for his signature.

We should not weigh this bill down with amendments that could undo the broad bipartisan support we so rarely see in this Congress. I applaud Senators KASSEBAUM and KENNEDY for their ongoing leadership and commitment to enacting this legislation.

S. 1028 was carefully crafted so that we could pass it overwhelmingly and see it enacted into law with the full support of the White House. For this reason, I will join my colleagues in opposing any controversial amendments that are offered, even those which I support in principle. We should learn from the past, Mr. President, and not try to bite off more than we can chew.

As I said, this bill is not a cure-all. We need to do more, of course. But, this is a reasonable, sensible first step and will go a significant distance toward guaranteeing coverage for millions of American workers and their families.

Mr. President, we owe it to those families to pass this bill, and pass it in its current form. To do anything which could jeopardize the fragile coalition of support for this bill would be irresponsible and bad public policy.

I appeal to my colleagues not to try and load up this bill with amendments that will ultimately kill the bill. Let us show our constituents that we can work together and we can put political differences aside for the greater good.

Much of what we are discussing here will not be news to people in my State. In 1993, we passed one of the most comprehensive health care measures in the country, and even after serious modification the people in Washington still have many of these same protections.

In some areas, like limits on pre-existing conditions, my State actually has a shorter limit of 3 months, which the Kassebaum-Kennedy bill will not preempt.

Earlier I said that we owe it to working families to pass this bill. I am talking about people across the country who have to worry about their health care coverage, people who want to work and take care of themselves and their families. People like:

The working family of three. Dad wants to change jobs to a higher paying company, but his daughter has multiple sclerosis. Under this bill, he wouldn't have to worry that she will not be able to get coverage under the new employer's plan. He plays by the rules, he pays his premiums—this family will not be confronted with a preexisting condition exclusion period.

By requiring insurance companies and employers to credit prior insurance coverage, this bill will give workers with disabled family-members peace of mind and the flexibility to change jobs without fear of losing their insurance.

Or a woman who had breast cancer who is starting a new job. Today, she could possibly be denied coverage or charged a higher premium because of her cancer history. But, tomorrow—under S. 1028—because insurance companies and employers would be prohibited from discriminating against workers because of past medical problems, this woman would be treated no differently than anyone else covered under the same plan.

And, the new small business owner and her three children. Mom was abused in her former marriage and is trying to start over. A woman in this situation is going to need all the help she can get to provide for herself and her kids.

Today, she could be facing not one but two obstacles to starting her new life for herself and her family. First, she could be denied coverage for herself for any preexisting condition that was caused by her years of being abused. Second, she is a new business owner and maybe can't afford to purchase insurance for her handful of employees.

S. 1028 will give this woman a chance to succeed. She will not be discriminated against because of her preexisting condition, and under the provisions of this bill—small businesses and individuals are permitted to form cooperatives to purchase insurance and negotiate with providers and health plans. This arrangement will spread administrative costs and empower the participants to negotiate for better prices.

In other words, S. 1028 will help this woman and her children put their troubled pasts behind them.

Mr. President, the examples are endless. We have heard many stories today, and as Senator KASSEBAUM pointed out—we all know someone who could be helped by this bill.

Even though this bill may not be as comprehensive as I personally would like, I want to reiterate my strong hope that we can pass S. 1028 without any controversial additions and move forward to address the many other issues facing America's families. That's why we're here.

Mr. COHEN. Mr. President, I rise in support of S. 1028, the Health Insurance Reform Act, which promises to relieve the anxiety that millions of Americans are feeling that they may lose their health care coverage if they change their jobs, lose their jobs, or become ill.

Health care reform is certainly not a new issue for any of us. In fact, I introduced my first comprehensive health care reform bill back in 1990. It was 76 pages long and it dealt with these same issues—the availability and affordability of health insurance.

Over the subsequent 6 years, we have spent countless hours studying and debating the issue. If we have learned anything, it is that the American people want health care reform, but they want something they can understand and afford, and something that builds upon rather than reinvents the current system.

The American public wisely rejected the big-government approach proposed in the last Congress by the administration—that 1,400 page proposal literally collapsed under its own weight. More Government bureaucracy is clearly not the way to lower health care costs or ensure access to care.

But rising health care costs and expanding gaps in coverage are still very much on the minds of the American people. Poll after poll continues to show that health care remains a top priority. In fact, a poll conducted late last year by Princeton Survey Research Associates found that more Americans are concerned about their own health care coverage than they are about crime, high taxes, the political system, or the economy.

Americans clearly want health care reform. But what they mean when they say that is: ''If I lose my job or get sick, I want to keep my health insurance and I don't want it to cost so

much.'' They want Congress to enact sensible, targeted reforms to make health insurance more affordable and available, and to ensure that they do not lose the coverage that they currently have.

We have that opportunity today. Despite the partisan and sometimes bitter debate over this issue in recent years, there is now broad-based, bipartisan support for this bill, which would benefit as many as 25 million Americans each year, at no additional cost to the taxpayers. The legislation currently has 65 Senate cosponsors and is supported by a wide range of diverse organizations including the National Governors' Association, the U.S. Chamber of Commerce, the American Association of Retired Persons, and the American Medical Association.

The Health Care Reform Act of 1996 builds upon and strengthens our current private insurance system to make it easier for individuals and their employers to buy and keep their health insurance. It contains a number of common sense, market-based reforms that are designed to guarantee that private health insurance coverage will be affordable, available, and portable. Most of these reforms have been included in my own health care bills over the years, and they have also been common elements of legislation introduced in past Congresses by both Republicans and Democrats.

First, the bill limits the ability of insurers and employers to restrict or exclude coverage for pre-existing health conditions like heart disease or cancer, making it easier for workers to change jobs and eliminating job lock. Insurers will also be prohibited from dropping or denying coverage for an individual when they or a family member becomes ill.

The legislation also provides a safety net for people who lose their employer-paid coverage—insurers will now be required to sell them individual policies. Some have expressed concern that this provision will cause premiums in the individual market to skyrocket. However, our experience in Maine—where insurers have been required to sell policies to any individual who applies since 1993—shows that this change should have only minimal price consequences. In fact, one Maine insurer reduced rates for its individual policies by 16 percent last year.

And finally, the bill assists employers and individuals in forming private, voluntary coalitions to purchase health insurance and negotiate with providers and health plans. These kinds of arrangements can provide small employers and individuals with the same kind of purchasing clout enjoyed by large employers, making insurance coverage more affordable.

No one pretends that the reforms contained in this bill are the answer to all of our Nation's health care woes. They are targeted and they are specific. But they will provide all Americans with what Robert Samuelson of Newsweek has termed ''a little more peace of mind.''

We should not underestimate the importance of providing this peace of mind to people like Susan Rogan, of Herndon, VA, who testified before the Labor Committee last summer.

She told the committee that the experience of obtaining health insurance after her husband's employers had gone bankrupt had been a nightmare, even though he quickly found a new job. Insurers were reluctant or unwilling to cover the family because their daughter has cerebral palsy.

She urged us to work together, saying:

> It is your responsibility, in Congress, to find a solution to the insurance problems that have caused so much heartache for so many American families. We voted for you, and we expect no less of you.

And Susan Rogan is right. She should expect no less of us. It is our responsibility to work together and take this positive step forward to tear down the barriers that millions of working Americans and their families face in obtaining and keeping essential health care coverage.

I therefore join the chairman and ranking member of the Labor Committee in urging my colleagues to resist the temptation to weigh down this important piece of legislation with highly controversial or extraneous amendments.

Some of the amendments that may be offered today are ones that I would, under other circumstances, support. For instance, I have been a long-time supporter of Senator DOMENICI's legislation to provide people with serious mental illness with health benefits and coverage that are comparable to those provided to people with physical illness.

However, this is neither the time nor the vehicle, and I intend to vote against all such extraneous amendments. We simply do not want to run the risk of having this very sensible and eminently doable package grow into yet another 1,400-page bundle of expensive mandates, more Government bureaucracy, and untested proposals.

We should not let the ghosts of health reform past destroy the promise that this important piece of legislation holds for resolving some of the most serious problems plaguing our health care system, and I urge my colleagues to join me in supporting it.

Mr. GORTON. Mr. President, let me make an important point about this bill. It is very narrow in scope, addressing portability and health coverage for preexisting conditions. It in no way resembles the expansive Clinton health care proposal this body defeated 2 years ago.

In the summer of 1994, many hundreds of Washington state citizens gathered in Westlake Mall in downtown Seattle to protest the proposed Government takeover of their health care. They were outraged by the hubris and the arrogance of that health care plan, and rightly so. The plan focused on setting up new bureaucracies, that it completely ignored the people who would have been affected by it.

This legislation takes a clear-headed approach, responding to one problem that people face regarding preexisting conditions. It follows the conclusions of the Senate health care task force, of which I am pleased to have been a member for several years. We came up with the lessons learned from the Clinton health care debacle, and topping the list was the fact that there simply cannot be a government-run health care system. Period. The only sane, responsible way to address particular problems that may arise is to take a very narrow, targeted approach. In other words, you don't solve a problem with grandiose, wholly unworkable schemes. You solve a problem with a commensurate response.

In this case, we have the problem of coverage for preexisiting conditions. The goals of this bill are strickly defined and few. They are to:

First, develop insurance reform legislation that builds upon and strengthens the current private market system;

Second, make it easier for individuals to keep and obtain private health insurance coverage, including measures to limit preexisting condition exclusions and expand portability;

Third, increase the purchasing clout of individuals and small groups.

With that said, let me enunciate what this bill will not do.

It will not require employers to offer or pay for health insurance coverage.

It will not require individuals to purchase health insurance.

It will not impose new and expensive regulatory requirements on individuals, employers, or States.

It will not create new Federal boards, commissions, or regulatory bodies.

It will not contain a standard benefit package or mandated benefits.

It will not subject ERISA plans to state regulation.

It will not impose any new taxes.

This is not ''Clinton Lite;'' this is a modest, narrow, targeted proposal. This is the way health care reform should be accomplished: not consumed with utopian visions and grand schemes of expensive government power, but realistic and down-to-earth.

I believe we have finally got it right. I know that many of my constituents in Washington State, and many Americans, are concerned any time Congress addresses the issue of health care reform. With the memory of the Clinton plan fresh in their minds, they certainly have reason to be wary. But I believe that, once they know what is in this bill, they will be pleasantly surprised. This Congress has neither the intention nor the desire to let the government take over American health care, the best health care system in the world. This Congress wants to take a very limited approach to specific problems.

The Health Insurance Reform Act is in concert with the beliefs of most

Americans, who do not want government-run health care, but who do expect Congress to address and resolve certain problems in the system. That is what this bill does, and I am glad to support it.

Mr. GLENN. Mr. President, as a cosponsor of S. 1028, the Health Insurance Reform Act, I am pleased that the Senate is considering this important legislation, and I urge its passage. I commend Senator KASSEBAUM and Senator KENNEDY for their leadership in crafting this bipartisan measure which will help many working Americans keep important health insurance protection for themselves and their families.

The purpose of the Health Insurance Reform Act is to ensure that people who have employer-provided health insurance will not lose their insurance if they change jobs, lose their jobs or become sick. This legislation makes changes in the private insurance market to protect employees, and to make insurance more affordable for small businesses and individuals.

The Health Insurance Reform Act requires insurers and health maintenance organizations to provide and renew group coverage to employers with two or more employees who want to purchase it, and this coverage must be available to all employees regardless of their health status. In addition, this legislation makes insurance portable by limiting pre-existing condition exclusions and by requiring group to individual coverage.

S. 1028 limits to 12 months exclusions for pre-existing conditions which occurred within the 6-month period prior to receiving insurance coverage. This 12-month limit will be imposed only one time for individuals who maintain continuous coverage even if they change jobs or insurance plans. Individuals who lose employer-provided health insurance will be guaranteed the opportunity to purchase an individual policy if they had continuous coverage for 18 months in a group plan, if they have exhausted their COBRA continuation coverage, and if they are not eligible for coverage under another group health plan. These provisions will go a long way toward ending the current problem of job lock, and ensuring that people who have been participating in health insurance plans do not lose protection when they change jobs or become sick.

S. 1028 is not comprehensive health care reform. It does not provide universal coverage for all Americans, and insurance costs will be unaffordable for others. However, it is a very important step forward in addressing problems in our current health insurance system, and it will provide peace of mind to many working Americans who have health insurance but fear losing it.

Mr. HATCH. Mr. President, I rise in strong support of the Health Insurance Reform Act, S. 1028. This important legislation represents a significant and reasonable step in extending health insurance coverage to a larger segment of the American population.

I am proud to serve as an original cosponsor of this bill and would like to take this opportunity to commend the distinguished chairman and ranking minority member of the Committee on Labor and Human Resources, Senator KASSEBAUM and Senator KENNEDY, for the outstanding contribution they have made in helping to provide literally millions of Americans with peace of mind that they will not lose their health coverage.

As my colleagues are aware, insurance market reform is a bipartisan issue and it is something we have been working toward for many years. I am thinking back to the Bentsen-Durenberger bill which many of us cosponsored 4 years ago.

Indeed, as most of my colleagues know, the Senate and House have spent considerable time and energy over the past 5 years debating various proposals designed to address problems with our Nation's health care system overall.

Perhaps no other issue in recent years has captured the attention and concern of the American people than the issue of health care reform and the role of the Federal Government in shaping that reform.

But I submit that today is not the time to debate measures of such tremendous scope.

Unlike the President's approach, S. 1028 is targeted and narrowly focused reform aimed at assisting nearly 25 million Americans in obtaining health insurance coverage.

Most of us in the Senate recall the innumerable hours spent considering President Clinton's legislation that was ultimately rejected by the American people and by the Congress.

One of the lessons we learned from that endeavor was the need to provide for greater access to health insurance than what is currently available.

And access to health insurance is unquestionably one of the fundamental problems facing Americans today.

The current health insurance market provides too little protection for individuals and families with significant health problems and makes it too difficult for employers—particularly small employers—to obtain coverage for their employees.

The health insurance reform bill is specifically designed to address this problem.

It will reduce many of the current barriers to obtaining health coverage by making it easier for people who change jobs or lose their jobs to maintain adequate coverage, and by providing increased purchasing power to small businesses and individuals.

The bill will not only increase access to health care coverage, but will also provide portability of insurance coverage and increase the purchasing power of individual and small employers who wish to seek to purchase insurance.

Specifically, the bill restricts the use of preexisting condition limitations by insurance carriers.

Some insurers today impose preexisting condition limitations or exclusions on individuals when they first become covered by an insurer.

These exclusions may limit coverage of a medical condition for a certain period or longer or may exclude coverage of a medical condition—forever.

Under the provisions of S. 1028, insurers, HMO's, and self-insured firms would be limited in the ability to use preexisting condition limitations to no more than 12 months after the enrollment date.

In addition, benefit limits or exclusions could not be imposed for newborns, newly adopted children, children newly placed for adoption, or for benefits for pregnancy.

Another important component of this bill is the provision regarding the guaranteed issue of health coverage benefits.

Under this provision, an insurer or health plan is required to cover any group or individual who applies, without regard to health status or claims experience. The bill would require all insurers who offer group coverage to accept coverage for all groups that apply.

Insurers would be required to offer individual coverage to all individuals moving from group coverage to individual coverage as well. However, to be eligible for this guarantee, the individual must satisfy the following four criteria:

First, the individual must have been covered under one or more group health plans for at least the past 18 months;

Second, the individual must not be eligible for group health coverage, or, if eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, or a similar State program, then they must have elected, and exhausted that coverage;

Third, the individual must apply for individual coverage not more than 30 days after the last day of coverage under the group plans, or the termination date of COBRA benefits; and

Fourth, the individual must not have lost group coverage due to nonpayment of premiums or fraud.

Accordingly, in order to be eligible for insurance coverage in the individual market, we have incorporated important benchmarks to foster individual responsibility and accountability in the purchasing or insurance plans.

We are all aware that this bill has engendered considerable debate on how it would impact existing premiums.

The American Academy of Actuaries has studied this issue in great detail and estimates that people who are newly eligible for individual coverage would pay an average of two to three times the standard-risk premium rate, unless States restrict premiums.

The Academy further states that S. 1028 will have no effect on individual insurance premiums for those currently purchasing coverage in the vast majority of States.

In States that restrict premiums, S. 1028 would lead to individual market premium increases in the range of 2 to 5 percent, spread out over a 3-year period.

Thus, I believe that fears the bill will lead to large increases in premiums are unwarranted. However, I recognize those concerns, and I will be monitoring this situation closely.

Another important provision in this legislation addresses insurance portability.

During our consideration of health care reform, it was clear that the use of preexisting condition provisions in insurance plans has contributed to a problem referred to as ''job lock''.

In effect, employees are locked into their current jobs because changing jobs might subject them to periods without health insurance coverage because of a preexisting health condition.

For an employee with a medical condition, or a dependent with a medical condition, loss of coverage during a limitation period, or worse, exclusion of coverage of the condition forever could mean significant out-of-pocket health care expenditures.

As a result, guaranteed issue and limits on the use of preexisting condition provisions by insurers provide needed portability of coverage for American workers.

It is also important to note that the legislation provides specific guidance with respect to State flexibility in compliance with this new law.

Federal provisions for group to individual portability only become effective if States do not have programs meeting Federal requirements for access.

S. 1028 will provide for state flexibility for compliance with Federal provisions.

State mechanisms could include guaranteed issue or open enrollment programs by one or more plans, a high risk pool, or mandatory conversion policies.

In my State of Utah, we have already enacted many of these reforms.

The legislation would permit a waiver from Federal law if a State could demonstrate that its law achieved the objectives of affordable individual market portability and renewability.

And finally, S. 1028 promotes group purchasing by small businesses by assisting employers and individuals in forming private, voluntary coalitions to purchase health insurance and negotiate with providers and health plans.

These coalitions will provide small employers and individuals with the kind of clout in the marketplace currently enjoyed by large employers.

It's important to note what this bill does not contain.

S. 1028 does not impose new, expensive regulatory requirements on individuals, employers or States.

S. 1028 does not create new Federal bureaucracies or agencies.

S. 1028 does not contain any new taxes, spending, or price controls.

S. 1028 does not require employes to pay for health insurance coverage.

And, S. 1028 contains no unfunded mandates on State, local, or Indian tribal governments.

In effect, this bill contains none of the onerous provisions contained in the ill-fated Clinton health care reform bill.

Mr. President, I will state in all candor that initially I had reservations about supporting this legislation.

As a general rule, I believe the Federal Government should not intervene in areas where consumer choice and natural marketplace conditions determine the level and costs of products and services.

And, indeed, in the past I have supported what I believe were true market-based reform proposals in the health care area. However, the problem of access to health insurance has long been a problem to millions of Americans.

This problem remains, and it will continue to remain until appropriate Federal action is taken.

Over the course of the past year, we have worked to develop and fine-tune the provisions embodied in S. 1028.

Most of these modifications were developed to more clearly reflect the intent of the bill.

These revisions were principally designed to provide more certainty to States and insurers as well as to respond to concerns that the Secretary of the Department of Health and Human Services was given too much discretion over alternative State programs.

I am pleased that the manager's amendment deals with concerns expressed to me from constituents in Utah over the need to revise the bill's provisions regarding conflict of interest language as it applies to purchasing cooperatives.

And, I would like to thank Senator KASSEBAUM's cooperation in resolving these issues.

This legislation will now permit insurers, agents, and brokers to serve on purchasing cooperative boards or be employed by a cooperative as long as they do not personally benefit from the sale of services or products to that cooperative.

I believe we have come as close as possible in this present political environment in developing a viable measure that will appropriately address the problem of access to health insurance for millions of Americans.

The General Accounting Office estimates that passage of S. 1028 will help at least 25 million Americans each year.

According to the GAO, an estimated 43 million Americans or 18.7 percent of the nonelderly population were without health insurance coverage for some period of time in 1995.

This bill will truly help people, and I believe it deserves our strong support.

It is clear that insurance market reform is one area which enjoys wide bipartisan support in both houses of Congress. The fact that the bill currently has 65 cosponsors and was reported unanimously by the Labor and Human Resources Committee serves as a testimonial to its strong bipartisan support in the Senate.

It is clear that this important piece of legislation with its strong bipartisan support has the potential to be signed into law by the President as he indicated in his State of the Union Address in January.

I commend Senators KASSEBAUM and KENNEDY, and all the cosponsors, and hope that we can move this key legislation forward today.

Mr. ROTH. Mr. President, I rise in support of the pending legislation. Labor and Human Resources Committee Chairman KASSEBAUM and Senator KENNEDY deserve to be commended for there efforts in crafting the bill before the Senate which assures that workers who intend to change jobs will no longer experience the fear of losing their health care coverage. Not only have Senator KASSEBAUM, other members of her committee, and their staffs labored many long hours to draft the bill, they have also successfully built a strong coalition of support. Thanks to Senator KASSEBAUM and Senator KENNEDY this bill is supported by big business, small business, a wide array of advocacy groups, many insurance companies, and many Americans.

While I do think the Kassebaum-Kennedy bill could be improved, I think it is a critical step forward. At a later time, I will join the majority leader in offering an amendment which makes health insurance more affordable.

The Kassebaum-Kennedy health insurance reform bill has an important focus. The bill will assist people who want and need to make necessary and correct decisions about their health care needs—people who work, people who join their group health care plans and have paid their premiums continuously for no less than 12 months. The bill eliminates ''job-lock'' for workers who fear they will lose their health coverage when they change jobs, and the bill eliminates the fear of losing coverage for individuals who have maintained their group coverage and have a preexisting condition.

Recently my office was contacted by a lady who has always been insured and paid her premiums. Yet she finds herself today in a situation where she is unable to obtain health care coverage because of a preexisting condition. Nancy Miller is 56 years old, after a divorce from a 27-year marriage, she was allowed access to continued group health coverage through her former spouse's employer plan at the group premium rate for 3 years. Mrs. Miller's 36 month COBRA coverage expires at the end of May. To make sure she will not have a gap in health coverage, Mrs. Miller has worked with her current insurer, called many other insurers, contacted our office, worked with an insurance broker and yet she has been rejected from every health plan she has

applied to. Mrs. Miller has a preexisting condition. She can not get health care coverage because she contracted breast cancer 2 years ago.

Mrs. Miller's situation could apply to anyone, because anyone could get sick. Mrs. Miller has not gamed the system seeking insurance only when she needed it. For years she was healthy, and for her entire life she has been insured. The letter Mrs. Miller's insurance broker recently wrote her could be a letter received by many women. The following is the letter she received from her broker:

> This letter is to inform you that we have contacted all of our standard individual health insurance carriers and are unable to find one that is capable of writing a policy for you because of your pre-existing condition. We have been advised by all of the carriers that they will not consider you for insurance until you are 5 years out from your time of release from the doctor.

The Kassebaum-Kennedy bill will provide assurances to responsible Americans. In particular, the bill provides portability in two settings: When individuals change from one group health plan to another group health plan (group to group), and when individuals leave their group health plan and seek coverage as an individual policyholder in the market (group to individual).

For group to group portability, the bill establishes uniform Federal standards for insurers, health maintenance organizations [HMO's], and employers who self-fund their health plan. There is a broad consensus that these measures should be enacted, and a very broad coalition of business as well as the insurance industry and advocacy groups support these provisions. There is a need to establish uniform Federal standards for the group to group portability measures as the bulk of employer sponsored health coverage is self-funded and exempt from State regulation. Under the Employee Retirement Income Security Act [ERISA], the Federal Government regulates private self-funded employer plans. ERISA prohibits States from regulating employer sponsored self-insured plans. Therefore, States cannot achieve all the reforms needed to assure portability when workers change jobs because the Federal ERISA law prohibits States from regulating any group health plan which is self-funded.

For those individuals leaving their group health care coverage and seeking coverage in the individual market, the bill provides access to coverage to individuals. The bill also provides States with important flexibility to meet the goals of this section of the bill. While there have been concerns raised regarding the bill's provision to guarantee that insurers make health coverage available to individuals, I think this section is important if we are to truly guarantee portability and access to coverage. States currently regulate insurance provided to individuals who are not in a group plan. The Federal role in this area of the marketplace has been minimal; therefore I agree with the bill's goal to retain a strong state role in the individual market. This section of the bill provides the needed flexibility for States to be creative.

It's important to note that the bill builds on responsible behavior because it requires that individuals have previous continued group health care coverage in order to qualify for the portability provisions. This is the case with Mrs. Miller who responsibly maintained her group coverage.

The pending bill provides that health plans can not impose preexisting condition limits on individuals who had prior group coverage. In fact no preexisting condition limits can be imposed on individuals who join a group health plan if they had continuous group health coverage for the previous 12 months. For individuals leaving a group plan, they must have had 18 months of continuous coverage in order to qualify for an individual policy without any preexisting condition limits. In either case, if individuals have less than the required months of coverage, their new plan would have to credit them for the time that they were covered.

Most Americans with private health insurance receive their coverage through their employers, and the majority of the uninsured are also tied to the workplace. The Kassebaum-Kennedy bill will strengthen the employer-based health care system we now have, and it will help responsible Americans like Mrs. Miller retain their coverage. In fact, the General Accounting Office estimates that as many as 21 to 25 million people per year could be affected by Federal portability standards in all markets. This is a good first step.

Mr. KOHL. Mr. President, I rise as an enthusiastic cosponsor of the Health Insurance Reform Act of 1995 and call on my colleagues to keep this straightforward measure clear of legislative land mines.

Passing this bill will help address a problem all too common in our health care system—the fact that people can lose their insurance coverage when they get sick even if they have paid their premiums.

Mr. President, there are a number of bipartisan initiatives that can and should be passed before we adjourn this fall. Chief among these proposals is this Health Insurance Reform Act.

Under the strong bipartisan leadership of Chairman KASSEBAUM and Senator KENNEDY, the bill unanimously passed the Labor and Human Resources Committee 8 months ago. It has since languished in the confounding waste zone between full Committee endorsement and Senate floor action because some are opposed to even narrow health reform.

Last Congress the American people called for comprehensive health reform. Unfortunately, consensus could not be reached on a single plan. Instead, the country watched in disappointment as a golden opportunity for health reform fizzled out. Partisan fights and interest group influence won the day.

It will serve no good purpose to rehash the health reform battles of the past. We now have the opportunity to move beyond party squabbling. Congress can clearly demonstrate the will to enact a bipartisan health reform bill. Or we can choose to remain gridlocked and at the mercy of special interests. I believe that choice is an easy one.

Fortunately, there still is a broad consensus in this country in favor of health insurance reform. Americans want to know that they won't lose coverage if they or someone in their family gets sick. Individuals and businesses want the ability to pool resources to get the best insurance coverage possible at an affordable price.

The Health Insurance Reform Act does not seek to change our Nation's health care structure drastically. Instead, it takes a careful approach to remedy widely acknowledged problems in the health insurance market. For the first time, preexisting condition exclusions would be limited, health coverage availability and renewability would be guaranteed, and small business group purchasing would be easier. At the same time, State flexibility would be maintained.

Many States have taken the initiative and made notable progress by enacting market-related reforms. But States are unable to achieve the most effective reforms because some businesses have federally protected self-insured health plans. This bill provides continuity by applying the same standards to all employment-based plans.

The bill is also notable for what it does not do. It won't require employer mandates, limit provider choice, set up new bureaucratic health structures, or create a global health spending budget.

Many strongly believe that health care reform should go farther than this bill. In fact, many Senators, including myself, worked hard last Congress on comprehensive measures to control health costs and expand health coverage. But those efforts turned out too complex to retain broad support.

We now have a more narrow consensus measure that can pass. Yet some Senators may offer a whole host of amendments to address special concerns. A few of these are popular, others problemmatic. The sponsors of this bill have taken careful steps to ensure that the bill is narrow and bipartisan. It should remain that way. For that reason, I too will oppose controversial, special interest amendments.

As we learned from previous attempts at reform, a consensus bill may be the only way we can pass health reform this year. I urge my colleagues to refrain from condemning this bill under a weight of controversial additions.

Nonetheless, we should not hold out on improvements if they are bipartisan and avoid endangering final passage.

As a long-time supporter of health care fraud and abuse legislation, I believe it is imperative that we act to tackle rampant abuse. If strong anti-fraud provisions, such as those included in Senator COHEN's anti-fraud bill, can be added without stalling the bill, they most certainly should. Similarly, provisions helping the self-employed afford insurance and incentives for long-term care may be possible.

However, there are other compelling issues that, if attached to the Health Insurance Reform Act, may kill this bill. We should not ingore those issues. They can and should be taken up at a later date.

Mr. President, if we keep this bill clean, we will take a huge step toward addressing compelling insurance problems facing the Nation. In the process, Congress will prove that it can act in a bipartisan fashion to help hard working Americans.

There are over 40 million people without health insurance in our country. I am proud to say that Wisconsin has one of the lowest numbers of uninsured people. However, there are still too many Wisconsinites without health coverage and still too many who fear losing their coverage.

The Health Insurance Reform Act will not solve all of the problems plaguing our health care system, but it does fill a huge gap by solving job lock. Workers will no longer have to live with the fear that if they change their jobs, they may lose their health coverage.

No doubt, there is special interest opposition to this bill. It is a rare legislative initiative that doesn't have critics. But this bill is a positive first step.

The Health Insurance Reform Act does not provide a handout to the public. No one gets a free ride at the expense of insurance companies. People must maintain their payments for a full year-and-a-half before qualifying for coverage guarantees. They also must be ineligible for another group policy and exhaust their COBRA benefits. Finally, people will still have to pay the rates charged by insurance companies. These requirements were added to minimize affects on insurance premiums. However, it is important to note that States would not be prevented from going further on insurance reform.

Mr. President, you cannot satisfy everyone, but this bill comes close. While there are opponents and critics on both sides, a large majority of Americans support passage.

If Senators need more impetus to allow this bill to go forward, the General Accounting Office estimates that passing the Health Insurance Reform Act will help 25 million Americans each year obtain or retain health coverage. That evidence alone is a compelling reason to pass a clean bill.

Mr. President, Americans have had little proof this session that Congress can act to help solve problems plaguing their families. Let's give them one good reason to have greater confidence in their elected officials and this institution. We should get the job done and pass the Health Insurance Reform Act now.

Mr. BAUCUS. Mr. President, I rise in support of this bill. I am very pleased to see that today, Congress is putting aside its petty divisions and rivalries to work together on a bill that will help people. Today, when the Senate votes on the Health Insurance Reform Act, we show our support for a bipartisan effort that will address the health needs of millions of Americans and thousands of Montanans.

RECORD OF THE CONGRESS

That is a truly important step forward for this Congress, and not only on health policy. At the beginning of 1995, a lot of Montanans had high hopes for this Congress.

But those hopes have vanished in the mess of bumbling revolutionary experiments and government shutdowns which the leadership, particularly in the House has created.

Rather than make people a little more prosperous and secure, the Congress seems to have deliberately done just the opposite. It has gone from closing Yellowstone and Glacier, to a proposal to let Medicare wither on the vine, to bills that would set up a Commission on closing National Parks and dump all the public lands on the States.

The fact is, the 104th Congress has let our state down pretty badly. All too often, rather than do something good and positive for the people, it has done something irrational and destructive.

A SECOND CHANCE

But this health insurance reform is a second chance for the Congress. A sign that with some more maturity and experience, we can accomplish something good.

This bill, taken as a whole, means some more security and stability for hard-working people.

It means that if you lose your job, you won't also face the loss of your health insurance and the constant threat of lifelong debt in the case of an accident.

It means that if you own a small business, you will have more ability to buy insurance for yourselves, your family and your employees.

And it means you can upgrade your skills and change your job without being denied insurance due to health troubles.

BELINDA BYRD

Look at the case of Belinda Byrd from Great Falls, Montana.

She wrote to me last year to explain her case and that of her sister. Belinda suffers from hydrocephalus, or ''water on the brain,'' and she is about to undergo her fourth brain surgery.

She is fortunate enough to receive coverage through the Government Champus program. But she wrote to me about the problem with pre-existing conditions because of the problems her sister is having getting health insurance. Belinda's sister has the same condition and can not get affordable health insurance because of her health problem.

MONTANA AND HEALTH INSURANCE

Mr. President, that is wrong. We should not tolerate it even in one case. And the sad fact is that it is not just one case. Thousands of Montanans, and millions of Americans, have concerns just about as grave as those of the Byrd sisters.

As I have walked across the State in the past 2 years, a few subjects come up everywhere. In towns, on ranches, at small businesses, and in roadside coffee shops. The need to raise the minimum wage. The low cattle prices. And the fear of losing health insurance.

For individuals, today's bill will make a big difference. It will let self-employed people deduct most of their health insurance costs. Big businesses can already do this. Folks who are self-employed and buy their own health insurance out of pocket should be able to deduct it too. That is basic fairness and decency. With this reform, we raise the deduction from today's 30 percent of insurance costs to 80 percent. It is not all the way to 100 percent, but it is a very big step forward.

For farmers, ranchers, and small business owners, health insurance will be available and more affordable. We may have to do more down the line, but we are making a good start here.

And for people like the Byrd sisters who have pre-existing health conditions, this means justice and security. No longer will having an illness, no matter how treatable it is, mean going without affordable health insurance.

MEDICARE FRAUD AND ABUSE

Finally, we take some initial steps to fight health care fraud and abuse, particularly in Medicare and Medicaid. Today, anywhere from 5 percent to 10 percent of our Nation's entire trillion dollar health care bill goes to fraud. We need to step up our Federal efforts to fight this problem and I support efforts to do so.

However, I would caution that the savings we get from fighting fraud and abuse in Medicare or Medicaid must go to guarantee solvency for these essential programs. It should not pay for new tax breaks as last year's Medicare cuts would have done, nor to pay for untested ideas like Medical Savings Accounts.

CONCLUSION

Mr. President, I am very happy to be here supporting this bill. It is a sign that Congress is getting the message. Moving away from partisanship and revolutionary experiments. And moving toward practical, effective steps that makes life better and more secure for Montanans and all Americans.

I appreciate the work of the Labor Committee Chair, Senator NANCY KASSEBAUM and her counterpart, Senator TED KENNEDY. They have done this country a great service with their

work on crafting this bill and moving it through the legislative process. I hope it will get the Senate's support.

Mr. BRADLEY. Mr. President, I am very pleased to lend my strong support to the Kennedy-Kassebaum health insurance reform bill. At long last, we are actually moving forward on the basic reforms that will make health insurance once again serve the function of insuring and protecting American families against devastating illness or injury.

The problem of health insurance is right at the center of the economic insecurity gripping American families. The 40 million or so people who have no insurance live in fear that a headache or stomach-ache will turn out to be a costly illness. But other workers, who have health insurance, are hardly blessed with security and comfort. As the American economy changes, they know that they can lose their jobs at any moment, with no certainty of being able to find new insurance, or if they do find new insurance, it might not cover the one medical concern that is most likely to become a problem.

We have lost the idea of health insurance as real insurance, in which we all pay premiums to spread our own risks over a lifetime, and to share risks across a larger number of people. Instead, health insurance has increasingly become a short-term privilege, that comes and goes with the job, that only comes with certain kinds of jobs, and that comes with exceptions and uncertainties. When you combine that with the increasing insecurity about jobs, working families can't afford the risk. People are trapped in jobs just to keep their insurance, rather than moving on to find the job that would better use their skills, or setting out as an entrepreneur, as many dream of doing.

This bill would restore the original concept of insurance to health care. It would allow workers to change jobs without putting insurance coverage at risk, to move from group to individual plans, and to buy insurance despite a preexisting condition. It will help small businesses afford insurance, and help people who want to start their own businesses to do so without worrying about the arbitrary nature of health insurance. It will help only some of the 40 million without insurance to become insured, but it will prevent that number from continuing to increase.

Mr. President, I hope that after this legislation becomes law, we will not stop here but continue to closely watch the health insurance market and make whatever further changes need to be made to keep the focus on health and security. The first such change, which I hope will occur by Mother's Day, and perhaps even before this bill gets through conference, is to end the practice of insurance companies forcing new mothers and their infants out of the hospital within a few hours, even against the best judgment of the mother's doctor. In general, I am concerned that this bill, because it is so narrowly targeted at certain insurance practices, could have unintended consequences. I hope that if rates do increase sharply, or if insurers cut back certain areas of business, Congress should be willing to look at slightly broader solutions that would address the health care crisis without unintended consequences.

I am generally confident, however, that this legislation will serve the purpose of protecting American families from the double risk of economic and health insecurity. I hope action will be completed quickly so that the President can implement these reforms without delay.

Mrs. FEINSTEIN. Mr. President, I rise to support the Kennedy-Kassebaum legislation on health insurance reform. This legislation, while not the comprehensive health care reform called for earlier, takes an important and long overdue step in addressing the insecurity many Americans feel about their health insurance.

Americans expect their insurance to be there when they need it. That is why we buy it. And yet many Americans find that, just when they need their health insurance, it is not there, or they are denied coverage, or they can't afford the policy premiums.

This bill provides a measure of health security in a number of ways.

No arbitrary, discriminatory terminations: This bill protects employers from having their policy terminated if their employees incur large medical costs. Insurers could not impose preexisting condition limitations for more than 12 months. This means that employees could change jobs without fear of losing their insurance.

Guaranteed access: Under this bill, insurers are required to offer insurance to all groups, regardless of the health status of any member of the group.

Nongroup coverage guaranteed: It protects people who leave their job from losing access to coverage. People who have had 18 months of prior employer group coverage and have exhausted their extended coverage—through COBRA—would be guaranteed access to an individual policy.

Enlarging small groups: The bill creates incentives for small employers to form cooperatives to strengthen their bargaining power with insurance companies.

Need for the bill: The need for insurance reform is very real:

Over 41 million Americans have no insurance. That is a 4-million increase since 1993;

In California, almost 23 percent of the population is uninsured—7.4 million people. And two-thirds of these uninsured people are under the age of 34;

Twenty-three million Americans lose their insurance every year;

Eighteen million people change insurance policies annually when someone in their family changes jobs;

Employer sponsored insurance is declining, going from 61 percent of employed workers in 1986 to 54 percent in 1996;

In California, it's even worse with only about 50 percent of people covered by employer sponsored insurance in 1994; and

With California's unemployment remaining above 7 percent for the last 5 years—employer sponsored insurance is getting more scarce.

Preexisting conditions: The problem of people being denied insurance because of preexisting health conditions is one of the most serious concerns people have today about their health care.

As a matter of fact, 81 million Americans have preexisting health conditions that could affect their health insurance;

Over 9 million Americans changed jobs in 1995; and

Millions more want to change jobs. The GAO estimates that as many as 4 million employees are ''locked into'' their jobs because they fear that the insurer for the next employer would refuse to insure them because of a preexisting health condition.

Take cancer as an example:

Over 1 million people are diagnosed with cancer each year. Over 10 million Americans alive today have a history of cancer.

About 184,300 new cases of breast cancer will be diagnosed this year—the most common form of cancer among women. And, 44,300 will die of breast cancer this year.

We probably all have some condition. And yet most policies sold to individuals, and over half of all plans provided by employers, deny coverage for some period of time for the conditions most likely to require insurance.

This bill addresses this serious problem by prohibiting insurers from imposing preexisting conditions for more than 12 months.

The Problem for Small Employers: Small employers acting alone often lack the leverage to negotiate good prices and benefits that large employers can get. More than half of all uninsured employees work in small firms.

Administrative costs are higher for small groups. One survey shows that health costs for large employers declined 1.9 percent in 1994, while small employers had an increase of 6.5 percent.

This bill creates incentives for small employers to form cooperatives to strengthen their bargaining power with insurance companies.

This approach can work. In 1993, California formed a health insurance purchasing cooperative for small businesses; 2,500 small businesses joined.

One year after formation, rates were 10 percent to 15 percent lower than conventional insurance plans.

Individuals: Finally, there are 10 to 20 million individual Americans seeking to buy insurance on their own. These people, who are not part of a large pool where risk can be offset, often find themselves excluded or unable to afford the premiums.

Genetic discrimination: I especially appreciate the agreement of Senators KASSEBAUM and KENNEDY to include in the managers' amendment provisions barring genetic discrimination by employer-based plans.

The language included in this bill is similar to S. 1600, a bill I introduced with Senator MACK, to prohibit health insurers from denying health coverage based on genetic information of the insured or applicant for insurance

Last fall, as co-chairs of the Senate Cancer Coalition, Senator MACK and I held a hearing on the status and use of genetic tests. Witnesses testified about the great promise of genetic testing in predicting and managing a range of diseases, but they also cautioned about the potential for discrimination.

In the past 5 years, there has been a virtual explosion of knowledge about genes. Scientists are decoding the basic units of heredity.

We know that certain diseases have genetic links, including cancer, Alzheimer's disease, Huntington's disease, cystic fibrosis, and Lou Gehrig's disease. Altered genes play a part in heart disease, diabetes, and may other more common diseases.

These advances pose some potential problems. Witness after witness at our hearing discussed the potential and the reality of health insurance discrimination based on genetic information.

They recounted actual cases where insurers denied or refused to renew coverage based on genetic information. This type of discrimination could have a catastrophic impact if it is not addressed:

About 15 million people are affected by one or more of the over 4,000 currently identified genetic disorders; genetic disorders account for one-fifth of all adult hospital occupancy, two-thirds of childhood hospital occupancy, one-third of pregnancy loss and one-third of mental retardation; and an even larger number of people are carriers of genetic disease. The June, 1994 issue of Scientific American estimated that every person has between 5 and 10 defective genes though they often are not manifested.

Insurance companies are poised to discriminate:

In a 1992 study, the Office of Technology Assessment found that 17 of 29 insurers would not sell insurance to individuals when presymptomatic testing revealed the likelihood of a serious, chronic future disease.

Fifteen of the thirty-seven commercial insurers that cover groups said that they would decline an applicant; and

Underwriters at 11 of 25 Blue Cross-Blue Shield plans said they would turn down an applicant if presymptomatic testing revealed the likelihood of disease.

The study also found that insurers price plans higher—or even out of reach—based on genetic information.

Another study conducted by Dr. Paul Billings at the California Pacific Medical Center, reached similar conclusions.

Here are a few examples of real-life cases:

An individual with hereditary hemochromatosis—excessive iron—who runs 10K races regularly, but who had no symptoms of the disease, could not get insurance because of the disease.

An 8-year-old girl was diagnosed at 14 days of age with PKU—phenylketonuria—a rare inherited disease, which if left untreated, leads to retardation. Most States require testing for this disease at birth. Her growth and development proceeded normally and she was healthy. She was insured on her father's employment-based policy, but when he changed jobs, the insurer at the new job told him that his daughter was considered to be a high risk patient and ''uninsurable.''

The mother of an elementary school student had her son tested for a learning disability. The tests revealed that the son had Fragile X Syndrome, an inherited form of mental retardation. Her insurer dropped her son's coverage.

After searching unsuccessfully for a company that would be willing to insure her son, the mother quit her job so she could impoverish herself and become eligible for Medicaid as insurance for her son.

Another man worked as a financial officer for a large national company. His son had a genetic condition which left him severely disabled.

The father was tested and found to be an asymptomatic carrier of the gene which caused his son's illness. His wife and other sons were healthy.

His insurer initially disputed claims filed for the son's care, then paid them, but then refused to renew the employer's group coverage. The company then offered two plans. All employees except this father were offered a choice of the two. He was allowed only the managed care plan.

A woman was denied health insurance because her nephew had been diagnosed as having cystic fibrosis and she was found to carry the gene that causes the disease. The insurer told her that neither she nor any children she might have would be covered unless her husband was determined not to carry the CF gene.

These are real horror stories.

If people with genetic conditions or predispositions cannot buy health insurance on the private market, they usually have nowhere to turn. To qualify for Medicaid, the primary public health insurance program for the nonelderly, families have to ''spend down'' or impoverish themselves.

Fear of discrimination can also have adverse health effects. If people fear retaliation by their insurer, they may be less likely to provide their physician with full information. They may be reluctant to be tested. This means that physicians might not have all the information they need to make a solid diagnosis or decide a course of treatment.

This bill can help make health insurance available to many who need it and who want to buy it. It can bring peace of mind to millions of Americans. It can restore insurance to what insurance is supposed to be.

I hope my colleagues will join me today in voting for this important bill.

Ms. SNOWE. Mr. President, I rise in support of The Health Insurance Reform Act of 1995, and would like to thank the Chairwoman of the Labor and Human Resources Committee, Senator KASSEBAUM, for bringing this common sense health care reform bill to the floor. Her knowledge and efforts in the area of health care have made progress on this issue possible, and her ability to craft consensus on this complex issue deserves enormous praise from both sides of the aisle.

I would also like to compliment the ranking Member, Senator KENNEDY, and the rest of my colleagues who serve on the Labor and Human Resources Committee—the strong bipartisan vote that brought this bill out of Committee restores my hope that bipartisanship is not completely lost in this Chamber.

It has been interesting to me, having ''survived'' the health care wars of the last Congress, to read some of the things that have been written about this bill. Talk about role reversal—you now have some members on this side of the aisle complaining that S. 1028 does not go far enough, and we have members on the other side of the aisle complaining that the bill isn't small enough. What a difference a year makes!

But one thing that has not changed is the fact that the American people continue to demand changes in the health care system. This bill, while not as large or as complex as the changes we considered in 1994, would provide security to millions of Americans—25 million according to the General Accounting Office. It would reassure them that their health care coverage could not be taken from them if they changed jobs, if they became pregnant, if their family situation changed, or if they lost their jobs.

It does not solve all our Nation's health care problems—but we tried the complicated, complex, approach with a more than 1,000 page bill in 1994 and we got nowhere. So what is wrong with taking a step in the right direction? It doesn't mean that this is the only change that Congress can or should make.

It is said that every journey begins with a single step. So let us consider the Kassebaum-Kennedy bill before us today as Congress' first step on the road to overhauling our health care reform system so that all Americans will have access to affordable, quality health care by the provider of their choice that can never be taken away.

The Health Insurance Reform Act of 1995 will achieve part of that shared goal by ensuring access to health care that can not be taken away. It will ensure that workers who are offered a

new job opportunity with a different company will be able to accept it—instead of turning it down because they are afraid that a pre-existing condition will prevent them from obtaining health care coverage at their new firm.

It will ensure that workers who lose their job and have had insurance coverage for the last 18 months will be able to obtain an individual policy. They will still have a lot to worry about—but at least they will know that they can obtain insurance for their family.

And it will ensure that small businesses will no longer find themselves dropped from the insurance roles because one of their workers has medical problems.

Every Senator—every Member of Congress—has received letters or spoken with individuals who have been denied coverage or had their coverage—or their firm's coverage—dropped because of a preexisting condition. Yet these are the people who need the coverage most. It is estimated that 81 million Americans suffer from a preexisting medical condition that endangers their access to health care coverage. This bill will provide them that protection.

The Kassebaum-Kennedy bill restricts health insurance exclusions on preexisting conditions by prohibiting insurers and employers from limiting or denying coverage under group plans for more than 12 months for a medical condition that was diagnosed or treated during the previous 6 months. For example, if an individual had been covered under another employer's plan for 8 months, they would only have to work for 4 months in their new job before being covered.

The bill also prevents group health plans from excluding any employee from coverage based on health status and requires insurers to renew coverage for both groups and individuals as long as the premiums were paid.

Once an individual had been covered for 12 months, no new pre-existing condition could ever be imposed, even if they changed jobs or insurance plans.

The bill also will help make health care coverage more affordable for America's small businesses by lifting barriers to the formation of private, voluntary coalitions to purchase health insurance. For states like Maine, where small businesses are the backbone of our economy, this provision will be particularly helpful. Banding together to obtain health insurance coverage will give our small businesses the ability to spread the risk among a larger population and to use their negotiation power to get quality coverage at the best price. This bill will give employers and employees the ability to obtain quality coverage at a competitive price.

The Health Insurance Reform Act of 1995 is a commonsense approach to a serious problem in this country—access to affordable, quality health care that can never be taken away. It is not the complete answer to our health care problems, but it is a big step in the right direction and will help millions of Americans retain their health care coverage.

I would like to address one of the arguments being made against this bill. Opponents of reform have argued that while the bill ensures access, the practical problem will be that the cost of premiums will soar, making coverage unaffordable for many. The American Academy of Actuaries, however, has estimated that any premium increases would be quite small, ranging between 2 and 5 percent. In fact, this potential increase is lower than the increases we have seen in recent years: over the last 10 years the average rate paid for individual insurance premiums has increased between 8 and 15 percent annually.

And in my own State of Maine, which has had a law on the books guaranteeing issue for employers with fewer than 25 employees since 1992 and guaranteed issue for individuals since 1993, these changes have not resulted in premium increases that are outside the bounds of the normal increases in the cost of health care coverage.

By passing this bill we will be renewing our commitment to the American public that we have heard and have understood their demand that we act on health care reform. It will provide security for millions of Americans who currently fear losing their health care coverage, and will provide access to more affordable coverage for our small businesses as they band together to enhance their purchasing power. Passage of this bill will leave us with a long road ahead of us to address the outstanding issues of health care reform, but at least we will finally be on the road.

I urge my colleagues to join me in supporting passage of this bill and I yield the floor.

Mr. CONRAD. Mr. President, I want to express my strong support for S. 1028, the Health Insurance Reform Act.

Over the past several years, access to health care has been one of the most important issues facing Americans. Far too many Americans—over 40 million this year—are uninsured, and an equal number are affected each year by preexisting condition exclusions and the job lock that results when workers fear that they will lose all or part of their insurance if they change jobs.

Two year ago, I and many of my colleagues spent countless hours trying to find a compromise health care reform bill that would ensure access to health insurance and health care, maintain choice and quality for consumers, and control the skyrocketing growth in health care costs. Given the importance of this effort to millions of Americans, I was disappointed that our effort to find a moderate solution to these issues was blocked.

The bill before us today takes a modest step in the right direction. It attacks the most egregious barriers to health insurance: the use of preexisting condition exclusions to deny coverage to those who most need health insurance, and the lack of portability when workers change jobs. Addressing these issues will guarantee access to health insurance for an estimated 25 million Americans who would otherwise be subject to these barriers.

However, it is important to remember that, although this is an extremely important step, it is only a first step. It guarantees access to health insurance, but it does not guarantee that the available insurance will be affordable. And, as a representative of a rural State, I wish this bill improved access to health care services in medically underserved areas. Thus, when we complete the first step by enacting this bill, our health insurance reform journey will not be complete. There is lots of room for further progress in making health care available and affordable.

Mr. President, with that caveat, let me explain why this bill is so important. Today, millions of Americans are denied insurance because they or someone in their family have so-called preexisting conditions. This means the family of a child born with a heart murmur can't find insurance because no insurance company wants to take the risk of covering the costs of treating this heart condition. And it means that someone who has paid insurance premiums through an employer-sponsored plan but then leaves that job because she needs a major medical procedure—for example, an organ transplant—may not be able to get insurance when she tries to return to the workplace. That's just wrong. No one should be forced to stay in a job she hates because she fears she will lose her health insurance if she tries to change jobs. And no one who has paid insurance premiums faithfully for years should lose his insurance because he becomes sick and an insurance company refuses to renew his employer's policy.

This bill fixes these problems. It strictly limits preexisting condition exclusions when a person or a family applies for health insurance for the first time. It prohibits any preexisting condition exclusions for people who have faithfully paid their insurance premiums for at least 18 months and then need to get new insurance because they change jobs or lose their jobs. This means that people who change jobs can rest assured that their new insurance policy will fully cover them.

The bill also requires insurance companies to provide coverage to any employer with two or more employees. This keeps insurance companies from denying insurance to certain types of business just because the company thinks the employees are likely to get sick. It prevents the cancellation of coverage for a company just because one of its employees has gotten sick and incurred large medical costs. And it allows small businesses and other groups to band together in voluntary cooperatives to bargain as a larger

group for lower premiums and better coverage.

Finally, the bill requires individual insurance companies to provide coverage to individuals who lose their job or become self-employed and exhaust their conversion coverage under COBRA. Coming from a State with large numbers of self-employed farmers and other small business men and women, I am keenly aware of the fragility of the individual insurance market. Average premiums in this market are much higher than in the group insurance markets because of adverse selection.

Although critics of this so-called group-to-individual portability provision greatly exaggerate its likely effect on this market, their arguments are not groundless. This provision will result in more sick people entering the individual market. In order to prevent this from greatly increasing premiums for those who are already in this market, I hope States will proceed very carefully in applying rating restrictions that could inadvertently worsen the adverse selection inherent in this market. I am encouraged that the bill gives States great flexibility in designing their own approaches to meet the goals of this legislation. This allows them to develop innovative solutions tailored to the special needs of their population while ensuring that workers still have access to affordable health insurance without unreasonable preexisting condition exclusions.

Mr. President, this legislation takes a major step forward in reforming the private insurance market. It removes the biggest barriers to health insurance and will enable Americans to change jobs freely without fear of losing all or part of their insurance coverage. I urge my colleagues to reject the controversial special-interest provisions added in the House that threaten to kill this important effort, and to instead pass a bill that commands broad bipartisan support.

Mr. CAMPBELL. Mr. President, I take this opportunity to support the health insurance reform bill, offered by Senators KASSEBAUM and KENNEDY. I am pleased to be a cosponsor of this legislation.

Reforming our Nation's health care system has been a concern for many Americans. I believe the bill before us today, although limited to the health insurance industry, is a significant step toward addressing some of the issues we face with health insurance—cost, portability, and preexisting conditions. Although this legislation will not fix all of our health care problems, I think we all need to recognize that it does make some progress toward addressing these issues.

Currently, reports indicate there are an estimated 40 million uninsured Americans. This, in and of itself, highlights one of the biggest problems within the health care industry—the availability of affordable, flexible insurance policies.

All too often, people are forced into a situation where they feel they must remain in a job they would rather leave just because they have long-term health care needs and have no other source for insurance other than through their employer. This ''job lock,'' coupled with skyrocketing health care costs, makes the prospect of paying for your own medical costs without insurance, a frightening, and financially crippling situation. People simply can't afford to take this risk.

Over the past few years, my home State of Colorado has taken a very progressive approach in dealing with the issues of health insurance portability and preexisting conditions and has worked cooperatively with the health insurance industry to develop what everyone seems to recognize as a positive step forward. I have often had constituents tell me how surprised they are to learn how little other States have done in the area of health insurance reform. The Colorado State legislature was instrumental in making this law, and in conjunction with employers, have forged a partnership that seeks to cover as many Coloradans as possible in the most cost-effective manner. In fact, many of the safeguards and reforms already instituted within the State of Colorado are very similar to the Kassebaum, Kennedy bill. Currently, there are roughly 20 States that don't have this kind of insurance protection, and I believe that through this bill, we can cooperatively work to mirror at the Federal level some of the provisions the State of Colorado already enjoys.

I feel this bill will establish a much-needed standard for the health insurance industry and will work toward achieving the goal that all Americans have access to more cost-effective and affordable insurance. I don't believe anyone can deny the need for this.

Mr. President, I yield the floor.●

Mr. SARBANES. Mr. President, I rise today to express my support for S. 1028, The Health Insurance Reform Act of 1995. While S. 1028 is not the comprehensive reform of our health system which would be necessary to guarantee quality health care for all Americans, it does make important strides in reducing the barriers to coverage for over 25 million people in this Nation.

The legislation before us today, S. 1028, would attempt to make modest incremental reforms in the health insurance market by addressing only those provisions upon which there is broad bipartisan agreement. In fact, the President and over 65 of my Senate colleagues are in agreement, supporting this legislation which would have an immediate impact on the lives of over 25 million people.

For these Americans who are unable to change jobs, who cannot leave their jobs to start a new business, or who lose their jobs, S. 1028 would provide an assurance of continued access to health insurance coverage. It would end the incidence of job lock in this country by limiting the ability of health insurers to deny coverage for people with preexisting medical conditions. Once an initial exclusion period of no longer than 12 months was exhausted no preexisting condition exclusion could ever be applied to a policy holder again. It would also guarantee that a group or individual who purchased an insurance policy and faithfully paid their premiums, could never have their coverage taken away from them or canceled.

Mr. President, the health care debate is one that goes to the heart of the quality of life of all Americans. Access to quality health care is a fundamental human need and is in my view a fundamental right in a democratic society. Our challenge is to achieve a situation in which every American has access to affordable, quality health care. While there is much more that I would like to do to ensure that each and every American is guaranteed the same high quality comprehensive care, the bill before us today makes important steps toward accomplishing this goal and improving the lives of over 25 million Americans and I urge its immediate passage.

The PRESIDING OFFICER (Ms. SNOWE). The Senate majority leader.

Mr. DOLE. Madam President, I think we have partial agreement here so we can move ahead. I want to associate myself with most of the remarks, probably all of the remarks made by my colleague from Texas. We do not want to have to refight that battle again. I think he raised some excellent points. I hope in part they have been addressed in the so-called Dole-Roth amendment, that I think does improve this bill substantially.

But I ask unanimous consent that during the consideration of S. 1028, the health insurance reform bill, and following opening statements and adoption of the managers' amendment as original text, the majority leader or his designee be recognized to offer his amendment concerning tax provisions and medical savings accounts.

I further ask that during the pendency of the Dole amendment, Senator KASSEBAUM be authorized to move to strike the medical savings account provision, there be 2 hours equally divided in the usual form on the motion to strike, and that no amendments be in order to the Dole amendment or the language proposed be stricken prior to the vote on or in relation to the motion to strike.

The PRESIDING OFFICER. Is there objection?

Several Senators addressed the Chair.

Mrs. KASSEBAUM. Reserving the right to object, I would just like to ask the majority leader, when we first discussed this we had 2 hours equally divided. So much time elapsed since then, I suggest that we would like to have the vote no later than 3:45, and time then be equally divided until that time because we have already eaten up

so much. It had been my hope we could get through to some other amendments as well, since we had some considerable time, and still will, on discussing the provisions of the Finance Committee package. If that would be agreeable?

Mr. DOLE. Obviously, I would have no objection to that. I will modify the request to say the vote occur not later than 3:45 p.m., and that any time between the time we start the debate on that motion and 3:45 p.m. be equally divided.

Mr. GORTON. Madam President, reserving right to object.

The PRESIDING OFFICER. The Senator from Washington.

Mr. GORTON. Madam President, the Senator from Washington would like a clarification. I have just presented a small technical amendment to the Dole amendment to the chairman of the Finance Committee. I want that amendment to be in order.

If the understanding is that second-degree amendments would be in order if the Dole amendment is not tabled or rejected, then I will have no objection. I just want to make certain that before the Dole amendment is adopted that it is itself subject to amendment. Is that correct? Under the unanimous-consent request?

Mr. DOLE. That will be—let me just proceed with the request.

Mr. GORTON. I just want clarification my amendment will be in order some time before the adoption of the Dole amendment.

Mr. DOLE. Is it an amendment to the Dole amendment or a separate amendment?

Mr. GORTON. An amendment to the Dole amendment.

Mr. DOLE. I think the way it is going to work, it would be in order. Because I would hope to have, if the motion to strike fails, we would then get on the Dole amendment. But I could not get that agreement, so the answer would be yes.

Mr. GORTON. I have no objection.

Mrs. BOXER. Madam President, I think this could be accommodated easily. I have been waiting just to make a 3-minute statement on the overall bill. I greatly would appreciate having that opportunity before we get into the debate on the medical savings account.

Mr. DOLE. I will be happy to accommodate the Senator from California.

Mrs. BOXER. I thank the majority leader.

The PRESIDING OFFICER. Is there any objection? Without objection, it is so ordered.

Mr. DOLE. The vote will occur then. Also following that vote the Senator from North Dakota would like 15 minutes in a general statement. Prior to discussion, then, the Senator from California would have 3 minutes.

I also ask, if the Kassebaum motion to strike is agreed to, then the Dole amendment be immediately modified to reflect that chapters 2 and 3 of subtitle (f) of title IV be withdrawn.

Let me explain what that is.

In other words, they were ''pay-fors,'' and if the MSA's were stricken we will take those ''pay-fors'' out of the bill. I think it has been cleared by both Senator KASSEBAUM and Senator KENNEDY.

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

Mr. DOLE. I will send the amendment to the desk on behalf of myself, Senator ROTH, and others.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Amendment No. 3675

(Purpose: To provide for a substitute amendment)

Mrs. KASSEBAUM. Madam President, first I send to the desk a substitute amendment and ask it be considered original text for purpose of further amendment.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mrs. KASSEBAUM] for herself and Mr. KENNEDY, proposes an amendment numbered 3675.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

The PRESIDING OFFICER. Under the agreement, the amendment is agreed to and is considered as original text.

The amendment (No. 3675) was agreed to.

AMENDMENT NO. 3676 TO AMENDMENT NO. 3675

(Purpose: To amend the Internal Revenue Code of 1986 to improve health and long-term care coverage in the group and individual markets by making health and long-term care insurance more accessible and affordable)

Mr. DOLE. Now I ask my amendment be called up.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mr. DOLE], for himself, Mr. ROTH, Mr. NICKLES, Mr. PRESSLER, Mr. LOTT, Mr. CRAIG, Mr. MCCONNELL, Mr. COVERDELL, Mr. GRASSLEY, Mr. D'AMATO, Mr. GREGG, Mr. SANTORUM, Mr. SHELBY, and Mr. FAIRCLOTH, proposes an amendment numbered 3676 to amendment No. 3675.

Mr. DOLE. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. DOLE. Madam President, I will explain, as will the distinguished chairman of the committee, Senator ROTH, explain in some detail what this amendment does. It is a very important amendment. It is about a $10 billion amendment. It is paid for. And it does help make health care more available and more affordable. That is the thrust of this bill and that is why, even though we certainly want to accommodate Senator KASSEBAUM and Senator KENNEDY, as far as amendments are concerned, we think this amendment does improve the bill and it does provide a great deal of opportunity for many Americans who are now denied health care. Let me tell you why.

I am committed to passing this bill and the amendment is designed to help make that happen.

For many years self-employed individuals have been uncertain as to whether they could deduct their health insurance premiums. And the Democrat-controlled Congress refused to make the deduction permanent to ensure that it would apply year after year.

Last year, one of the first things Republicans did when we took control of the House and Senate was to make this deduction permanent, and to increase it to 30 percent.

But we said then and we say now that 30 percent is not enough. The amendment I now offer would raise the deduction for the self-employed to 80 percent by phasing in increases over the next 10 years.

This will provide equity and much needed tax relief to farmers, small business men and women, and other self-employed Americans.

My attempts to raise the deduction for the self-employed are not new. An amendment I offered last year passed the Senate with strong bipartisan support, but that did not stop the President from vetoing it, just as he vetoed our $500 per child tax credit.

My amendment will also provide important tax relief regarding long-term care expenses. The Internal Revenue Service has not seen the wisdom to allow taxpayers a deduction for long-term care expenses or premiums paid on long-term care policies.

So this amendment is needed to force the IRS to recognize that expenses to care for those unable to care for themselves are legitimate medical expenses that should be deductible.

It is in the best interest of the country to provide appropriate incentives for families to give proper long-term care for family members or to plan for future expenses, such as by purchasing long-term care insurance. Families want to care for their own and the IRS should not stand in the way.

This provision is particularly important for Americans who are likely to face these expenses in the near future for their parents and grandparents. Expenses to provide long-term care of a disabled or elderly relative could bankrupt a family. We cannot and will not let that happen. And neither should my Democratic friends, although they have voted against this relief in the past and the President has already vetoed this tax relief once before.

I have also included medical savings accounts in this amendment. You may have heard a lot about MSA's already. But let me tell you about them. First of all, they are hardly a radical new concept. They are being used today in 13 States and have enjoyed bipartisan support for many years.

MSA's provide individuals with choice and flexibility. If an individual

chooses to accept an MSA, the individual can tailor his or her own health care to his or her own needs. Individuals would have their own personal savings accounts dedicated to health care spending—similar to the way they have IRA's for their retirement savings.

Under the MSA proposal in this amendment, individuals could purchase a high-deductible plan and then use the money they accumulated in their savings account, up to the deductible limit, for health care expenses. They could deduct the amount they contribute to the MSA and the savings would accumulate tax free.

Who could argue against providing additional options and flexibility? The answer is the same people who thought that the best way to reform the health care system was to hand it over to the Federal Government—to impose more mandates and Government controls. The American people are thankful that the Democrat efforts to turn the health care system over to the Government failed, and they hope that Democrats will fail in their effort to block this amendment.

Let us remember that the Joint Tax Committee recently analyzed this MSA proposal and concluded that 88 percent of the MSA tax benefits would go to those making under $100,000 a year, with 78 percent of the benefits going to those making under $75,000 a year.

I urge my colleagues on both sides of the aisle to join with me in support of substantial tax relief for Americans.

Madam President, health insurance reform is, by no means, a newly debated issue in this Chamber. In fact, it predates many individuals in this town. The concern about the availability and affordability of health insurance goes back as early as the Nixon administration when President Nixon declared that the American health care system was in need of repair, particularly when it came to affordability.

Madam President, that was 25 years ago. Since then, there have been dozens of health care bills debated in this Chamber—the Bentsen bill, the Dole-Packwood bill, and others, all of which were drafted with the sole purpose of making health care more available and more affordable.

To this date, Madam President, none has been signed into law.

We now have before us a bipartisan bill that contains the kinds of commonsense insurance reforms that this Senator and many of my Republican colleagues have long advocated. I commend my colleague from Kansas, Senator KASSEBAUM, for her hard work and determination to craft a health insurance reform bill that could be supported by the vast majority—if not all Members—on both sides of the aisle.

Madam President, as I stand here, I have to say that I feel a great sense of relief—as I am sure many Americans will feel—that common sense has finally prevailed.

For nearly a decade now Republicans have been trying to pass an incremental health insurance bill that would solve many of the problems with the availability and affordability of insurance.

During the Bush administration, however, the Democrat-controlled Congress refused to give President Bush's proposal the time of day.

And then came the Clinton administration, and President Clinton's insistence that turning the American health care system over to the Federal Government was the only solution. It was a solution chock full of mandates, Government intrusion, and untold costs. And the American public took one good look at it and said, ''No thanks.''

From almost the very first day of the Clinton administration through the entire long national debate over the President's plan, I said the same thing day after day after day. And what I said was this: Fix what needs fixing, makes changes in the insurance market so that more Americans are able to obtain and afford health care, and leave the many very good parts of American health care alone.

Here we are, however, 2 years later, and still talking about insurance reforms that are still badly in need. And the tragedy of that, Mr. President, is that there are millions of Americans who could have been helped these past 2 years, had President Clinton not insisted on his plan or nothing.

Madam President, our first priority is to start with portability. This will assure that no American is denied coverage because he or she changes or loses a job. I am committed to passing that change because it will help millions of job-locked Americans with preexisting medical conditions and their families.

As I have said, eliminating job lock should have passed at least 2 years ago. Regrettably it did not.

Before we get much further into this debate, I want to underscore at the outset that it is very important that we pass a bill, once and for all, that can be signed into law. There is no hidden agenda—no surprises—no smoke and mirrors. This is serious work that we have promised to the American public for a very long time.

I also want to take a moment now, that I will elaborate on later, to describe an amendment Senator ROTH and I plan to offer to this bill. In that amendment there will be a number of tax provisions that will enhance the insurance reforms in this bill.

Again, I want to underscore, this amendment is not meant to defeat this bill or diminish its chances of being signed by the President. To the contrary, my amendment will strengthen this bill and help more people obtain affordable health insurance—all without the overdose of Government control the American people already rejected.

My amendment will include an increase in the deduction of health insurance premiums paid by the self-employed and provides deductions for long-term care expenses so that families have real incentives to plan for their later years. It also provides for tax-exempt high-risk pools, and allows for tax-free accelerated death benefits. In addition, this amendment makes medical savings accounts available to all Americans.

Medical savings accounts are not a new concept and have enjoyed bipartisan support. My view is that medical savings accounts are another choice for Americans. They may not be right for everyone. They may appeal to many others. They are included in this amendment as another option. Choice, after all, is one of the greatest virtues of American health care.

These are all provisions to help make insurance more affordable thereby increasing the number of people who are insured.

Madam President, this Congress has worked very hard to keep the promises we made to the American people when they gave us a majority. This bill represents relatively noncontroversial needed change—change we have promised for a long time. We owe it to the millions of Americans who need our help to do today what we should have done several years ago.

Passage of this bill will not only improve our health care system, it could very well restore the faith of the American public that the work for the Congress is not just a series of political stalemates. Even in an election year, we can work on a bipartisan basis to pass legislation that will improve the lives of so many Americans.

Let me indicate that the distinguished Senator from Maine, Senator COHEN, will discuss his part of this amendment, proposals to clamp down on health care fraud and abuse. Senator COHEN has been working on it for a number of years, and they save about $3 billion. They are a very important part of this overall amendment.

I will just say, as I said earlier, this is a very important piece of legislation. It is a bill that should be passed. It is a bill that can be signed into law. There is no hidden agenda, no surprises, no smoke, and no mirrors. This is a serious work product that we have promised to the American people for a long time. It seems to me we can get this done yet today. The House has passed a different version. We will go to conference. In my view, we can come up with a very reasonable proposal that I think President Clinton will sign.

We have offered what we believe will be an amendment to strengthen this bill. I happen to believe the medical savings account is another addition that will strengthen this bill. I know there is some objection to it. But all this is done without an overdose of Government control which the American people rejected just a few years ago.

For all the reasons I can think of, I urge the adoption of this amendment without anything being stricken from

it. I hope at 3:45 the motion to strike will be defeated, and then we can determine if we can vote on the Dole-Roth amendment or should there be other amendments. Maybe the Senator from Washington has other amendments or maybe other people. We can then dispose of those amendments.

I yield the floor, and I thank the Chair.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Madam President, will you tell me when my 3 minutes are up? That is all I really need.

I believe we can have a rational debate about this bill. The Senator from Texas said it is hard to be rational when you debate health care, but I think Senator KASSEBAUM is a very rational woman, and I think Senator KENNEDY is a very rational Senator. I think the two of them have come together. They have brought us a bill that I am very proud to support.

In 1993, I authored a bill that would make it unlawful to cancel or reduce an employee's benefits because the employee suffered from a particular disease or illness, and it made it unlawful for employers to impose different benefit caps for different diseases.

What happened, as we all know, is we got off track with health care reform. It was derailed, and it took us some time to mend some frayed feelings, and now we are back here in a bipartisan effort. We are on the brink of a bipartisan success to bring some fairness to this world of health insurance coverage.

Clearly, millions and millions of Americans are going to be better off as a result of the Kassebaum-Kennedy bill, because we know we will have portability now of health care coverage. Many Americans who are locked in jobs because they fear losing their insurance—and I know so many myself who are in that situation—will no longer be fearful of that.

We think that will impact 25 million Americans. This bill will prohibit group health plans from excluding any employee based on their health status. We know that we do not want to encourage people just buying insurance when they get sick, so we require a 12-month waiting period, and then they cannot be denied for a preexisting condition. We think 81 million Americans, Madam President, have conditions that could subject them to such exclusions, so we are talking about more than 100 million Americans benefiting from this, as well as small businesses.

I strongly urge us to support the Kassebaum-Kennedy bill. I think if we can support Senator KASSEBAUM's amendment to the Dole amendment, it would be far better off, because the medical savings accounts are good for some of the wealthiest and healthiest in our Nation but would be damaging to the vast majority of Americans.

So I look forward to voting for this bill. I think it will be a bright moment for this U.S. Senate.

I yield the floor, Madam President.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. Madam President, the purpose of the leadership amendment to the Kassebaum-Kennedy health insurance reform bill is to help individuals and employers purchase affordable health and long-term care insurance, and it will particularly help small business men and women go a long way toward combating fraud and abuse in the Medicare system.

Affordability of health and long-term care insurance has long been a major problem in our country, and the leadership amendment provides concrete solutions. By eliminating many of the financial barriers to affordable health and long-term care insurance, Americans will take greater responsibility for their health and long-term care needs, relying less on the Federal Government.

The leadership amendment provides affordable health and long-term care insurance and personal responsibility by increasing the health insurance deduction for self-employed individuals to 80 percent. On average, employers pay about 80 percent of their employees health insurance costs. But under current law, employers can exclude this benefit tax.

In comparison, Madam President, under current law, self-employed individuals can only deduct 30 percent of their health insurance. Raising the health insurance deduction for self-employed individuals will eliminate this inequity and will be a good first step toward putting self-employed individuals on a par with workers who receive health insurance from their employer.

But this is not all this amendment provides. It provides tax clarification for long-term care insurance. Under this amendment, long-term care insurance that meets certain consumer standards will receive the same favorable tax treatment as medical insurance. The consumer standards require insurance companies to disclose information to consumers that will aid them in buying a long-term care policy that best fits their individual needs.

Long-term care insurance tax clarification will provide the much needed incentive for Americans to buy this insurance. All too often individuals without long-term care insurance end up depleting their life savings for their care and end up on Medicaid. Long-term care insurance will give Americans with long-term care needs the dignity of providing their own care and at the same time reducing the burden on Medicaid.

Additionally, Madam President, this amendment allows tax-free benefits from the early termination of life insurance. It permits terminally and chronically ill individuals to take tax-free withdrawals from their life insurance. Many terminally and chronically ill individuals end up depleting their life savings for their care and end up on Medicaid. This provision will provide an additional source of funds for the terminally and chronically ill to attend to their health care needs and at the same time will reduce the burden on Medicaid for their care.

This amendment also includes tax-favored medical savings accounts. Our medical savings account proposal permits an individual with a high-deductible health plan to make tax-deductible contributions to an MSA. Contributions to the medical savings account are limited to $2,000 for single coverage and $4,000 for family coverage. Distribution from the medical savings account can be used for medical expenses without being taxed.

Excess funds in a medical savings account can be carried over to the next year, would be available to pay for unexpectedly high health costs, long-term care insurance, or to continue health insurance during periods of unemployment, often called COBRA coverage. Madam President, among the great freedoms that Americans cherish is the ability to make choices and decisions about how to take care of their families. Medical savings accounts will place control of America's health care back in the family. It does so in significant ways that create the right incentives for health care.

With the medical savings accounts, Americans will be able to choose their physician, their hospital, and their health care plan. Not only will Americans be allowed to go to the doctor of their choice, but to the optometrist, the dentist, or the chiropractor of their choice as well. Traditional low-deductible health insurance may not cover visits to the dentist or optometrist, but the medical savings accounts will.

In addition, Madam President, many traditional low-deductible health insurance plans do not pay for preventive care. For working poor Americans, this feature of medical health savings accounts will be especially helpful. That is because Americans with medical savings accounts will have the money to pay for preventive care for their families, whereas they may not have the money in the absence of a medical savings account.

Beyond offering patients a choice, medical savings accounts will lower health care spending by empowering people to become knowledgeable about health care costs. As a result, medical savings account users become more effective consumers of health care and reject unnecessary or duplicative treatment. Unused medical savings account funds will accumulate from year to year, providing an incentive for people to remain healthy and consume medical care wisely.

In addition, Madam President, medical savings accounts will also restore the physician-patient relationship, something that has eroded over time. Patients are finding their choice of health care providers being limited and bureaucracies are interfering with their doctor-patient relationships.

With medical savings accounts, a patient can go to any doctor, nurse, or other health care provider of their choice without worrying about whether their insurance will cover the bill.

Madam President, we already know about the success of medical savings accounts because hundreds of companies, including the United Mine Workers, are experimenting with them with great success. Companies that offer medical savings accounts have experienced significant reductions in health care spending by their employees. Most of these companies find that medical savings accounts are attractive to workers in both low- and high-income categories and workers in all health conditions. In fact, the Joint Committee on Taxation anticipates that about 78 percent of medical savings account users will have an annual income of less than $75,000.

Madam President, the problem with current medical savings accounts is that employees are treated worse under the tax laws by selecting a medical savings account and high-deductible health plan. At the end of each year the employee must include the full amount of the money deposited in his or her medical savings account as income. That is a grossly unfair result when employees with traditional low-deductible insurance do not pay tax on their employer provided insurance.

Furthermore, medical savings accounts advance an important goal of Senator KASSEBAUM's health insurance reform bill, and that is health insurance portability. Health insurance portability is something Americans have been requesting for years. The lack of health insurance portability is a problem with the current health insurance market and results in job lock for millions of Americans. Medical savings accounts will help end job lock for millions of American workers because they will be able to take their medical savings account with them when they change jobs. This would promote continuity of insurance coverage.

Another feature of a medical savings account is that it will allow a lower cost insurance alternative to millions of self-employed Americans. American farmers and small businesses will be able to buy high-deductible health insurance and fund a medical savings account to provide for their family's health care needs. This feature has the potential of removing millions of people from the ranks of the uninsured.

Madam President, it is interesting to note that 13 States and at least one city have passed medical savings account legislation and dozens more are moving to pass similar legislation. For example, Jersey City, NJ, has implemented medical savings accounts as an alternative for their city employees. Ohio is implementing a test program for State employees. Clearly, medical savings accounts offer Americans a choice about their health care that should be fundamental in a country built on free-market principles. It is the Federal Government that must now move ahead with the idea.

Madam President, strong efforts have been made to defeat medical savings account legislation by those who have a vested interest in the current health care system that is not working for millions of Americans. The real winners under medical savings accounts will be the hundreds of thousands of Americans who will grab control over their family's health care spending.

I hope the encouragement from hundreds of companies with successful medical savings account programs and the many States that are pioneering in medical savings accounts will serve as strong incentives for my fellow colleagues to join me in supporting the medical savings account provisions and the leadership amendment.

Madam President, I ask unanimous consent to have an editorial in the Wall Street Journal by Nobel Prize-winning economist Milton Friedman entitled ''A Way Out of Soviet-Style Health Care'' printed in the RECORD.

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

[From the Wall Street Journal, Apr. 17, 1996]

A WAY OUT OF SOVIET-STYLE HEALTH CARE

(By Milton Friedman)

In a chapter in his novel ''The Cancer Ward'' titled ''The Old Doctor,'' Alexander Solzhenitsyn compares ''private medical practice'' with ''universal, free, public health service'' through the words of an elderly physician whose practice predated 1918. A by-product is an eloquent statement of the major advantages of medical savings accounts for the U.S. in 1996.

Mr. Solzhenitsyn himself had no personal experience on which to base his account and yet, in what I have long regarded as a striking example of creative imagination, his character presents an accurate and moving vision. The essence of that vision is the consensual relation between the patient and the physician. The patient was free to choose his physician, and the physician free to accept or reject the patient.

In Mr. Solzhenitsyn's words, ''among all these persecutions [of the old doctor] the most persistent and stringent had been directed against the fact that Doctor Oreschenkov clung stubbornly to his right to conduct a private medical practice, although this was forbidden.''

EASIER TO FIND A WIFE

In the words of Dr. Oreschenkov in conversation with Lyudmila Afanasyevna, a longtime patient and herself a physician in the cancer ward: ''In general, the family doctor is the most comforting figure in our lives. But he has been cut down and foreshortened. * * * Sometimes it's easier to find a wife than to find a doctor nowadays who is prepared to give you as much time as you need and understands you completely, all of you.''

Lyudmila Afanasyevna: ''All right, but how many of these family doctors would be needed? They just can't be fitted into our system of universal, free, public health services.''

Dr. Oreschenkov: ''Universal and public—yes, they could. Free, no.''

Lyudmila Afanasyevna: ''But the fact that it is free is our greatest achievement.''

Dr. Oreschenkov: ''Is it such a great achievement? What do you mean by 'free'? The doctors don't work without pay. It's just that the patient doesn't pay them, they're paid out of the public budget. The public budget comes from these same patients. Treatment isn't free, it's just depersonalized. If the cost of it were left with the patient, he'd turn the ten rubles over and over in his hands. But when he really needed help he'd come to the doctor five times over. * * *

''Is it better the way it is now? You'd pay anything for careful and sympathetic attention from the doctor, but everywhere there's a schedule, a quota the doctors have to meet; next! * * * And what do patients come for? For a certificate to be absent from work, for sick leave, for certification for invalids' pensions; and the doctor's job is to catch the frauds. Doctor and patient as enemies—is that medicine?''

''Depersonalized,'' ''doctor and patient as enemies''—those are the key phrases in the growing body of complaints about health maintenance organizations and other forms of managed care. In many managed care situations, the patient no longer regards the physician who serves him as ''his'' or ''her'' physician responsible primarily to the patient; and the physician no longer regards himself as primarily responsible to the patient. His first responsibility is to the managed care entity that hires him. He is not engaged in the kind of private medical practice that Dr. Oreschenkov valued so highly.

For the first 30 years of my life, until World War II, that kind of practice was the norm. Individuals were responsible for their own medical care. They could pay for it out-of-pocket or they could buy insurance. ''Sliding scale'' fees plus professional ethics assured that the poor got care. On entry to a hospital, the first question was ''What's wrong?'' not ''What is your insurance?'' It may be that some firms provided health care as a benefit to their workers, but if so it was the exception not the rule.

The first major change in those arrangements was a byproduct of wage and price controls during World War II. Employers, pressed to find more workers under wartime boom conditions but forbidden to offer higher money wages, started adding benefits in kind to the money wage. Employer-provided medical care proved particularly popular. As something new, it was not covered by existing tax regulations, so employers treated it as exempt from withholding tax.

It took a few years before the Internal Revenue Service got around to issuing regulations requiring the cost of employer-provided medical care to be included in taxable wages. That aroused a howl of protest from employees who had come to take tax exemption for granted, and Congress responded by exempting employer-provided medical care from both the personal and the corporate income tax.

Because private expenditures on health care are not exempt from income tax, almost all employees now receive health care coverage from their employers, leading to problems of portability, third party payment and rising costs that have become increasingly serious. Of course, the cost of medical care comes out of wages, but out of before-tax rather than after-tax wages, so that the employee receives what he or she regards as a higher real wage for the same cost to the employer.

A second major change was the enactment of Medicare and Medicaid in 1965. These added another large slice of the population to those for whom medical care, though not completely ''free,'' thanks to deductibles and co-payments, was mostly paid by a third party, providing little incentive to economize on medical care. The resulting dramatic rise in expenditures on medical care

led to the imposition of controls on both patients and suppliers of medical care in a futile attempt to hold down costs, further undermining the kind of private practice that Dr. Oreschenkov ''cherished most in his work.''

The best way to restore freedom of choice to both patient and physician and to control costs would be to eliminate the tax exemption of employer-provided medical care. However, that is clearly not feasible politically. The best alternative available is to extend the tax exemption to all expenditures on medical care, whether made by the patient directly or by employers, to establish a level playing field, in terms of the currently popular cliché.

Many individuals would then find it attractive to negotiate with their employer for a higher cash wage in place of employer-financed medical care. With part or all of the higher cash wage, they could purchase an insurance policy with a very high deductible, i.e., a policy for medical catastrophes, which would be decidedly cheaper than the low-deductible policy their employer had been providing to them, and deposit all or part of the difference in a special ''medical savings account'' that could be drawn on only for medical purposes. Any amounts unused in a particular year could be allowed to accumulate without being subject to tax, or could be withdrawn with a tax penalty or for special purposes, as with current Individual Retirement Accounts—in effect, a medical IRA. Many employers would find it attractive to offer such an arrangement to their employees as an option.

Some enterprises already have managed to do so despite the tax penalty involved. MSAs have proved very popular with employees at all levels of income, and they've been cost-effective for employers. The employee has a strong incentive to economize, but also complete freedom to choose a physician, and the equivalent of first-dollar coverage. There are no out-of-pocket costs until the employee spends more than the total amount in the MSA. Such costs are then limited to the difference between the amount in the account and the deductible in the catastrophic policy. Moreover, the employee can use money in the MSA at his or her discretion for dental or vision care that is typically not covered under most health plans. No need to get ''authorization'' from a gatekeeper or an insurance company to visit a specialist or to have a medical procedure—until the catastrophic policy takes over.

LIMITING COMPETITION

The managed care industry has come to recognize that MSAs might threaten its growing control of American medicine by offering a more attractive alternative. As a result, the managed care industry has recently become a vigorous enemy of MSAs. Every believer in competition will recognize that opposition for what it is: a special interest using government to limit rather than expand competition.

Medical savings accounts are not a panacea. Many problems would remain for an industry that now absorbs about a seventh of the national product. However, I believe that they offer the closest approximation that is currently feasible to the private medical practice that Dr. Oreschenkov cherished.

Mr. ROTH. Madam President, in his editorial, Dr. Friedman recognizes medical savings accounts can be an important factor in restoring the freedom of choice for both the patient and physician and to control health care costs.

These important provisions in the leadership amendment are not all that we are offering. Our amendment also permits penalty-free withdrawals from IRA's for health and long-term care insurance. The leadership amendment encourages people to purchase health insurance by allowing penalty-free withdrawals from IRA accounts to buy health and long-term care insurance and to pay for major medical expenses.

This provision will allow unemployed workers the ability to access their IRA funds to continue their health insurance for their families.

The leadership amendment provides tax exemptions to State-sponsored, high-risk insurance pools, a provision that will encourage States to set up insurance pools from which high health risk individuals can purchase affordable insurance.

Madam President, the leadership amendment also contains new tools for law enforcement to aggressively attack fraud and abuse in health care. GAO estimates that as much as 10 percent of health spending in the United States is lost to fraud and abuse. Law enforcement officials believe that most health care fraud goes undetected.

The leadership amendment makes substantial new funds available to the Justice Department, the FBI and the IG of the Department of Health and Human Services for investigation and prosecution of health care fraud. These provisions also create for the first time a criminal statute for health care crimes, tough new penalties for fraud in Federal health programs, including Medicare and Medicaid.

Madam President, these health care fraud and abuse provisions were crafted by Senator COHEN over the past 3 years. I commend him and his staff on their tireless and important work. Madam President, the leadership amendment is actually paid for. The offsets are, first, large corporations will no longer be permitted to borrow corporate-owned life insurance and deduct the interest. The provision is a major corporate tax loophole that will be closed. The same proposal was included in the Balanced Budget Act of 1995 and is similar to the administration's proposal in its fiscal year 1997 budget.

Second, expatriates, those persons who leave the United States for tax avoidance purposes, will be subject to taxation upon exit from the United States. The proposal is similar to the expatriation provision in the Senate version of the Balanced Budget Act of 1995.

Third, starting in 1996, thrift institutions will calculate their tax deduction for bad debts the same way as banks. This provision will facilitate future legislation to harmonize the bank and thrift charters, and has widespread support. A similar proposal was included in the Balanced Budget Act of 1995 as well as an administration revenue proposal in the fiscal year 1997 budget.

Fourth, a measure to combat fraud and the earned-income credit program. This proposal is identical to the earned-income credit compliance provisions in the House health care bill.

Mr. President, I recognize that there are many other popular tax proposals championed by other Members that would likely find their way into this bill. However, this is a health insurance reform bill. The focus of this and other amendments should be on expanding the affordability of health and long-term care insurance for Americans. To stray from the purpose of this amendment may doom the entire health insurance reform effort. I suggest that no Senator wants to do that.

Mr. COATS. Madam President, the Congressional Budget Office reported that health care spending, rather than cost, is the major problem in U.S. health care. The report states that ''a major reason for high and rapidly rising health cost is the failure of the normal discipline of the marketplace to limit the quantity of services supplied.''

Today, nearly 80 percent of medical expenses are paid by somebody other than the patients themselves.

Out-of-pocket expenditures have declined from 60 percent of the Nation's total health bill in 1960 to 20 percent today. Since that time, the Government's share has doubled to 46 percent.

This means that most health care expenditures in the United States today are paid for by someone other than the consumer of health care—by the Government or by insurance carriers. Unlike any other purchase, when Americans receive medical care, they use someone else's money.

Our health care system has effectively insulated Americans from the cost of care. There is little incentive to spend wisely. There is no need to look for the best buy for the health care dollar.

Six years ago, I introduced the first MSA legislation in the Senate. My plan provides a financial incentive for Americans to choose a healthy lifestyle and to be better consumers of health care. Under my plan, employers provide an umbrella catastrophic policy and invest the rest of the money in a tax free account for each employee. I am pleased to be a cosponsor of the Finance Committee amendment which builds on these same principles.

For example, the average employer spends $4,500 on health benefits for an employee. Under the typical MSA, an employer would buy a catastrophic policy—with a $3,000 deductible—at an average cost of $1,500. The remaining $3,000 would be given to the employee to cover out-of-pocket medical expenses. Whatever is unused would be given to the employee. We would provide a financial incentive both to stay healthy and to shop for bargains in the system.

I was discussing this idea with some constituents in Indianapolis. One woman told me she knew exactly what I was driving at. She called her local hospital to inquire how much a mammogram would cost. When told $300,

she asked if they ever offered any sales. Sure enough, Mother's Day week, the screenings cost only $50. However, because her insurance covered the cost, she had no incentive to purchase the care at the reduced price.

This sounds complicated, but the effect would be simple. People would be allowed to choose their own doctors, make their own health care decisions, have a financial incentive to live a healthier life, and control medical costs through increased competition.

Medical savings accounts are working. People with these plans are looking for and finding bargains. And they are getting more preventative care from their doctors.

Listen to a letter from one woman in Indiana:

When the MSA account became an option at my company, I decided to try it with my family. For the last half of [the first year], our family will be receiving a refund for our unused portion. With five on our policy, this was a nice surprise.

''I was told I would be needing surgery performed in the near future. I have already made arrangements to pay our [catastrophic] deductible in full * * * the total surgeon's charge was $9,843. However, they have agreed to take off $3,797. With this account I have realized there is no set doctor's charge.''

This Indiana woman has become a wise consumer of health care services. She bargained and saved nearly $4,000 in surgery costs. She scrutinizes her bills and makes sure that she is getting what she pays for.

Another Hoosier had this to say:

''The MSA plan has helped me become a more frugal shopper of health care for myself and my family. I now ask the doctor for generic prescriptions when available, and try to utilize our family doctors when available, instead of the more expensive immediate care centers.''

Another Indiana resident was surprised to learn that the price of treatment does vary depending on the status of her insurance. Treatment to an ear damaged in an auto accident was $900 through insurance, but only $200 since she paid out-of-pocket.

A resident of Indianapolis writes, ''I am a single parent who receives no outside support. Therefore, it is very important for me to have insurance coverage for my 12-year-old daughter and I. I made the decision to try the medical savings account because although vision and dental expenses were not covered under the traditional plan, I would be able to use the MSA money for these expenses * * * both my daughter and I wear glasses. Both our prescriptions had changed this past year, therefore I incurred the cost of the exams along with the cost of new glasses.

''I did have necessary medical expenses last year that used all but $37 of my MSA fund. While I may have received less than others who had MSA's last year, I gained a great deal more than those who had the traditional plan. I had no out-of-pocket expenses and still had $37 come back to me. There was nothing to lose, and everything to gain.''

In addition to empowering people, medical savings accounts help control the costs of providing coverage for many companies.

In Indiana, 81 percent of employees at Golden Rule Insurance elected the medical savings account option the first year it was offered. These workers got $468,000 in reimbursements from their MSA's. Not surprisingly, the next year, 90 percent of the employees selected the MSA option. Golden Rule benefited as well—the company saw no increase in health care costs for 2 straight years, with $734,000 refunded to employees, an average of $1,000 per employee.

Dominion Resources has encouraged workers to opt for a high deductible plan and to place the monthly premium savings into a health account. Some 80 percent of Dominion's employees have selected this plan and the company has seen no increases in premiums since 1989.

Knox Semiconductor in Rockport, ME, has experienced only one rate increase in the last 4 years under its Health-Wealth Program. Its president, John Marley, claims that the program saved his company more than $100,000 in 3 years—a significant savings for a small business.

These savings are particularly impressive given the cost increases experienced by companies in conventional plans. The Clinton-Mitchell bill, for instance, claims it will achieve its major savings through encouraging HMO styled delivery of services. But even HMO costs are rising—13.6 percent a year between 1988 and 1992. In 1993, they jumped another 6.5 percent.

MSA's could potentially achieve savings in another significant way. Not only would they unleash the collective bargaining power of the American consumer, but they could significantly reduce the administrative burden on our health care system. Less than 15 percent of all Americans spend $3,000 a year on medical care, and therefore the accumulated cost of paperwork processing are for small claims. By paying these bills directly, our health care system would realize significant savings in paperwork reduction and substantially reduce the $90 billion in administrative costs we spent each year.

Forbes magazine has experimented with this concept. In order to cut down small claims, they give each employee an annual account of $1,200. For every dollar filed in medical claims, the employee loses $2 from the account. Employees can keep what is left in the account at the end of the year. This system obviously encourages employees to pay for small claims out-of-pocket. After the system was implemented, the paperwork on routine claims fell dramatically. The company's health costs fell by 17 percent in 1992 and by 12 percent the following year.

We are paying a high price for our social and behavioral attitudes, our personal lifestyle choices. The United States pays $52 billion each year on illnesses related to smoking. Unhealthy eating habits contribute directly to 5 of the 10 leading causes of death in the Nation. Two out of three deaths in the United States can be linked to tobacco use, alcohol use and abuse, controllable high blood pressure, overeating, traumatic injury, and lack of preventative care.

One man in Indiana commented, ''the plan has also given me a better outlook on staying healthy. It provides financial incentive for not over utilizing health care, but at the same time provides a way to cover the more routine expenses which one would incur at regular intervals. Getting a regular check up could help prevent more costly health care bills. Its nice to have an outlet to pay for expenses when you really should go to the doctor instead of waiting to the last minute because our deductible is not satisfied.''

The MSA is the only health reform plan that provides incentives to remain healthy. Indeed, the Kennedy bill entitles those at high risk of sexually transmitted disease more health care than it does to others not considered at risk. The Kennedy bill requires all Americans to pay for smoking cessation classes regardless of whether or not you smoke. So smokers get more care than nonsmokers under the Kennedy bill. Under the MSA, non-smokers, who likely will remain healthier than smokers, reap the rewards of their behavior.

The Wall Street Journal recently editorialized, ''Most of the health bills before Congress remind us of Henry Ford's philosophy behind the Model-T car: ''You can have any color you want as long as its black.'' [but] health care reform that includes medical savings accounts would represent real consumer sovereignty; patient self-interest would be harnessed to keep costs down, and workers would build up tax-free health care funds for when they were between jobs. Health care security would be enhanced, but not at the cost of quality or freedom of choice.''

This Congress faces a fundamental choice. We can use the lessons of our experience—Americans empowered choose wisely—competition in the free market enhances quality and drives down costs—principles which guide reform through medical savings accounts. Medical savings accounts leave health care choices where they belong—in the hands of individuals. I urge my colleagues to support real reform—and to retain medical savings accounts.

AMENDMENT NO. 3677 TO AMENDMENT NO. 3676

(Purpose: To strike medical savings accounts)

Mrs. KASSEBAUM. Madam President, I send to the desk an amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mrs. KASSEBAUM] proposes an amendment numbered 3677 to amendment No. 3676.

The amendment is as follows:

Strike subtitle C of title IV.

Mrs. KASSEBAUM. Madam President, the purpose of this amendment is to strike the portion of the package put forward by Senator DOLE and Senator ROTH regarding medical savings accounts. It is difficult for me to stand and do so because I think the rest of the provisions in the package that have been put forward are ones that are generally agreed to on both sides of the aisle. Senator DOLE has been a longtime leader of efforts to increase the deductibility for those who are self-employed. It is a very positive amendment. It will be a very positive part of this bill.

Also, Senator DOLE has been a longtime leader in wanting to address long-term care and to be able to provide some means of helping those who have high costs for family and long-term care. This will provide tax credits to do so.

The chairman of the Finance Committee, Senator ROTH, has also been a long-time proponent of such measures. I think the way in which the measure is crafted is a very constructive addition to the legislation before the Senate.

When the ranking member of the Labor Committee, Senator KENNEDY, and myself completed the work of the committee in a unanimous vote last August, we agreed that we would not support any additional amendments that were highly contentious. This included ones that individually we would support, as well as those that we would oppose. Cumulatively, they could cause a real collapse if they carried too much baggage, plus or minus. Therefore, we have agreed, whether we individually supported those amendments or not, to not support any amendments which were going to prove to be controversial.

I would like to speak for a moment about medical savings accounts and my own concerns regarding them. As has been pointed out, 13 States have now in place such savings accounts and I think that is going to be useful to analyze the effect of medical savings accounts. The proponents say it will bring down health care costs by encouraging consumers to shop more wisely for health care, that they will increase coverage by making health care that is affordable for individuals, and they will reduce health care spending for employers.

Nevertheless, we are not really certain, and I still believe that we need to carefully consider what medical savings accounts are about. I think it is not a question of either/or. Medical savings accounts should be considered and we should debate the merits of medical savings accounts. I strongly question whether they should be attached to this particular bill as they do not really enhance the provisions of this bill that we are debating today.

I do believe that medical savings accounts are of benefit, particularly to the healthiest and most financially secure Americans. They do not really address those with preexisting conditions, nor those with catastrophic illnesses at the time, nor those without a job or income who need coverage the most.

I think the medical savings accounts could provide a false sense of security because it does offer choices to individuals. It lends encouragement to invest wisely. It lends to a shelter in the Tax Code which would allow one to build up support that could be used at times that are important. However, it is a false sense of security, Madam President, I believe.

They are sold as giving Americans freedom to exercise choice and that people will be protected when they get catastrophic illnesses. However, as our colleague, Senator JEFFORDS knows, most so-called catastrophic policies have very low lifetime limits. He will be offering an amendment, as a matter of fact, to address that concern. So, people are not protected for truly catastrophic illnesses. Medical savings accounts are an experiment, not without merit. From the States that are already experimenting with the accounts and have passed legislation, we will be able to gather data which will be useful to us.

I suggest that Blue Cross Blue Shield of Ohio has shown that MSA's would increase, not decrease, employer costs because there would be less money in the pool to cover above average costs of high-risk individuals. There needs to be the ability to have a risk pool, to have reinsurance, so that those costs can be spread, of which all of us would have to pay. That is not going necessarily to lead to escalating premiums so much as spreading the costs across the board.

Blue Cross and Blue Shield has observed that there is a concern that MSA's will segment the market into people who are very healthy and people who are not healthy. If that happens, you lose the ability to spread the risk pool. Senator BREAUX spoke to that earlier this morning. So for all those reasons, Madam President, I have some serious reservations. Senator COHEN from Maine, as Senator ROTH pointed out, has legislation regarding fraud and abuse that helps provide savings, which has been incorporated in this amendment. I think that is a positive part of the package put forward by Senator DOLE and Senator ROTH.

But as long as medical savings accounts have such a high degree of uncertainty, I think it is a package that should be viewed with some skepticism as we regard this particular proposal before us, which has universal support and will continue to have if we give some care to the amendments that are added to it.

I have the highest regard for the efforts of the majority leader, as he has put forward what I believe are positive additions to our bill. It is my hope that those additions can be accepted and that medical savings accounts, with my motion to strike, will be defeated.

I yield the floor.

Mr. KENNEDY. Madam President, how much time does the Senator from Connecticut need?

Mr. DODD. Seven minutes.

The PRESIDING OFFICER. The Senator is recognized for 7 minutes.

Mr. DODD. Madam President, 2 years ago the 203d Congress spent a great deal of time discussing the merits of comprehensive health care reform.

The Committee on Labor and Human Resources held more than 40 hearings debating the issue.

And in the end those opponents of comprehensive reform, who said we needed to go slow, won the day.

I, for one, thank that was a mistake.

But, at the same time, I understand the apprehension of my colleagues about comprehensive reform.

Well today, the legislation before us today—the Kassebaum-Kennedy Health Insurance Reform Act—gives us the opportunity to pass sensible, incremental and common-sense health reform measures that will help millions of Americans.

This bill may not solve every problem in our health care system. But, it is good public policy.

And it will make a real difference in the lives of millions of Americans.

And if we, as a body, believe that American workers should not live in fear of losing their health care when they change their job, then we must pass these sensible reforms.

In fact, recollecting our debates from 2 years ago, it's hard to imagine that this bill would not pass on a unanimous vote.

Not once in our many committee meetings did any member argue for the preservation of exclusions based on preexisting conditions.

Not once did anybody argue against insurance portability. Even while we were debating health care reform on the Senate floor, not once did anybody raise objection to the sort of market reforms that are included in this bill.

THE HEALTH CARE PROBLEM

And, I think we all recognize the huge scope of the problem.

Almost 40 million Americans have no health care insurance.

Approximately 12 million of those uninsured are children under the age of 21.

In my State of Connecticut, 300,000 people were uninsured in 1993.

That is 12.1 percent of the population, up from 9.7 percent in 1992. That's a 25 percent increase.

In fact according to a recent poll, 22 percent of Connecticut Residents who needed health care did not go to a doctor or receive health care services because it was either too expensive or simply inaccessible.

These are unacceptable statistics, and they make clear the need for reform.

JOB LOCK

And, throughout Connecticut and the Nation as a whole, millions of others live in fear that if they change their job, they will lose their health care as well.

Various surveys have found that as many as 30 percent of Americans report that either they or a family member suffer from job lock.

Too many Americans are being forced to stay at a job because they simply can not afford to lose their health care coverage.

But if this legislation passes, the provisions in this bill would relieve as many as 3 to 4 million Americans from the burden of job lock.

KASSEBAUM-KENNEDY IS A GOOD FIRST STEP

While I think that even my colleagues Senator KENNEDY and Senator KASSEBAUM would agree that this bill will not solve every problem with America's health care system, it is a crucial step in the right direction.

The KASSEBAUM-KENNEDY would limit exclusions for pre-existing conditions.

It would allow small businesses to form purchasing alliances, which would be a difference for the 30 percent of employees at firms with 10 or less workers who do not have health insurance.

And most important it would guarantee to every American worker that if you change your job, you will not lose your health insurance.

The GAO estimates that 25 million Americans would be helped by this legislation.

These are common sense reforms and I believe that is one of the main reasons this bill is receiving huge bipartisan support.

The Kassebaum-Kennedy bill not only has more than 60 cosponsors, of which I am one, but it also passed our committee unanimously.

CLEAN BILL

With this clear level of bipartisan support it is hard for me to understand why many of my colleagues are insisting on offering amendments to this bill, that they know will make it impossible for it to pass.

Unfortunately, over the past few years it has become increasingly difficult for this body to reach compromise on any issue.

I think all my colleagues, from both sides of the aisle, bemoan this lack of bipartisan agreement.

And today we have a bill with over 60 cosponsors, with wide bipartisan support and with endorsement from much of the health insurance industry and yet several of my colleagues stubbornly insist that we allow amendments to be tacked on to this bill.

In particular, the insistence of some of my colleagues to add medical savings accounts, or MSA's, to this bill threatens the enactment of any health reform measure this year.

We all have provisions we would like to see included in this legislation. I, for one, would like to see greater health care coverage for our Nation's children.

But, this is not the time to be focusing on our individual projects, particularly at the expense of genuine reforms that we can all agree upon.

Today, we have the opportunity to help 25 million Americans with the Kassebaum-Kennedy bill and applying MSA's or any other provision to this bill will only undermine that effort.

The Kassebaum-Kennedy bill truly represents common sense, effective reform.

These are reforms that will spare millions of Americans the pain and suffering of losing their health care or being denied coverage because of preexisting conditions.

Today, we have a historic opportunity to make a real difference in the lives of millions of Americans.

As I do not need to remind most of you, cynicism toward Congress runs rampant in this Nation.

Too often the American people look to Washington and they shake their head at the partisan political games we play.

In the last two elections they have demanded that we start working together, Democrats and Republicans, and pass legislation that makes a real difference in their lives.

And I believe that if we polled the American people and asked them: Should Congress remove preexisting conditions in the health insurance industry?

Should Congress make health insurance more portable?

Should Congress guarantee that if you lose your job you do not lose your health insurance?

I think, the vast majority of the American people would respond with a resounding yes.

So today, let us uphold our responsibility to the American people and pass these sensible and commonsense reform measures.

Madam President, I ask unanimous consent to have printed in the RECORD a letter dated today from Cecil E. Roberts, international President of the United Mine Workers of America.

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

UNITED MINE WORKERS OF AMERICA,
Washington, DC, April 18, 1996.

Senator BOB DOLE,
Hart Senate Office Building, Washington, DC.

DEAR SENATOR DOLE: In recent days, certain special interest groups have wrongly portrayed members of the United Mine Workers of America as recipients of Medical Savings Account akin to those that would become more widely available under an amendment you are slated to offer to S. 1028.

The UMWA has been grossly misrepresented by these groups who have wrongly counted us as supporters in their effort to weaken the health care system through Medical Savings Accounts.

In recent collective bargaining agreements, we have negotiated a comprehensive health care plan for our members. Our members also receive a bonus and are responsible for pay equivalent deductibles under their medical plan. This plan is not an MSA.

Representing more than 200,000 working and retired coal miners and their dependents, the Mine Workers know that MSAs are not a panacea for the health care crisis. It would be unthinkable to leave such a group of people, many of whom suffer from injuries or disease brought on from working in the mines, dependent on MSAs for their health care coverage.

Sincerely,

CECIL E. ROBERTS,
International President.

Mr. DODD. Madam President, I commend our two colleagues. It has been a long ordeal, dealing with this very important piece of legislation. They deserve our universal acclaim for their efforts. It was a very good process in our committee. As the chairman of the committee, Senator KASSEBAUM, pointed out, this particular proposal was unanimously voted out of committee. To the credit of all of our members on the committee, Republicans and Democrats alike, we all have ideas that we would have liked to have incorporated in this legislation. But the agreement was that we would try and limit the bill to those areas where there was consensus, so that we could deal with the problems that 25 million Americans face today. With the passage of this legislation, and a Presidential signature, we would solve the problems immediately for 25 million Americans. It would immediately solve the problems they face with portability and preexisting conditions—not to mention some of the proposals in the leadership amendment, which the Senator from Kansas pointed out we all agree with and go back many years supporting.

We have a wonderful opportunity here. It has been almost since last August that this bill came out of committee. We are almost in May now, and the weeks are rolling by. Here is a chance to do something for 25 million Americans, without getting into a real disagreement and argument over a controversial proposal—the medical savings accounts.

Madam President, I would like to spend a few minutes on that particular subject matter. I will leave the remarks I have inserted in the RECORD that go to the general provisions in the bill, which have been discussed today at some length. I compliment my colleague from Kansas and my colleague from Massachusetts for doing a remarkably fine job in putting those provisions together.

I have inserted the letter from the United Mine Workers because there has been some discussion here on the floor that this was one organization that has a medical savings account. Without reading the entire letter, let me read paragraphs 2, 3, and 4 of the letter:

The UMWA has been grossly misrepresented by these groups who have wrongly counted us as supporters in their effort to waken the health care system through Medical Savings Accounts.

In recent collective bargaining agreements, we have negotiated a comprehensive health care plan for our members. Our members also receive a bonus and are responsible for paying equivalent deductibles under their medical plan. This plan is not an MSA.

Representing more than 200,000 working and retired coal miners and their dependents, the Mine Workers know that MSAs are not a panacea for the health care crisis. It would be unthinkable to leave such a group of people, many of whom suffer from injuries or disease brought on from working in the mines, dependent on MSAs for their health care coverage.

I think that is important, since their names have been used as an example of an organization with an MSA, and by implicit suggestion that they are supporters of MSA's. I voted twice for medical savings accounts, back when we considered the larger health care package. I am proud of those votes. I have no inherent objection to the idea of a medical savings account. But they need to be, as the Senator from Kansas suggested, in the context of a larger discussion of health care.

Whether you agreed or disagreed with the large health care proposal of a year or so ago, in that context, medical savings accounts make sense. In the absence of it, you are running the risk of leaving people aside who cannot afford to get into these programs.

It is very controversial, too. As many have pointed out, the major insurance groups and consumer groups, which rarely agree on these matters, all agree on this point—that this could create some real problems. They all agree that this would segment and undermine the insurance market. They would divide the health care system and cater to the healthier and wealthier people at the expense of those with financial constraints, leaving those in traditional plans to pay a higher price tag on health care costs, as their risk pool shrinks and as the percentage of individuals with serious health conditions increases.

They point out that according to the Joint Committee on Taxation, it would cost taxpayers about $1.8 billion.

Again, I am not talking about one group versus another. The insurance industry, consumer groups, the Blues, are not saying that they are totally opposed to this, but that in this context, it does not make a great deal of sense.

I also point out there have been some studies done on the medical savings accounts. According to the Congressional Budget Office, medical savings accounts could threaten the existence of standard health insurance, placing a far greater burden on lower-income patients, individuals with chronic ailments, and patients with disabilities, who have larger out-of-pocket expenses. The Blue Cross Blue Shield of Ohio, as the Senator from Kansas pointed out, says, ''MSA's would bankrupt our current system of financing health care and significantly add to the cost of medical care.'' That is their language, not mine.

The American Academy of Actuaries said, ''Less healthy individuals will likely pay more for their coverage, since the most healthy and highest persons in the group are likely to select MSA programs.'' That is not the Senator from Connecticut, or the Senator from Massachusetts, or the Senator from Kansas. That is the American Academy of Actuaries speaking.

We have a wonderful opportunity to deal with something we all agree on, in a bipartisan way. The current bill is bipartisan, as we have some 60 cosponsors. Why take on an MSA issue that is highly controversial with major private sector groups and consumer groups that are saying, ''Please do not do this''? This is not the right suggestion at this hour. It jeopardizes what we could do for 25 million Americans, by eliminating the problem of portability and preexisting conditions, issues that we all agree on.

I do not know of anybody who stood up and suggested that we ought not to make those changes. We have the chance to do that in a bipartisan way. If you add the MSA's, given all the arguments raised by the private sector, consumer groups, and others, including the American Academy of Actuaries, and the Blues, who have looked at this issue carefully, then you do great damage and jeopardize what we can accomplish this afternoon by passing a good bill and showing the American public we care about their concerns and we are determined to see to it that they are addressed.

I strongly urge the adoption of the Kassebaum amendment to strike the MSA provisions, adopt the other provisions, and then adopt this overall piece of legislation.

I yield the floor.

Mr. KENNEDY. Mr. President, how much time remains?

The PRESIDING OFFICER (Mr. KEMPTHORNE). The Senator has 24½ minutes.

Mr. KENNEDY. I yield myself 10 minutes of our time.

Mr. President, our distinguished colleague and friend, Senator KASSEBAUM, has outlined, I think very effectively, the reasons why we should reject the part of Senator DOLE's proposal that deals with medical savings accounts. Senator KASSEBAUM has outlined the principal issues which are at stake—both the cost and the health implications of MSAs, and I am in total agreement. My friend and colleague from Connecticut has expanded on those thoughts in a very effective way.

I think many of the provisions that the majority leader has introduced are useful and, by and large, helpful. He brings focus on the need for long-term health care for the American people. If there is a part of our Social Security system that has been really left out over the period of the recent years, it has been the failure to deal effectively with long-term care for our parents, for neighbors, for friends, for communities, and for the American people. We are blessed and fortunate to have people living longer lives and more productive lives. That is an increasing phenomenon. The fragile elderly increasingly are an important concern before us. To be able to attend to their particular needs in a thoughtful way either through long-term care, through nursing homes, or through home care is immensely important. The idea that we have long-term care insurance included in this legislation, I think, is commendable.

The leader as well has identified additional areas—providing the deduction for the self-employed; the small businesses around this country, in rural towns and in cities as well, have a particular disadvantage in terms of the cost of health care for their employees. And certainly there is a strong justification for that provision.

I believe the provisions which apply as well in terms of terminal illnesses, to help those that have terminal illness, to give them at least some assistance in terms of the tax system, again, to give them some tax relief, is a commendable system.

So I hope at the time we have an opportunity to address those particular issues that we will find broad bipartisan support throughout the Senate on those measures. There may be a feature or two that we might discuss, but I commend the leader for bringing attention to that and for adding that particular measure.

Mr. President, I agree that those issues have been debated and discussed. There is broad understanding of them and broad support for them, and we are certainly justified in accepting those. But the issue in terms of the medical savings account is another matter entirely.

For the reasons that have been outlined, the overall Kassebaum/Kennedy legislation has broad support. Senator KASSEBAUM and I are in agreement that we will resist amendments that do not have the overwhelming support of the Members. There are many different provisions that I would like to see which I think have been tried and tested and for which there is a very important need.

My good friend from Vermont has talked about lifting the lifetime limits in terms of health insurance because many of those that have serious disabilities run up against the top limits in their health insurance. I would like to support that measure. Senator JEFFORDS spoke passionately about it, and he believes in it, and I look forward to working very closely with him on a different health care proposal. I am convinced that we will pass that proposal here in the U.S. Senate and the House of Representatives.

I agree with my friend, Senator DOMENICI from New Mexico, who is one of the real leaders in this body in terms of mental health issues. During the course of the debate the last time we addressed the comprehensive issues of health reform, one of the real important features that we effectively worked out was that we were going to consider the challenges of mental illness as well as physical illness similarly and treat them equitably. They are not treated equally under current law. I have supported that. We debated

it. There is broad support for it. It is justified as a health improvement measure.

I support mandatory preventive services for children. That has been an issue where there has been broad support. It passed overwhelmingly in the Finance Committee as part of our previous discussions. There is strong justification for providing the range of services—immunizations, preventive, screening, and attention for children in our society. It is not costly. We have the expenditures for that proposal. Out of the list that is included in here, we certainly could have worked on that measure. There is broad support. But we have resisted that. Why? Because, as has been pointed out before, the range of different supporters that we have been able to gather for this measure—we have said that on this issue, on this bill, we will not accept provisions which are going to be untested, untried, and controversial in terms of their health implications and their cost implications.

There is not a lot of difference in this body—Republican and Democrat—about providing preventive health care services for children. There is not a lot of difference in this body in trying to equate mental health with other physical challenges. There is not a lot of difference I say in raising lifetime limits.

Those are measures that I feel strongly about and that I would like to support, but we do not have those measures up here. The reason we do not have them up here is because we have an understanding; we have an agreement that we are going to keep this legislation as close to the target as we possibly can in trying to deal with the problems of preexisting conditions so that individuals who are working and are playing by the rules of the game and are paying their premiums are going to be able, if they lose their job or change their job, to take their insurance with them. We are going to provide the incentives in terms of small business so that they can pull together and develop the economic advantages that the major corporations have. We have agreed to move in that area.

Now we have medical savings accounts. I have myself serious problems with that issue. Others have expressed support. The question should not be so much how we stand on these particular issues, but I want to just express very briefly my very serious concerns about it. But, nonetheless, it is highly divisive, highly controversial, and highly unacceptable. I think all of us understand that if this measure is included in the proposal, school is out—school is out in terms of amendments; school is out in terms of what may be added or what may be subtracted; school is out in terms of the focus and attention on a very important proposal that has the broad support and the unanimous support of Republicans and Democrats out of our committee.

So I hope that the proposal of Senator KASSEBAUM to strike this provision will be acceptable.

Let me mention briefly why I am opposed and others are opposed to medical savings accounts. First of all, over 10 years this is $3.2 billion. It is going to cost $3.2 billion. The fact of the matter is, we have to ask ourselves: Are we going to raise the deficit by $3.2 billion when many of us were around here trying to increase education programs, trying to even increase the various programs on Head Start? We were told we did not have the money when we tried to expand support for education on the Goals 2000, increasing academic achievement. We do not have that money. When we were out here trying to do something about increasing child care, we did not have the money. Now suddenly we have $3.2 billion. That is the cost, $3.2 billion.

So we have to ask ourselves: Well, $3.2 billion, who is going to benefit from the $3.2 billion? Is this going to be something that is going to be across the board in terms of beneficiaries? We can start right out and say, as the Joint Tax Committee has pointed out, no one whose income is below $20,000 will benefit one nickel—not one. Only one percent of all the benefits from the MSA proposal, will go to individuals who earn less than $30,000—only 1 percent of the benefits. Ninety-seven percent of the benefits will go only to people above the median family income in this country—only 3 percent of the benefits from MSAs will go to those below the median family income.

Who benefits from this? Who benefits are the wealthiest individuals. Sound familiar? Sound familiar? The higher income individuals are the ones that will be participating in this program.

So we ask ourselves at the beginning: Can we afford the $3.2 billion? If we get it, not according to my estimates, not by the various actuary and other groups, but by the Joint Tax Committee, Republican and Democrat alike, it has been pointed out that the great majority of Americans will not be eligible.

And why? It is quite understandable. They do not have the income to pay the deductibles for the MSA's. So therefore it does not do them any good. In order to be able to benefit from an MSA, an individual has to be able to afford the deductibles, and ordinary working Americans simply will not be able to do that; they won't be making enough money.

Secondly, we can ask, what is going to be the impact on our whole health care system? Well, the various reports that we have received—and we will have a chance perhaps to get into them in greater detail—demonstrate that what is going to happen in this situation is that the younger people and the wealthier people are going to take this opportunity to participate in the MSA's. They are going to take the opportunity. Why? Because they know they are not going to need to spend up to $3,000 for a sickness over the period of that next year. That is the deductible, $3,000. They know that by and large they are not going to get sick during that period of time. So they are not really at risk. They know they only need help if something serious is going to happen to them.

So the healthy and the individuals who have the resources are going to be the ones who use those MSA's. What about everyone else? Are they going to use it? Probably not. Because they know they are going to have deductibles and they know that they are going to have particular health care needs like every family has.

And the health implications of this are profound. It means that the general insurance pools are going to continue to include the sicker people, and the premiums are going to go up for everyone because they are going to have the sicker Americans and they are going to have the working Americans who can't afford the MSA's. And what is going to happen, the premiums are going to go up and therefore workers are going to begin to disband their commitment to health care for themselves because the costs are going up.

We have to ask ourselves: Does this really have an advantage in terms of savings? Is this a new process of delivering health care that many of us had hoped the HMO's would be? We hoped that by having the payment for health care at the beginning of the year and the incentives on the various kinds of HMO's to develop preventive programs that they would keep people healthier so they save money through prevention. But with MSA's, this won't happen.

To the contrary, every time a woman goes and gets a mammography test, they are going to have to pay out. Is that covered by your health insurance? No. Because you are not up to $3,000. Every time a woman gets a pap smear, she has to pay out. Is that going to be offset by health insurance? Absolutely not. They are going to have to pay out. All the screening for children, for the sons and daughters of working families, are they going to be encouraged to go to preventive health care? Absolutely not, because they are going to have to pay out.

Finally, make no mistakes—medical savings accounts are also part of the long-term Republican anti-Medicare agenda. Every senior citizen and every Senator who cares about Medicare should be aware of this Trojan horse. The special interests who are urging this provision now are part of the ongoing effort to undermine Medicare by turning it over to the private insurance industry. If we open the door to medical savings accounts for the non-elderly today, we will be opening the door to medical savings accounts for the elderly tomorrow and that is not a step Congress should take.

So, Mr. President, in summary, this proposal is skewed financially. The financial benefit goes to the wealthiest

individuals and to the healthiest people. It is poor health policy because it is going to disadvantage the incentives in the areas where you can provide true savings on health care, and that is going about the business of providing preventive health care.

One of the extraordinary ironies in terms of our budget policy here is you do not get any credit in terms of CBO when you move towards preventive care. Even though you save the Government millions and millions of dollars over the period of years, you cannot get credit for any kind of preventive care. That is where savings come about—when you immunize children, when you give well-baby care, when you give an expectant mother good kinds of care and nutrition so the child is going to be healthy rather than have medical complications at birth.

This vote is not just about medical savings accounts. It is also about whether Americans will get the genuine health insurance reform they deserve. Senator KASSEBAUM and I have pledged that we will resist controversial amendments, because they will kill this bill. We intend to vote against even controversial amendments that we support. Many other Senators on both sides of the aisle have made the same pledge. This vote is the test. If Senators insist on their narrow agenda, this health reform will die.

This is an unwise, untested, unjustified measure. It is effectively a poison pill. There are many other, more deserving health care issues that we ought to be accepting or addressing ourselves to that are a lot less costly than this particular measure, and I hope that Senator KASSEBAUM's amendment is accepted.

I would be glad to yield 12 minutes——

Mr. NICKLES addressed the Chair.

Mr. KENNEDY. Twelve minutes to the Senator, 12 minutes to the Senator from West Virginia.

The PRESIDING OFFICER. The Senator from Massachusetts controls 10 minutes.

Mr. KENNEDY. Twelve minutes to the Senator from West Virginia.

The PRESIDING OFFICER. Does the Senator from Oklahoma have an inquiry?

Mr. NICKLES. Mr. President, I believe that both the Senator from Delaware and the Senator from Massachusetts have control of the time, and I also think the Chair has usually recognized Senators seeking recognition, and then the Senators delegate how they allocate that time, I think is the normal procedure.

Mrs. KASSEBAUM. Mr. President, not to intervene here, but I would suggest that I think the Senator from Oklahoma has been waiting quite some time to speak. And while I am not in charge of the time at this point, it would seem to me best to let that back-and-forth proceed.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. I yield 10 minutes of the leader's time to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized for up to 10 minutes.

Mr. NICKLES. Mr. President, I thank you. I thank my colleague from West Virginia. I will be happy to accommodate my friend as well. I think it would be better if we go back and forth a little bit, if that is possible. I say to my colleague from Massachusetts, that was my interest because my colleague from Massachusetts has generated a little interest in me to respond.

I also compliment the Senator from Massachusetts and the Senator from Kansas for their work, but particularly I wish to compliment the Senator from Delaware and the Senator from Kansas, the majority leader, for this amendment. This amendment is probably the most significant health care provision that the Senate has considered in a long time.

I have heard a lot of people say we want to make insurance more portable; we want to make insurance more affordable. If you do, then we need to support Senator DOLE and Senator ROTH's amendment. That would include some tax equalization. The Tax Code is really skewed. It is really inequitable. It is not fair.

Let me just give you a couple of examples. The amendment that we have dealing both with the medical savings account and deductibility for self-insured help fix the problem—not totally, but they certainly improve it.

The Tax Code right now discriminates against people who do not work for generous employers. If you work for a generous employer, they can pay for your health care benefits and the individual can receive that tax free benefit, does not have to pay anything for it. It is nice. If you work for General Motors, they can deduct 100 percent for health care costs.

What if you do not work for a generous employer? What if you work for an employer who maybe cannot afford it or does not subsidize your health care? Then as an individual you have to pay for your health care with after-tax dollars. That is not fair.

What if you are self-employed? Right now, if you pay for your health care, you get a 30-percent deduction. Let me make sure everybody understands that. If you work for General Motors or a generous corporation, they get a 100-percent deduction, the company does. If you are self-employed, you get a 30-percent deduction.

That is not right. I used to run a manufacturing company, and at one time we paid 100 percent of health care costs. It was all deductible, a tax-free benefit for employees. I also used to be self-employed. Right now, they get 30 percent. I used to have a janitor service when I was self-employed. They only get 30 percent. But a big manufacturing company or a little manufacturing company, a corporation, they get 100 percent.

Now, what is right about that? That makes no sense, no sense whatsoever. This bill is going to help fix this.

What about an individual who maybe does not work, is unemployed. They need health care just as much as anybody else. This bill helps fix that. And the Senator from Massachusetts does not want to allow it to happen. He said, well, school is out if we allow medical savings accounts. Medical savings accounts are the only thing, the only thing, that will benefit somebody who does not have a job and wants to get health care. We do not help them in other areas. We are going to help them. We are going to say, yes, you can get health care; you can have your medical savings account; it is yours; it is portable; you do not have to have a job; it goes with you. It is not contingent on a job.

We use the Tax Code to encourage homeownership and so we say, you are entitled to an interest deduction on your home. And we do not say you have to have a job to get the interest deduction; it is yours; you designed the house, or you can buy the house. That is your decision, and it is your deduction. We do the same thing for other things. You make that decision. But we do not do it on health care. We say, well, you have to work for a generous employer. You get a real nice benefit. You work for yourself, you only get a third as much. You get a 30-percent deduction.

This bill takes it up to 80 percent for self-employed. And that is about what the average of a lot of companies is. So that is pretty equitable. It takes some time to get there, I might mention. We do not do it overnight. But at least it gets it up to 80 percent. That is a good move.

I compliment Senator DOLE. When we passed this originally in the Balanced Budget Act, it only went to 50 percent and Senator DOLE said, ''Let's make it 80 percent.'' He was right. That is equitable, and that means that Don NICKLES' janitor service gets just about as good a deal as a manufacturing company in 7 years.

That is a good provision. It needs to pass. But equally as important is that individual who does not have a job or that individual who is unemployed or that individual who works for an employer that does not give anything to their health care. Right now, they have to buy their health care with after-tax dollars. And they need health care as much as somebody working for any company in America. Let us help them. Medical savings accounts will help them, and they are not something untested and untried, as my colleague from Massachusetts said. We have something like 3,000 firms right now offering those.

Seventeen States now have MSA laws, an additional 11 States have called on Congress to enact MSA legislation. We ought to do it. Everybody ought to have the opportunity to have this choice. We are not mandating it on

anybody, but it should be a choice. They should have the opportunity.

What is the choice? Yes, they can buy insurance, I think pretty good insurance. They can buy insurance that is for the catastrophic illness. We say a medical savings account is very comparable to an Individual Retirement Account. Individuals can put in $2,000, families or couples can put in $4,000, and then use it for medical expenses. They have to buy at least catastrophic coverage, to cover the really expensive care. That makes sense.

We are encouraging this with medical savings accounts. A lot of the private sector is doing the same thing. In our company we used to ensure the first dollar coverage on anything. That is very expensive and it is not what insurance is for. When you buy car insurance you do not buy car insurance to fill the car up with gasoline or fill it up with oil. You buy car insurance for collision or something that is really expensive that you need insurance for. That also makes sense in the medical field, to let people use their own dollars for the small things, the routine things, the doctor's office visit. And they will use their own money. If they do not use it they can save it. It is not use it or lose it. They can save it, accumulate it. We encourage savings and they can use that money later for something that really is serious, that is problematic. Or they can use it for long-term health care.

This is a good provision. This will help countless middle-income families. Mr. President, 88 percent of the benefit falls to individuals who make less than $100,000. It is not for wealthy people, it is for American families and it will help people who get no help whatsoever from the present Tax Code. If we want to eliminate a lot of this tax inequity, medical savings accounts will go a long way to doing that. Let us give them some benefit. Right now they get zero. An individual who is unemployed, an individual who works for a corporation that does not subsidize his or her health care, they get zero tax benefits. Finally, if we pass this they will get something and to me that is a very positive contribution.

So I urge my colleagues, let us not make this a partisan issue. I know Senator BREAUX introduced a MSA bill in 1992. Senator DASCHLE, Senator NUNN, Senator BOREN, Senator Dixon—they cosponsored the bill. Representative GEPHARDT, in 1994—almost all Members but one of the Democrat Party on Ways and Means supported Mr. GEPHARDT's provision that had medical savings accounts. So why all of a sudden are we being partisan? This is a good provision. It is a bipartisan provision. It should be passed.

We should help individuals. We are not helping individuals. We should make insurance truly portable and we do that with medical savings accounts. It is not contingent on a job. If they lose their jobs they still have their medical savings account. It is portable. It stays with them. It is not contingent on employment. It is a good provision. So I am very disappointed in some of the comments that have been made.

This is a good provision. It will make health care more portable. It is the most portable health care plan you can have. It goes with the individuals. It is theirs. If they save the money and they do not spend it, it grows, it accumulates. They can use it for later times.

Also, it makes it more affordable. People are a lot more frugal with their own money than they are with employer money or than they are with Government money.

Mr. President, I urge my colleagues to pass the medical savings account provision, to vote against the amendment to delete this provision, and then also to pass the underlying Dole-Roth amendment. It is an excellent amendment that will help expand coverage to countless Americans that right now, because of inequities in the Tax Code, really come up short.

Again, I thank my colleague from Delaware for his leadership. And also Senator DOLE for proposing this amendment. I hope my colleagues will agree to it.

Mr. ROTH. Before we conclude action on the measure before us, I want to specially commend the Senator from Kentucky, Senator MCCONNELL, for his invaluable contribution to this effort. His introduction of S. 1658, the Family Choice in Long-Term Care Act, along with his behind-the-scenes advocacy on this issue, has made the difference in getting long-term care on the must-do list of health care reforms. Senator MCCONNELL has shown tremendous concern for the long-term care needs of elderly Americans and their families, and he has played a key role in proposing common sense and compassionate solutions to the problem. We all know how some people just talk about an issue; the junior Senator from Kentucky works issues, and the legislation before us reflects the work that Senator MCCONNELL has devoted to this crucial health care concern.

Mr. MCCONNELL. Let me thank the chairman for his generous remarks and for his tremendous work on this legislation. The need to provide meaningful long-term care coverage cannot be overstated. It is estimated that at least 40 percent of those aged 65 and over will require nursing home care at some point, costing an average of $38,000 per year. As the chairman knows, this poses a terrible Hobson's choice for most seniors and their families. Many seniors are forced to liquidate their life savings and sell off family heirlooms just to pay for this expensive care, and only when they have depleted nearly all of their assets will Medicaid pick up the tab. Because of the massive costs involved, private insurance has thus far played a negligible role in the financing of long-term care, accounting for less than 2 percent of long-term care payouts. The dearth of private planning options for long-term care is also having a devastating impact on strained State Medicaid budgets. Long-term care costs are draining away Medicaid resources that are needed to provide health care for indigent and disabled Americans. We cannot continue to rob Peter to pay Paul much longer. America's elderly population is expected to increase by almost 25 percent between 1993 and 2011, and this will place an unbearable burden on the Medicaid Program unless decisive action is taken. This bill provides essential private financing options for long-term care, and takes a positive step toward meeting the long-term care needs of future generations of Americans. Again, I want to thank the chairman for addressing this issue in his amendment, and look forward to having it signed into law.

Mr. SANTORUM. Mr. President, I wanted to take some time to discuss a specific provision included in the majority leader's amendment.

I have had the pleasure of working with the long term care industry in Pennsylvania during my service in Congress. I am extremely pleased that the leadership amendment included long-term-care provisions which will fill a void in the security of older Americans. I wrote my Senate colleagues this past week as well as the majority leader directly urging the inclusion of the long-term-care language. The long-term-care section will improve this bill by giving long-term-care insurance the same Federal tax treatment as health insurance and by establishing Federal long-term-care insurance standards and consumer protections.

The cost of long-term care is easily the biggest financial threat facing elderly Americans. The average cost of nursing home care has risen to $38,000 per year. We also know that more than 40 percent of those who turn 65 this year will require nursing facility care at some point in their lives. Medicaid does pay for nursing home care, but only after the costs of long-term care makes the recipient destitute. Basically, people in need of long-term-care services must pay for the care out of pocket until they spend down all their assets to the point of poverty. Then and only then do they qualify for Medicaid.

The real crime here is that people do not know that they will have to lose all their assets to obtain long-term-care services. They think Medicare covers it.

Even after 30 years of Medicare, many Americans remain confused regarding what Medicare does and does not cover—particularly regarding long-term care. Year after year, public surveys show that nearly half of Americans believe that Medicare covers long-term care. Because of this misconception, many Americans come to a rude awakening when they need long-term care for which they have not prepared. Helping individuals and families understand the limits on Government long-

term-care assistance and giving them incentive to prepare for their needs will encourage more Americans to plan for, save for, and insure against the costs of long-term care.

We currently allow acute health care expenses and insurance premiums to be deducted. State laws require car insurance, home or flood insurance, and other protections for individuals and families. Yet we do not require, much less encourage, people to plan for something that more than likely will impact them—the need for long-term-care services.

The language in the leadership amendment would correct this. Specifically, the provisions will give long-term-care insurance the same Federal tax treatment as health insurance and link tax provisions to Federal long-term-care insurance consumer protections. This second part is so important because it ensures that policies offer value to consumers and pay appropriately and adequately for quality long-term care when needed.

Not only would greater use of long-term-care insurance help protect individuals and families from impoverishment due to long-term-care costs, but it would also help control Medicaid costs. Mr. President, in the long run this will save money for the Medicaid program.

In a 1994 article in Health Affairs, Marc Cohen, Nanda Kumar, and Stanley Wallack estimated that having a long-term-care insurance policy reduces the probability of spending down to Medicaid eligibility levels by some 39 percent. The authors estimate that, in the aggregate, Medicaid expenditures would be reduced by $8,000 to $15,000 for every nursing home entrant who had a long-term-care insurance policy. According to the analysis, this translates into cutting what Medicaid pays per nursing home entrant in half for long-term-care policy purchasers. It is in our best interest to encourage people who can meet their long-term-care needs to do so. Medicaid will then take care of truly needy individuals.

The majority leader's amendment assists America's elderly and their families with long-term care by putting policies in place that help assure the affordability and value of long-term-care insurance. Giving Americans tax incentives to insure against the potential costs of long-term care will also save Medicaid dollars in the long run. Since we cannot continue to rely so heavily on scarce Government dollars to pay for long-term care, individuals and families should be encouraged to plan for, save for, and insure against the potential long-term-care costs. I urge my colleagues to vote for this amendment and to support this specific language.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that there be 10 additional minutes for debate, equally divided in the usual form.

The PRESIDING OFFICER. Without objection, it is so ordered. Who yields time?

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

Mr. ROTH. I am sorry, I did not hear.

Mrs. KASSEBAUM. There will be 10 additional minutes added, equally divided.

Mr. ROTH. I ask whether, because we agreed to a very brief time, whether at least on our side we could have another 10 minutes, total of 15 minutes.

Mr. KENNEDY. I will give you my 5.

Mrs. KASSEBAUM. That gives you 10 minutes additional.

Mr. ROTH. Can I have 15?

Mrs. KASSEBAUM. I think maybe you better take it. A bird in the hand is worth two in the bush.

The PRESIDING OFFICER. Who yields time? The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, how much time do we have remaining?

The PRESIDING OFFICER. The Senator from Massachusetts has 14 minutes and 55 seconds.

Mr. KENNEDY. I yield 10 minutes to the Senator from West Virginia.

The PRESIDING OFFICER. The Senator from West Virginia is recognized for up to 10 minutes.

Mr. ROCKEFELLER. Mr. President, I agree with the Senator from Oklahoma that this could be the most significant health care legislation that we have passed in a long time, which is why I think it is terribly important that we pass it. What has been made very clear, very distinct throughout this discussion, is that we are in an argument now on MSA. We have not been in an argument on anything else. We are in an argument on MSA. The agreement, from the very beginning, was to take the controversial stuff out; leave that for now, and do it later. It will probably pass on its own, but now is not the time.

To back that up, I have a letter from the NFIB. This NFIB letter, signed by Dan Danner, says, ''The NFIB opposes the adoption of any amendment to S. 1028 which would draw a Presidential veto or cause the bill to be defeated in the Senate.''

I repeat the statement of administration policy from the White House, in which they indicated, as their first priority, that for the bill to include medical savings accounts would, as they say, ''create grave risks to the passage and enactment of this bipartisan legislation.'' I think those who are pushing the MSA, for whatever the various interesting reasons that have floated around here for the past several days, ought to bear very carefully in mind that they are putting the entire bill in jeopardy. If the amendment passes with MSA's, as the Senator from Massachusetts said, ''school is out.'' Everything else comes in. The bill is down. The bill is gone. An opportunity is finished.

I hope people will take moral responsibility in considering the decision which they are making. In fact, every single serious health policy analyst—and you can laugh at them, except when you realize they are just about the whole gamut—they all say that giving a tax break for medical savings accounts is a very bad idea. I repeat—it is a very bad idea. Medical savings accounts, they say, would cherry pick the healthy people —yes—and drive up health care costs for the sick—yes. Medical savings accounts would further destabilize an already seriously fragmented insurance risk pool. And of course we understand what that means.

The insurance risk pool gets fragmented when companies self-insure; many big companies do that now. They did not 25 years ago. That puts more pressure on the small business market where you have individual insurance. It is a very, very risky business in any event, without thrusting MSA into it.

Another thought worries me. The Republicans put MSA's into reconciliation, with respect to Medicare. CBO has determined that only about 1 or 2 percent of Medicare beneficiaries would, in fact, select a medical savings account. But let there be no doubt in the mind of anyone here that what is hoped is that the MSA's would spread, indeed, to the whole concept of Medicare. This should represent to every one of my colleagues a very severe threat to the future of Medicare. That, I think, is what is in mind here. Furthermore, CBO concluded that healthy seniors would opt in and out of traditional Medicare based on whether they thought they would be using health services in that particular year. In other words, there would be no predictable pattern.

Lewin-VHI, a well respected consulting firm, concluded that ''An optional health coverage program that promises potential cash benefits to persons who are able to keep their health spending low will experience extreme selection bias.''

The American Academy of Actuaries has also been quoted. This is an interesting quote from them. ''Those who have little or no health care expenditures. . .would save money on MSA's. The greatest losses will be for those employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women.

A report from the Congressional Research Office, written by the nonpartisan folks there says, ''If MSA's only attracted the healthy, the cost of insurance for everyone else would increase due to adverse selection.''

The Kaiser Family Foundation has concluded that, ''Enrollees who leave the traditional Medicare plan would be healthier on average than those who remain in the traditional plan.''

Again, notice that threat—the Medicare beneficiaries lost to MSA's would

be healthier on average than those who remain in the traditional plan.''

That foreshadows an ominous future for Medicare. And you have this broad, broad coalition that is saying exactly the same thing.

Mr. President, I do not think it is any secret that there have been special interests working very hard on this in the last several days, and those who are in the process of making up their mind at this point, I think, might consider that there is really one group that is especially interested in this particular medical savings account activity. Their president was working the entire Capitol yesterday and saw a number of people. In exchange, they are hoping to win approval of a special tax break that they hope will throw millions of dollars in new insurance business their way. Is that a crude thing to say? I do not know. I think it is a major part of this debate, and I think it is a major part of the reason that we are in a debate we should not be in at all. Debate on this bill was to be based on the clear premise that we agree that controversial stuff should be left out—so we can take, as the Senator from Oklahoma said, 25 million kids and adults and improve their lives substantially, in terms of health care.

This is a bill which enjoys strong bipartisan support. MSA's do not enjoy strong bipartisan support. I have to conclude that the vote on this will be very close, and I hope as people vote, they will consider the pressures which have been brought, particularly by one single company, on Members on both sides of the House and the Senate.

Are we really going to do their bidding, or are we going to help 25 million people in this country when we have a historic chance to do it? I think the answer is easy. I hope my colleagues will move to strike the MSA provision. I thank the Presiding Officer.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield 4 minutes to Senator FAIRCLOTH.

The PRESIDING OFFICER. The Senator from North Carolina is recognized for up to 4 minutes.

Mr. FAIRCLOTH. Thank you, Mr. President.

Mr. President, what a difference 2 years makes. All of us remember that at this time 2 years ago, the Clinton administration was struggling to keep afloat their Health Security Act—the Clinton plan for a nationalized health care system.

In case anyone's memory needs refreshing, I have reproduced the chart that Senator SPECTER used to illustrate the workings of the Clinton plan. Once Members of Congress and the American people saw what was behind the President's rhetoric, nothing could save the Clinton plan. Once the American people realized that the Clinton plan was a big-government power grab on the most enormous scale ever attempted in this country, they rejected it.

Mr. President, in contrast, the general philosophy of Republicans in Congress supports health care reform that benefits and empowers Americans and their families on an individual scale. As these charts illustrate, this philosophy is about improvements for individuals, not big government.

On my chart, I have included four principles: affordability, availability, flexibility, and portability. In the bill we are now debating, Senator KASSEBAUM has done a fine job of addressing two of these principles. In the provisions for insurance reform and for insurance purchasing pools, Senator KASSEBAUM'S bill takes important steps to improve the availability and portability of health care coverage.

It is my strong and sincere hope that we can further improve this legislation by amending it to include provisions that enhance the flexibility and affordability of health care coverage for all Americans on an individual basis. The provisions I have in mind include those that I have placed on my chart: medical malpractice reform, increased deductibility of insurance for self-employed individuals, and medical savings accounts.

The majority of uninsured Americans are adults who work full-time jobs, usually in small businesses. Measures like more favorable rules for the formation of voluntary purchasing pools, increased deductions for health care expenses, medical malpractice reform, and medical savings accounts would give small employers more options at lower costs to help them offer the health coverage they currently cannot afford. Under these proposals the decisionmaking will remain where it belongs, with individuals and their employers.

To reduce the number of uninsured Americans, President Clinton proposed an employer mandate that would have required all businesses to cover their employees with a Cadillac plan designed in Washington. The result of this policy would have been hundreds of thousands of lost jobs, and hundreds of billions of dollars in increased costs for businesses.

President Clinton also proposed that his nationalized health care system would have been run by a system of health alliances. Through a complex system of cost controls and rationing, the bureaucrats who ran these alliances would have decided what Americans spent health care dollars on, and how much they spent individually and collectively. If medical savings accounts were available to Americans, any individuals who chose them would gain full control of their own health care decisions.

As chairman of the Labor Committee, Senator KASSEBAUM has done a commendable job of advancing the difficult issue of health insurance reform within the jurisdiction of her committee. But, medical savings accounts fall within the jurisdiction of the Finance Committee.

Mr. President, the rules of the Senate should not deprive the American people of the most meaningful free-market health care reform measure that we could give them.

Perhaps the most important debate that we can have is a debate on medical savings accounts. It is unfortunate that the administration has already tried to poison this debate by threatening to veto a health care reform bill that contains them. Their accusation is that anyone who wants to include medical savings accounts wants to kill the Kassebaum bill. That simply is not true. The truth is the President knows that if medical savings accounts become law, they will drive the final nails in the coffin of the Clinton plan, and bury his dream of nationalized health care.

Once individual Americans have the power to control how their own health care dollars are spent, they will never allow the Government to take that power back.

In his last State of the Union Address the President stated that ''the era of big-government is over.'' I wonder if he really meant it, or if he was just echoing a decision already made by the voters in the last elections. Regardless, the decision has been made. We should pass health care reform that ensures that the power to make health care decisions is placed in the hands of individual Americans, not big-government. That means health care reform that includes medical savings accounts.

I applaud the decision of Chairman ROTH and the majority leader to bring an amendment to the floor that contains medical savings accounts. Just as he has done so many times in the past Senator DOLE has shown the leadership necessary to make the difficult decisions, and push aside the administration's rhetoric.

Mr. President, there are very different goals involved in this debate. Our goal should be health care reform based on improvements for individuals, not health care reform based on big-government solutions.

I plan to strongly support the Dole-Roth amendment, and I urge my colleagues to do the same.

Thank you Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. FAIRCLOTH. I plan to support the Dole amendment and urge my colleagues to do the same.

Mr. ROTH. I yield 5 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized for 5 minutes.

Mr. SANTORUM. Thank you, Mr. President. I appreciate that.

As I always like to say, I was one of the first Members of Congress in either the House or Senate to introduce a medical savings account bill. I introduced a bill with JOHN KASICH, TOM DELAY and John Miller, a former Member from Washington, back in January

1992. I have followed it for a long, long time prior to corporate lobbyists being up here on the Hill, and I believe very strongly in its concept.

Let me explain. I guess we had a lot of talk about what is going on here with this specific MSA bill. Let me explain the concept behind medical savings accounts and the fear many of us have with, the best way I can put it, the ''corporatization'' of the health care field and how we see medical savings account as, really, the last chance for patient choice and for compassion in an industry that is becoming more and more regulated by third parties in the fundamental relationship between doctors and patients.

If I can, let me just walk back to the system we had before managed care came into place. What we had was a doctor/patient relationship. That was the problem. There was nobody in this relationship who had any incentive to control costs. As a rule, costs escalated out of control. Why?

If you were the patient and had first-dollar coverage, who asked how much things cost? Who asked whether you needed one or two or five of these? You took whatever the doctor suggested and you did not pay for it, so why did you care?

So, on the other side is the doctor, and what is the doctor's incentive in this doctor/patient transaction? The more the doctor does, the more money he gets paid. The more the doctor does, the less chance the doctor gets sued. So you have a doctor who gets more money, with less chance of being sued, and you have a patient who does not pay for anything.

Then we sat back and wondered several years ago, gee, why are health care costs going up? It was very simple. There was nobody with any incentive to control costs. We understood that and companies understood that and insurance companies understood that, and they did a very logical thing. They brought someone in to control costs, the gatekeeper, the insurance company, who came in; and now they are governing the relationship between the doctor and patient. If you want something done, you go through the insurance company. You get approval, and it can be done. That is now the governor, the one who is in charge of this relationship.

What many of us believe is that that is not the most compassionate, and some would suggest that it may not result in the best quality of care. It certainly does not result in the maximization of patient choice. So what we have put forward is a concept called medical savings. I think it is really misnamed. I think we should call it ''patient choice accounts,'' because that is what is left. If we do not do medical savings accounts, if we do not do patient choice accounts, the doctor-patient relationship which we know will disappear in America. It will disappear. It is disappearing, has disappeared, in a lot of communities already in this country.

We hear so much from so many people on both sides of the aisle about being compassionate, about caring for people, about doing things to give people choices and to give people the ability to do what is best for them and their families. What we have here is a situation going on in the private sector in America where that choice is going away. Private practice is almost a thing of the past in many communities and is growing more apparent in all States across this country.

What medical savings accounts do is provide a chance, an opportunity, for the traditional doctor-patient relationship to be restored where now the incentive is on the patient to be cost conscious. How? Because, instead of the old system where you had first-dollar coverage and the insurance company pays for everything, we are going to say, look, we are going to take a higher deductible policy like an auto insurance policy—we do not pay, as Senator NICKLES said, for gasoline or oil changes—but you pay for the incidental costs of health care, the day-to-day costs, and we insure you for the catastrophic illness or for a year where you had a lot of serious problems.

So you take a high-deductible policy and you pay for the out-of-pocket expense and you afford that because, when you take a higher deductible policy, the cost of that policy is less.

Senator CRAIG gave an example earlier where a policy with a $250 deductible and a $500 cap and a 20-percent copay cost $458 a month for a family. A $3,000 deductible policy, same coverages, no copay, costs two-thirds less, costs under $200 a month. Where did that savings go between the $200 and $450? It went into the pocket of the person who had the medical savings account.

It would go, under this bill, tax free into an account you set up at your bank. You get a little debit card. You could then use it to purchase health care. You could use it to make choices about what doctor you wanted to go to, what hospital, and how much you wanted to spend.

I always ask people, ''Who are the lowest paid doctors in this country?'' Well, they are pediatricians and family practitioners and dentists because they are not covered under insurance. Why? They have to charge people who pay out of pocket, so they have to keep their costs down. Just imagine if we did that to most of the health care sector in this country. It would be an enormous contraction, I believe, in costs in our society. It would not lead to higher costs in other areas, in other insurance pools. I think this is a dramatic step forward. This is the reason that I applaud Senator DOLE for fighting to the end because this is the kind of dramatic reform that this country needs to preserve freedom of choice for patients.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. Mr. President, I yield 2 minutes to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas is recognized for up to 2 minutes.

Mrs. HUTCHISON. Thank you, Mr. President.

I appreciate the chairman's generosity in letting me talk on this very important issue. I wanted to speak on two points on the amendment. First, the deductibility for the self-employed is such an important step forward that the people who are self-employed will be encouraged to get health care coverage for themselves, and that is what we are trying to do here. It is what we have been trying to do for 2 years. To increase the tax deductibility for them to 80 percent from 30 percent is a big step in the right direction to encourage more people to get health care coverage.

The issue of medical savings accounts—''patient choice accounts'' is a great name for it because it really will make a difference for so many people and so many small businesses in this country, giving them an opportunity they would not have had.

Senator KENNEDY's bill in 1994 had language saying that they hoped there would be medical savings accounts included in the health reform bill passed by the Senate. This is not a partisan issue. Congressman JACOBS and Congressman TORRICELLI today wrote the President of the United States asking him to support MSA's.

Let me give you some examples of companies that have benefited from MSA's, medical savings accounts, patient choice accounts.

Dominion Resources in Richmond, VA. Since 1989, the company's health care costs have risen less than 1 percent a year while other health care costs all over this country have risen over 10 percent. Here we are at 1 percent a year. Not only have their costs come down, but their employees are happy because they have had improved and expanded medical benefits under their medical savings accounts.

Knox Semiconductor in Rockport, ME. Their president says they have saved the company $100,000 over 3 years. That is with just 42 employees.

The National Center for Policy Analysis in Dallas, TX, has been on the leading edge of giving their employees the choices. They have been able to contain their health care costs, and their employees are happier with their coverage.

Mr. President, medical savings accounts are a key part of the reform that is necessary to give more health care coverage to more people, more working people, in our country. That is why it is important to keep this amendment, the medical savings account, in the bill. Thank you, Mr. President. I thank the chairman.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield 4 minutes to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Delaware controls 2 minutes 30 seconds.

Mr. ROTH. With 1½ minutes of leader time, we have a total of 4 minutes.

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

The Senator from Iowa is recognized for 4 minutes.

Mr. GRASSLEY. Mr. President, the best thing we can do for health care reform is to let the marketplace operate to a greater extent in the delivery of health care. This issue is the most important one that faces us today. You know how strong our argument is from the weakness of the argument made by those on the other side of this question.

The other side's argument is that we should leave this medical savings account provision out of this bill because it happens to be controversial. Well, that is the strength of their argument: it is controversial in Washington, DC; that is, inside the beltway. Well, Mr. President, medical savings accounts are not controversial outside of Washington, DC.

The people who oppose this amendment are some of the same people who believe that Washington knows best, that Washington knows how to dictate the delivery of health care better than the people themselves do, particularly people at the grassroots. It seems to me a weak argument when the strongest argument against this legislation is that it is controversial. Since when is giving people more choice in health care controversial? That is what people want. That is what people know will work better. This is the usual big Government argument against any changes.

It is the argument in favor of big government versus letting the free marketplace work. It is the old in favor of big government making decisions for people, as opposed to letting people themselves make decisions.

Medical savings accounts give people choice. It is letting people control their resources for health care. Quite frankly, it is going to save us a lot of money and reduce health care costs.

I am very happy that the leadership puts forth this amendment, because allowing medical savings accounts is a step in the right direction. They are basically like IRA's, giving people an opportunity to save for their retirement. Medical savings accounts are giving people an opportunity to save for themselves and to control their resources for their own medical expenses.

There is a widespread use of medical savings accounts already in this country that speaks better than any of us can to their legitimacy and to their hope for success. They should reduce health care costs. Administrative costs are lower. Consumers with MSA's should use health care services in a more discriminating manner. Consumers with MSA's should be more selective in choosing providers. This should cause those providers to lower their prices to attract medical savings account holders as patients. Medical savings accounts can also help to put the patient back into the health care equation.

Patients should make more cost-conscious choices about routine health care. Patients with medical savings accounts would have complete choice of providers. Medical savings accounts should make health care coverage more dependable. Medical savings accounts are completely portable. Medical savings accounts are still the property of the individual, even if they can change jobs.

Hence, for those reasons, I support medical savings accounts. I very much thank the leadership for providing this amendment. I yield the floor.

Mr. DASCHLE. Mr. President, I know that we want to have a vote by 4 o'clock so I will divide the time remaining with the distinguished Senator from Delaware.

How much time remains?

The PRESIDING OFFICER. Six minutes and twenty-two seconds.

Mr. DASCHLE. I yield 3 minutes to our side and leave the Senator from Delaware the final 3 minutes.

Mr. President, given the very short period of time we have remaining, and the fact that all of the arguments have been made, let me simply summarize the case against including MSA's on this bill.

Two years ago we all agreed that comprehensive health care reform would not pass. In the last year and a half we have all agreed that we can only pass something which enjoys broad bipartisan support. It was with that understanding and with the remarkable leadership of the Chair of the Labor Committee, the distinguished Senator from Kansas, and the Senator from Massachusetts, we now have a bill that we all agree is the only health reform legislation that can pass this Congress with broad, bipartisan support. This narrowly drafted bill some of the most pressing health problems facing Americans.

Portability and coverage for preexisting conditions are two of the most important issues we face. So let there be no mistake, we have an opportunity today to pass something, but we also have an opportunity to kill that very bill with this MSA provision in this amendment. The NFIB clearly stated in a letter dated today, and they have said very clearly, ''We oppose any amendment which will bring about a defeat of the legislation before us.''

They recognize the importance of this moment. They recognize what an opportunity we have before us. We should not blow it. We should not kill this bill. Let us recognize there will be another day to have yet another debate about many other health care issues. But let us not destroy the golden opportunity we have today to pass meaningful legislation, by adding something as controversial as MSA's. We can do better than that. We will do better than that if we can, on a bipartisan basis, strike the MSA portion of the Dole amendment and pass this bill intact, as we know we can.

If we do that we can look back on this Congress with some satisfaction that we have done our best under these circumstances to address some of the real health care problems working Americans face.

I yield the floor.

Mr. ROTH. Mr. President, medical savings accounts are among the most important steps that must be taken to address this country's health care needs, particularly the need for portability. MSA's are of such importance in our effort to address our health concerns that on September 8, 1992, several of my distinguished colleagues signed a letter calling for the introduction of MSA's as part of their bill.

Let me quote a portion of that letter:

> Unlike many standard third-party health care coverage plans, Medical Care Savings Accounts would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their ''own'' money. . . Once a Medical Savings Account is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. Recent studies show that at least 50 percent of the uninsured are uninsured for four months or less. . . . Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventative care services. With Medical Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services.

Mr. President, these are important arguments that were made for MSA's over 3 years ago. They are equally, if not more, important today. That letter was signed by Senators BREAUX, BOREN, DASCHLE, LUGAR, COATS, and NUNN, a formidable bipartisan coalition of Senators taking a necessary stand on a critical issue.

Mr. President, I have a copy of a letter received from the Vice President of the NFIB that makes it clear that they are supporting the MSA. This letter, dated today, April 18, 1996, to the Honorable DON NICKLES says, ''Overall, NFIB members need health care reform. It has been a top priority for years. MSA's are among the provisions we have consistently supported. These also include portability, no preexisting condition exclusion, deductibility, and small business purchasing groups. We will continue to fight for all these provisions of importance to small business.''

For these reasons, Mr. President, I urge my colleagues on both sides of the aisle to vote against the motion to strike. I yield the floor.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to the KASSEBAUM amendment No. 3677.

Mr. KENNEDY. 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 clerk will call the roll.

The legislative clerk called the roll.

Mr. LOTT. I announce that the Senator from Florida [Mr. MACK] and the Senator from Colorado [Mr. CAMPBELL] are necessarily absent.

The VICE PRESIDENT. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 46, as follows:

[Roll Call Vote No. 72 Leg.]

YEAS—52

Akaka	Feinstein	Levin
Baucus	Ford	Lieberman
Biden	Glenn	Mikulski
Bingaman	Gorton	Moseley-Braun
Bond	Graham	Moynihan
Boxer	Harkin	Murray
Bradley	Hatfield	Nunn
Breaux	Heflin	Pell
Bryan	Hollings	Pryor
Bumpers	Inouye	Reid
Byrd	Johnston	Robb
Chafee	Kassebaum	Rockefeller
Conrad	Kennedy	Sarbanes
Daschle	Kerrey	Simon
Dodd	Kerry	Wellstone
Dorgan	Kohl	Wyden
Exon	Lautenberg	
Feingold	Leahy	

NAYS—46

Abraham	Gramm	Nickles
Ashcroft	Grams	Pressler
Bennett	Grassley	Roth
Brown	Gregg	Santorum
Burns	Hatch	Shelby
Coats	Helms	Simpson
Cochran	Hutchison	Smith
Cohen	Inhofe	Snowe
Coverdell	Jeffords	Specter
Craig	Kempthorne	Stevens
D'Amato	Kyl	Thomas
DeWine	Lott	Thompson
Dole	Lugar	Thurmond
Domenici	McCain	Warner
Faircloth	McConnell	
Frist	Murkowski	

NOT VOTING—2

Campbell	Mack

So the amendment (No. 3677) was agreed to.

Mrs. KASSEBAUM. Mr. President, I move to reconsider the vote.

Mr. KENNEDY. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. DOLE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. CRAIG). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DOLE. 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. DOLE. Mr. President, we had hoped that we might have a vote on the Dole amendment, a rollcall vote here. I need to check with one Senator on this side. Is there any objection on the other side to having a vote at this time or not? Are you prepared?

Mr. DASCHLE. Yes.

Mr. DOLE. I would say with reference to the last vote, I think it was a close vote. As one of the conferees on the tax side, I think there will still be opportunities in conference. We wanted as many votes as we could have. We have one absentee so I think we have about 47 or 48 votes, which puts us in a strong position in the conference.

But, in any event, the outcome here may permit us to conclude action on this bill today, hopefully. I trust that is what the managers have in mind.

So, perhaps maybe Senator DORGAN might proceed at this time so we would not lose any time, if he wants to take his 15 minutes now while we are checking to see if we can go ahead and have the vote?

Mr. DORGAN. I say to the majority leader, if the majority leader wishes to proceed I will defer my time until after the vote. I do not need to intervene at this point. All I want to do is get the appropriate time following the vote.

Mr. BUMPERS. Will the majority leader yield for a question?

The PRESIDING OFFICER. The Senate is not in order.

Mr. DOLE. I will be happy to yield to the Senator.

Mr. BUMPERS. Mr. President, I wonder if it is too early for the majority leader to tell us if plans have been made for a session tomorrow and, if so, will votes be included tomorrow?

Mr. DOLE. If we can complete action on this bill tonight I do not anticipate any votes tomorrow. We will probably move to term limits, unless we could have some agreement. There would not be any votes.

I do not believe there are that many amendments left on this bill. So, as soon as I check with the Senator from Texas, we will be able to proceed.

Mr. COHEN. Will the Senator yield? I inquire whether or not he included the antifraud provision in his amendment?

Mr. DOLE. We included the Cohen antifraud provision, which I think will save $3 billion.

Mr. COHEN. According to the CBO, they scored a $3 billion savings. I want to commend Senators DOLE and ROTH for including it in the package. We are losing roughly $18 billion a year just out of the Medicare Program itself, and we are losing about $100 billion itself throughout the health care system. It works out to about $275 million a day, $11.5 million an hour. I would also like to thank Mary Gerwin, Helen Albert, and Priscilla Hanley from the Aging Committee for all their hard work on the fraud legislation.

Mr. President, last spring the Medicare trustees, on a bipartisan basis, issued an urgent warning that the Medicare hospital trust fund will go broke by the year 2002, unless major changes are made to protect the system. Since that alarm was sounded, the Congress has been wrestling with ways to bring Medicare spending under control, in order to forestall impending bankruptcy and to strengthen Medicare for both current and future beneficiaries.

The debate over how—and how much—to control the unsustainable growth of Medicare spending was part of the budget reconciliation process which now remains stalled.

A major step we can and must take toward Medicare reform is to crack down on the fraud and abuse that drives up the costs of health care for senior citizens and taxpayers. Estimates are that Medicare loses over $18 billion each year to fraud and abuse, and that fraudulent schemes cost the entire health care system and our economy over $100 billion each year.

The investigation of the Senate Special Committee on Aging, which I chair, has revealed that it is shockingly simple to commit health care fraud, and that the size, complexity, and splintering of the current health care system creates an environment ripe for abuse.

Health care fraud is equal opportunity employer that does not discriminate against any part of the system. All Government health care programs—Medicare, Medicaid, CHAMPUS, and other Federal and State health plans, as well as private sector health plans, are ravaged by fraud and abuse.

Similarly, no one type of health care provider or provider group corners the market on health care fraud. Scams against the system run the gamut from small companies or practitioners who occasionally pad their Medicare billings because they know they'll never get caught, to large criminal organizations that systematically steal millions of dollars from Medicare, Medicaid, and other insurers. According to the FBI, health care fraud is growing much faster than law enforcement ever anticipated, and even cocaine distributions are switching from drug dealing to health care fraud schemes because the chances of being caught are so small—and the profits so big.

Of particular concern is the growing evidence that health care fraud has infiltrated the health care industries providing services to our nation's elderly and disabled Americans, and in turn, contributing to the runaway costs of these entitlement programs.

The Inspector General of the Department of Health and Human Services, for example, has cited problems in home health care, nursing home, and medical supplier industries as significant trends in Medicare and Medicaid fraud and abuse. Padding claims and cost reports, charging the government and patients outrageous prices for unbundled services, and billing Medicare for costs that have nothing to do with patient care are just a few of the schemes that are occurring in these industries.

Unscrupulous providers are enjoying a feeding frenzy on Medicare and Medicaid, while taxpayers are picking up the tab for their feast.

It is time that we crack down—and shut down—these schemes that are bilking billions of dollars from Medicare and other health care programs. If we have asked honest health care providers to take cuts in reimbursement and asked Medicare and Medicaid recipients to pay more out-of-pocket costs to bring spending under control,

we have an absolute duty to ensure the American public that their health care dollars are not lining the pockets of criminals and greedy providers who are manipulating the system through fraud and abuse.

I was very pleased that the budget reconciliation bill includes anti-fraud legislation that I introduced last year as a result of an investigation of the Special Committee on Aging and I am pleased that my legislation is included in the leadership amendment on the Kassebaum bill.

Specifically, the proposal creates tough new criminal statutes to help prosecutors pursue health care fraud more swiftly and efficiently, increases fines and penalties for billing Medicare and Medicaid for unnecessary services, overbilling, and for other frauds against these and all Federal health care programs, and makes it easier to kick fraudulent providers out of the Medicare and Medicaid Program, so they do not continue to rip off the system.

Most importantly, the bill establishes an antifraud and abuse program to coordinate Federal and State efforts against health care fraud, and substantially increases funding for investigative efforts, auditors, and prosecutors.

According to the Congressional Budget Office, these provisions will yield over $3 billion in scorable savings to Medicare—without costing a penny to senior citizens. I am convinced that the long-term savings are much greater, and that billions more will be saved once dishonest providers realize that we are cracking down on fraud, and that they can no longer get away with illegally padding their bills to pad their own pockets.

The legislation has received the support of the FBI Director, the Attorney General, the HHS' Secretary, and the Congress, which passed it as part of Budget Reconciliation. We should not let an opportunity to pass this bill go by. We lose as much as $275 million per day or as much as $11.5 million per hour to health care fraud and abuse. Every day we wait, will be a victory to those unscrupulous providers who are bankrupting our public health programs.

I urge my colleagues to support this important endeavor and I would like to thank Senators ROTH and DOLE for including this proposal as part of the leadership amendment.

Mr. HATCH. If my colleague would yield for a moment, I would like to take this opportunity to discuss some concerns I have with the section which pertains to establishment of a new health care fraud and abuse data collection program.

Mr. COHEN. I would be glad to yield to my colleague.

Mr. HATCH. As you may be aware, the alternative medicine community has expressed concerns about this provision. I have received communications from, for example, the American Preventive Medical Association and the National Nutritional Foods Association. In general their concerns—which I share—focus on the potential abuse of the fraud provisions we are passing today. I am sure my colleague is aware, for I know he shares my strong support for alternative medicine, that providers of alternative medical treatments sometimes find themselves in the cross hairs of the more traditional medical establishment. Personally, I believe that both alternative and traditional medicine are important and that both can benefit patients. But, this cooperative coexistence has not been fully realized it seems.

While we are all supportive of strong efforts to weed out health care fraud and abuse, I hope the Senator from Maine will agree that we do not want to create an opportunity for those who might want to eliminate or discourage such alternative treatments by threatening fraud actions under the new language we are considering today.

Mr. COHEN. My colleague is correct. I have long been interested in promoting alternative medical treatments and I do not have any desire to enact a new law which might treat such providers unfairly. Could the Senator from Utah share with me specific concerns?

Mr. HATCH. I would be glad to. I have concerns in four specific areas. First of all, would the Senator agree that the mere practice of unconventional or non-standard therapies would not fall within the definition of fraud? I am not asking you to amend the bill here, but rather to give me your assurances and the implementing agencies your guidance that such is the case.

Mr. COHEN. I agree with my colleague that the practice of alternative medicine in itself would not constitute fraud.

Mr. HATCH. Thank you. My next concern relates to creation of the health care fraud and abuse data collection program. As you know, some people are concerned about the very establishment at the Federal level of this new program. I understand those concerns, but I also am very sympathetic to my colleague's argument that this would be a strong weapon in our Federal arsenal to fight the fraud and abuse which are costing our health care system so many billions of dollars each year and robbing us of valuable resources which would be better used for patient care.

The specific concern I want to raise now is that the program not duplicate existing data bases which already collect information about credentialing, licensing, and malpractice violations against providers. Is that the Senator's intent?

Mr. COHEN. My language does not cover malpractice at all. Further, it is my intent that the new data collection system be coordinated with existing data bases, so that there is no costly and burdensome duplication of effort. I have revised the language to reflect my colleague's concerns in this area. The new language makes it clear that there should be coordination with existing databases.

Mr. HATCH. I appreciate my colleague's actions to accommodate my concerns here. Turning to another concern I have with respect to reporting action on licensing and certification of health care providers, suppliers and licensed health care practitioners, I understand that the Senator intends that the actions to be reported are final actions, after completion of due process. Is my understanding correct?

Mr. COHEN. That is correct. I would want to make certain that participants in the system can avail themselves of due process guarantees, and that only final actions be included in the new database.

Mr. HATCH. The last issue I wish to raise is with respect to a data base requirement of reporting providers, suppliers, and licensed health care practitioners who are excluded from participation in Federal or State health care programs. This is my concern. Increasingly, managed care organizations are excluding providers from participation solely because of economic concerns, not because of any wrong-doing or program violations. For example, a physician could be excluded from a managed care organization certified by the State to care for the Medicaid population solely because that provider may have ordered more services than the managed care plan allows. If a provider were excluded from participation in such a plan because of such ''economic decredentialing,'' could that provider be reported to the data base?

Mr. COHEN. That is certainly not my intent. I have revised the language in the bill to state specifically that only exclusions for program violations are to be reported.

Mr. HATCH. I thank Senator COHEN very much for his work in this area, and specifically for his efforts to clarify the bill with respect to the treatment of alternative medical providers. I think that his changes have improved the bill greatly. I appreciate his efforts in this regard.

Mr. PELL. Mr. President, I ask unanimous consent to speak as in morning business for 4 or 5 minutes.

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

THE TRAGEDY IN LEBANON

Mr. PELL. Mr. president, I am deeply upset by this morning's news from Lebanon. As many of my colleagues have heard, Israeli shells hit a United Nations base in the village of Cana near the city of Tyre, within which approximately 500 Lebanese civilians had taken refuge from the recent fighting between Israel and Hezbollah. According to early press reports, the shelling caused the death of at least 75 Lebanese refugees—and perhaps many more than that—including men, women, children, and the elderly. At least 120 have been wounded, and two Fijian peacekeepers were killed.

Both the United Nations and Israel agree that minutes before the Israeli attack, Hezbollah guerrillas had fired Katyusha rockets at Israel from a position roughly 300 meters from the refugee camp. Clearly the Israelis were responding to the Katyusha attack, and unintentionally hit the refugee camp. Israeli officials, including Foreign Minister Barak, have issued assurances that Israel is not targeting civilians and would not have fired intentionally on a U.N. base.

If today's early news reports are correct, then we have witnessed a tragedy in the classic sense of the word—the deaths of these innocent civilians need not have occurred. Hezbollah has no right to launch rockets in such proximity to a refugee camp, apparently hoping to use the refugees as a shield against Israeli retribution. Israel, by the same token, has no right to respond as it did if it had any inkling that civilians would be harmed. If either party had put the best interests of the refugees first, then some 75 innocent noncombatants would be alive right now.

I do not dispute that Israel has a right to its own self-defense. I have taken care not to criticize Israel for its actions in Lebanon for the past 8 days because I understand well the threat that Hezbollah poses to Israel's security. I am keenly aware of—and condemn—Hezbollah's actions and intentions towards Israel. There can be no doubt that Hezbollah aims squarely to undermine the Middle East peace process, and I, in fact, agree with the widely held public sentiment that Israel was prodded into this latest operation in Lebanon. The overwhelming carnage of the past 8 days, however, compels me to call attention to what increasingly looks to be a disproportionate Israeli response. We cannot wring our hands about Hezbollah attacks against civilians and say nothing of Israeli excesses, whether or not they were intentional. Human life, after all, means as much on one side of the border as the other.

In the effort to root out Hezbollah, the Israelis appear to be attempting to cripple Lebanon's civilian economy and infrastructure. But as it tries to turn Lebanon against Hezbollah, Israel is running the risk that Lebanese Government and people will lose any stake in settling their differences with Israel peacefully. I fail to see how such an outcome serves Israel's long-term interests.

In being critical of Israel, I do not wish to absolve the Lebanese Government or Syria of their own responsibilities. Lebanon does not have the luxury of throwing up its hands and saying that it has no control over Hezbollah, and then complaining when Israel takes matters into its own hands. That is having it both ways. And I reserve special criticism for Syria. Syria has both the power and the means to shut down Hezbollah, but cynically lacks the will and has allowed Hezbollah's terrorism to go unchecked.

President Clinton has just announced that U.S. Special Middle East Coordinator Dennis Ross—and subsequently Secretary of State Christopher—will go to the region to try to end the violence. I join the President in calling for an immediate cease-fire. After today's tragedy, I would urge Israel—our friend, ally, and presumably the most advanced democracy in the region, to show greater restraint. As the stronger and more enlightened party, Israel even should contemplate a unilateral cease-fire. I understand fully that Israel faces enormous security risks, but its obligations to avoid miscues such as today are equally great.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senate majority leader.

HEALTH INSURANCE REFORM ACT

The Senate continued with the consideration of the bill.

Mr. DOLE. Mr. President, I wonder if we can get the yeas and nays on the Dole-Roth amendment. I 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. DOLE. Maybe that vote can follow the statement of the Senator from Delaware, if it is all right with the Senator from North Dakota to wait for a later time.

Then after 3 minutes for the Senator from Delaware, we can start the vote on the Dole-Roth amendment.

TRAGIC MISTAKE IN LEBANON

Mr. BIDEN. Mr. President, I thank the majority leader. I was not going to take the occasion today, but in light of the distinguished Senator from Rhode Island speaking on this issue, I do not take issue with what he said but emphasize a very important point, from my point of view: this issue of sovereignty in Lebanon and whether or not there was a tragic mistake made in this particular raid. I do not deny there was a tragic mistake that was made.

I know we all know and heard that the Israeli military had no intention of striking the target they, in fact, struck. That happens in war. But the full responsibility, in my view, falls on the Lebanese Government and the Syrian Government. How can we talk about sovereignty, how can we talk about the notion that you cannot violate a nation's borders when, in fact, one nation—and the nation in this case, Lebanon—has within its borders Hezbollah that is, in fact, not under its control but within its mandate, and take no action to stop the action they are taking, firing Katyusha rockets into civilian populations into Israel and Syria, which has control of much of that area, refusing to do anything to stop it, and then criticize Israel for acting.

I just ask you all, what would happen if across the Mexican border Katyusha rockets were being fired into El Paso, TX, on a regular basis and the Mexican Government did nothing whatsoever to stop the terrorists from that action? Is there any American who would say we should withhold taking action on the grounds that we are crossing an international border? I think we would not even think twice about it.

I regret deeply the mistaken target that was, in fact, hit. I am confident the Israelis do as well. But we should be putting international pressure on Syria and Lebanon to act and deal with the Hezbollah operating almost in plain view across the Israeli border terrorizing Israeli citizens.

I yield the floor and thank my colleagues.

HEALTH INSURANCE REFORM ACT

The Senate continued with the consideration of the bill.

VOTE ON AMENDMENT NO. 3676, AS AMENDED, AS MODIFIED

The PRESIDING OFFICER. The question occurs on agreeing to amendment No. 3676, as amended, as modified, offered by the majority leader.

The yeas and nays have been ordered. The clerk will call the roll.

The bill clerk called the roll.

Mr. LOTT. I announce that the Senator from Colorado [Mr. CAMPBELL] and the Senator from Florida [Mr. MACK] are necessarily absent.

The PRESIDING OFFICER (Mr. DEWINE). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 73 Leg.]

YEAS—98

Abraham	Feinstein	Lugar
Akaka	Ford	McCain
Ashcroft	Frist	McConnell
Baucus	Glenn	Mikulski
Bennett	Gorton	Moseley-Braun
Biden	Graham	Moynihan
Bingaman	Gramm	Murkowski
Bond	Grams	Murray
Boxer	Grassley	Nickles
Bradley	Gregg	Nunn
Breaux	Harkin	Pell
Brown	Hatch	Pressler
Bryan	Hatfield	Pryor
Bumpers	Heflin	Reid
Burns	Helms	Robb
Byrd	Hollings	Rockefeller
Chafee	Hutchison	Roth
Coats	Inhofe	Santorum
Cochran	Inouye	Sarbanes
Cohen	Jeffords	Shelby
Conrad	Johnston	Simon
Coverdell	Kassebaum	Simpson
Craig	Kempthorne	Smith
D'Amato	Kennedy	Snowe
Daschle	Kerrey	Specter
DeWine	Kerry	Stevens
Dodd	Kohl	Thomas
Dole	Kyl	Thompson
Domenici	Lautenberg	Thurmond
Dorgan	Leahy	Warner
Exon	Levin	Wellstone
Faircloth	Lieberman	Wyden
Feingold	Lott	

NOT VOTING—2

Campbell	Mack

So the amendment (No. 3676), as amended, as modified, was agreed to.

Mr. MCCONNELL. Mr. President, 2 years ago, the Senate debated President Clinton's massive, 1,400-page proposal to radically restructure America's health care system. After great fan fare, this big-government era proposal faltered under the crushing weight of its 8 new entitlements, 17 new taxes, 50 newly-minted government bureaucracies, 177 new State mandates, and nearly 1,000 new Federal powers and responsibilities.

Republicans promised then that we would provide the focused, consumer-based health care reform plan that Americans have asked for by an overwhelming margin. Today, under the leadership of Senator KASSEBAUM, Senator ROTH, and Senator DOLE, we deliver on that promise.

S. 1028, the Health Insurance Reform Act, focuses on alleviating key burdens that restrict the ability of Americans to obtain and maintain health care coverage—a lack of portability and the barrier of preexisting conditions. Today when Americans change jobs or face layoffs, they are at-risk of becoming uninsured or subject to preexisting condition exclusions. When employers are forced to frequently change health care plans to control costs, employees with medical conditions find themselves further exposed to coverage gaps.

S. 1028 presents reforms that definitively address these problems. This bill limits the ability of insurers and employers to impose preexisting condition exclusions. It prevents insurers from dropping coverage when an individual changes jobs or a family member becomes sick. It helps small companies gain more purchasing clout in the market by allowing them to voluntarily form purchasing coalitions. According to GAO, S. 1028's portability reforms will help 25 million Americans each year.

By alleviating job lock and providing States with greater flexibility to address the coverage needs of high-risk consumers, S. 1028 presents broadly supported, commonsense reforms that build upon successful State health care initiatives.

I am proud to join with 64 of my colleagues in cosponsoring S. 1028's reasonable plan to promote private sector competition and market-driven innovation. This proposal fulfills Americans' request 2 years ago for sound, focused solutions to our Nation's health care concerns.

S. 1028's reforms to enhance the availability of health care coverage is further supported by the Finance amendment's provisions to address the affordability of health care insurance.

First, the Finance amendment increases the tax deduction for self-employed who purchase health insurance by 5-percent increments from the current 30 percent to 80 percent.

Second, it provides tax exemptions to State-sponsored risk pools which help bring down the cost of health insurance for businesses and high-risk individuals.

I am particularly supportive of the long-term care provisions included in the Finance package. The ability to access quality, private long-term care insurance plans is pivotal to families facing the emotional and financial challenges of long-term care.

Traditionally, a family member, most likely a wife or daughter, has cared for an ailing spouse or parent at home. However, today's pressures of work, child-rearing, and family mobility greatly restrict the ability of adult children to administer to the day-to-day needs of a chronically ill parent. In addition, the rigors of home-based care can have a debilitating impact on the health and well-being of a caring spouse.

As America's population ages, the need for long-term care increases. In 1993, almost 33 million Americans were over the age of 65, and by 2011, the elderly population is estimated to number close to 40 million. While the opportunity for a happy and healthy retirement is better than ever, an October 1995 long-term care survey by Harvard/Harris revealed that one in five Americans over age 50 is at high risk of needing long-term care during the next 12 months.

Today, a variety of long-term care services are available, from help in cleaning one's home and getting groceries to skilled nursing care with 24-hour supervision. However, the means to pay for long-term care are still very limited and the expense can be overwhelming. For example, $59 billion was spent on nursing home care for the elderly in 1993, and 90 percent was covered by out-of-pocket payments and Medicaid.

The cost of paying out-of-pocket for 1 year in a nursing home is more than triple a senior's average annual income. Long-term care expenses put a lifetime of work and investment at risk. To gain Medicaid coverage, seniors must ''spend down'' their assets in order to meet State eligibility requirements. While Medicare takes care of hospital costs and home care, it provides only limited coverage for short-term stays in skilled nursing facilities.

The medical side of long-term care has seen enormous advances over the years in new technologies, facilities, treatment methods, and even psychological studies of the effects of long-term care on patients. But the financing side of long-term care has simply failed to keep up, and as a result it is ill-prepared for seniors' future needs. Today, private insurance pays for less than 2 percent of long-term care costs. As Federal mandates for Medicaid coverage have increased, States have attempted to contain costs by restricting services for the elderly. State-imposed caps on the number of Medicaid-sponsored nursing home beds has separated families from their loved ones because the only Medicaid beds available were hundreds of miles away from their community. Most disturbingly, the remaining assets of a deceased elderly couple can be tapped through an estate recovery action to compensate the State for the couple's Medicaid expenses.

Since 1990, Medicaid expenditures for long-term care have been increasing by almost 15 percent annually, causing costs to double every 5 years. Medicaid's service as the sole long-term care safety net for middle class seniors may seriously impair the program's ability to serve the underprivileged. While low-income families accounted for 73 percent of Medicaid's beneficiaries in 1993, nearly 60 percent of expenditures went to nursing home care and other long-term care services. For example, in 1993, Kentucky's Medicaid spending per enrollee for children was $964; while the cost for elderly beneficiaries was $6,540. Without relief, a harsh battle between generations may emerge.

Mr. President, I am pleased that my work with Senator ROTH has produced a sound plan in response to this critical health care need. The Finance amendment includes several reforms which I supported through my own long-term care bill: providing long-term care insurance with the same favorable tax treatment now available to medical insurance; allowing tax-free withdrawals from life insurance policies for terminally and chronically ill patients; and establishing sound consumer protections.

Private long-term care insurance translates into quality, flexible care for seniors, more Medicaid funds for low-income families and the disabled, and essential support for families who want their loved ones to be safe and secure. These are priorities that all members of Congress share. We should not miss this opportunity to help America's families prepare for the challenges of long-term care.

I regret that the Senate was unsuccessful in retaining Finance's proposal to provide Americans with the choice of Medical Savings Accounts, better known as MSAs. Today, we have witnessed a full-court press against MSAs by those who favor greater government management of health care rather than the expansion of private-sector health care choice. They raise the specter of how MSAs would wreck havoc across our Nation's health care system, and present the threat of a Presidential veto of any health care bill that contains MSAs.

Mr. President, I find this attitude starkly contrasts the promotion of MSAs by the Democratic leadership just a few years ago. In 1992, Senator DASCHLE viewed MSAs as a means to effectively control medical spending by allowing employers to provide their employees with an annual allowance through a MSA to pay for their routine health care needs. During the 1994 consideration of the Clinton health care plan, Representative GEPHARDT offered a MSA plan in his leadership proposal, and all but one Democratic member of the House Ways and Means Committee supported it.

Just last week, President Clinton called for an expanded use of retirement accounts to pay for certain health care expenses. Ironically, Democratic members tell us today that the President firmly rejects the specific establishment of a medical account to pay for health care costs.

This inconsistent rhetoric blurs the potential benefits of a MSA option. In 17 states, 3,000 businesses as well as state and local governments are using MSAs. Based on a recent survey by Blue Cross/Blue Shield, 67 percent of employers surveyed were interested in MSAs. For employers who can not afford conventional coverage, and particularly for lower income workers, MSAs offer an affordable option to securing much-needed health care insurance.

As the House health care bill contains MSAs, it is my hope that this provision will be included in the conference committee's final legislative proposal for health care reform.

Mr. President, in sum, S. 1028 and the reforms included in the Finance amendment provide sensible, fundamental solutions to America's health care concerns. President Clinton has promised that ''the Era of Big Government is over.'' In fulfillment of his promise, the President should support S. 1028's effort to provide health care security through greater consumer choice, not greater Federal regulation.

Mr. KENNEDY. Mr. President, it is a little after 5 now. We started off early today at 9:30. We had a number of speeches, a good debate, and, I think, we had two enormously significant votes here which, I believe, open up the way for an early conference. Hopefully, if our good friends in the House view the medical savings accounts the way it was reflected here in the Senate, we can have this bill on the President's desk in very short order.

The leaders have instructed that we will stay here through this evening. We want to deal with these various measures. Earlier today, we asked Members, if they had amendments, to come up and see us. We are working through some, which are effectively universally accepted. We will try and make sure they are. If they are controversial and not unanimously supported, we will resist them. We want to try to move this along.

We have had a good day. We still have some outstanding amendments, but there is no reason we cannot finish this by 8 or 9 o'clock this evening. So we hope the Members who have amendments will come in now. There are some people that will just wait and see. But Senator KASSEBAUM and I are committed to trying to get this finished up in short order. We will ask those that planned to offer their amendments, if they would, to contact us right away. Otherwise, we will move to third reading.

Mr. DOLE. Mr. President, let me indicate and underscore what the Senator from Massachusetts just stated. We want to complete action on this bill. If we do, we will not have votes tomorrow. We may have debate on term limits, but no votes. We need to complete this to keep on schedule here. We still have to go back and finish illegal immigration. We have a day or two to make up there. Maybe we can do that next week, and, if not, the following week.

I hope anybody who has amendments will come to the floor. I know the Senator from North Dakota wishes to speak. That will be 15 minutes. So anybody that has an amendment, if you can be on the floor at, say, 5:30, it would be helpful to the managers.

Mr. LOTT. Mr. President, I want to talk about a needed addition to the Kennedy-Kassebaum legislation.

If you are an employee of a Fortune 500 company, you will probably make out okay under Kennedy-Kassebaum. If you are a union member, you'll definitely come out ahead.

But there is not enough in Kennedy-Kassebaum to address the needs of working families and small businesses. How can you have health care portability when you cannot afford health care, like many small businesses cannot afford to provide for their employees?

In the House-passed health portability bill, there was a pro-small business provision that I think we should include in any bill sent to the President.

The provision, which the House called the Health Coverage Availability and Affordability Act of 1996, clarifies existing law. It allows small employers to join together to purchase health insurance for their employees. This act also included provisions allowing individuals to open medical savings accounts—something I support.

But let me dwell on the small-business pooling aspect of this act. Right now, before we pass any bill in this Chamber, certain groups can pool their resources to buy lower cost insurance for their members or employees. These certain groups are large corporations and unions. For years, these groups could bargain for lower prices with insurers. If you are bigger, you can dictate better terms. That is just economics.

Unions and big business also could exempt themselves from burdensome State regulations. Each State has a different list of benefits that insurers usually must pay for.

Back in 1974, there were only 158 State-mandated benefits. Now, there are over 1,000 State-mandated benefits that insurers usually must cover. Some benefits covered in various States included massage therapy, acupuncture, hairpieces—and there are more exotic treatments. Many of these mandates are expensive. No wonder health costs are going up each year.

I said that insurers usually must cover these benefits. Under the Federal ERISA law, unions and large corporations are exempted from some State rules, and can set their own benefits. They also have less paperwork—complying with one general standard as opposed to 50 different State standards saves a lot of trees.

So we see that unions and big business have it easy when it comes to covering their members or workers. What about the small businessperson?

Well, the self-employed or small business owner does not have the bargaining power of a large corporation or union. They do not qualify for ERISA exemption. They have to comply fully with State regulations.

So, says the National Federation of Independent Businesses, small businesses' premiums are 30 percent higher than large corporations due to State mandates. Also, small businesses pay 30 percent more for similar benefits than larger corporations.

We talk a lot about the uninsured in this body. The Kennedy-Kassebaum bill is one way of addressing part of the problem. A large source of uninsured Americans though, is the inequity between small businesses and large businesses and unions. Kennedy-Kassebaum does not adequately address this issue.

Any final bill should include what the House did, and allow small businesses to form groups to purchase full health coverage or cover their employees under self-insured health plans. Allowing small companies to join together would give them bargaining powers similar to big businesses or unions. They would be exempt from certain burdensome State mandates.

Also, the House proposal allows States that allow small employers access to the small group market to opt out of the bill. The House bill balances the need for uniformity of laws across States, while maintaining States' rights.

The House bill is a good bill, and would have an immediate effect.

About 85 percent of the 40 million uninsured are in families with at least one employed worker, many of whom work for small businesses. That is a lot of people who could be covered if we changed the rules.

The National Center for Policy Analysis says that one in five small companies that do not now offer health insurance would do so if they could get free of heavy State mandates.

If these companies could have the same opportunity as big companies and unions, 6.3 million people would have access to health care. Immediately, you would take care of almost 16 percent of the uninsured in America. Others say 50 percent of the uninsured could probably have access to health care.

Whatever the number, we can take a substantial leap toward providing health care for all Americans—all without new taxes or unfunded mandates.

I am not the only one who thinks this is a good idea. Mr. President, I will soon submit for the RECORD two letters to the House leadership from the National Association of Manufacturers

and the National Restaurant Association in support of the House bill.

Also, the chamber of commerce, National Association of Independent Businesses, National Retail Federation, and other groups supported the bill I have been talking about here.

So there is much support for this, and I hope at least in conference we can look at this issue, and provide some relief for small business and the self-employed. I personally believe that we have been unfair to the job creators and those who want to be their own boss.

Right now, self-employed people can only deduct 30 percent of their health care costs. Big businesses and unions can deduct 100 percent. This year, Congress passed a bill that would have raised this 30 to 50 percent. Guess what? The President vetoed it! Is this fair? Is this pro-business? Is the President for entrepreneurship in this country?

I think it is high time that the President signs the bill he vetoed, and we should eventually pass the House bill that expands health care for Americans who work for small businesses.

The large companies and the unions have had the benefits and advantages for too long. If they can do it, a small businessman in Pascagoula should be able to cover his family and employees.

Let us help small business in this chamber. Remember them in this debate we are having about health care.

I ask unanimous consent that the letters I mentioned be printed in the RECORD.

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

NATIONAL ASSOCIATION OF MANUFACTURERS,
Washington, DC, March 8, 1996.

Hon. J. DENNIS HASTERT,
Chief Deputy Whip, House of Representatives, Washington, DC.

DEAR REPRESENTATIVE HASTERT: I am delighted to hear that the House Republican leadership has put together a package of realistic and achievable health care reforms and will pursue them as part of the 1996 legislative agenda. It is my understanding that these reforms include:

Portability reforms to ensure that employees won't be denied health coverage if they change or lose their jobs;

Medical malpractice reforms so that valuable dollars intended for health care won't be wasted on frivolous litigation;

Increased health insurance deductibility for the self-employed to further mitigate unfair differences based solely on the form of doing business;

Reforms to facilitate small group pooling and thereby improve both affordability and access for small businesses;

Medical savings account provisions to further improve both choice and affordability for all Americans; and

Accountability provisions to curb fraud and abuse, leading to lower costs throughout the system.

These are all provisions which NAM has supported in the past and continues to support. In our view, this kind of targeted, incremental approach, which retains the private, voluntary health system while improving and strengthening it, is exactly the right approach. The NAM is therefore pleased both to endorse and to enthusiastically support your plan.

Sincerely,

JERRY JASINOWSKI,
President.

NATIONAL RESTAURANT ASSOCIATION,
Washington, DC, March 27, 1996.

House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE: On behalf of the National Restaurant Association and the 739,000 foodservice units nationwide, we urge you to support H.R. 3103, the Health Coverage Availability and Affordability Act.

As you may know, our industry has been working to enact healthcare reform legislation for years. Our research continues to demonstrate that the basic reason why employers and individuals do not purchase health insurance is because of the cost. This legislation takes a major step forward by eliminating some of the barriers that prevent people from purchasing health insurance, while at the same time helps keep down the cost.

The restaurant industry is dominated by small businesses. More than four out of ten eating and drinking places are sole proprietorships or partnerships. Nine out of ten eating and drinking places have less than 50 paid employees. Seventy-two percent of eating and drinking places have sales of $500,000 a year or less. While many would like to offer their employees health benefits, the cost has proven to be prohibitive.

In addition to addressing key concerns about portability and preexisting condition limitations, H.R. 3070 would increase the deductibility of health insurance for the self-employed from 30 percent to 50 percent. For small businessmen and women—and their families—deductiblity of health insurance premiums is a must. Other important components of the legislation tackle medical malpractice reform, fraud and abuse and administrative simplification. Also, this legislation will allow small businesses to form voluntary purchasing pools which would help level the playing field by giving them some of the negotiating tools of large businesses and reducing the cost of providing coverage.

The National Restaurant Association is strongly opposed to any amendment that would raise the cost of health coverage with federal mandates or by expanding COBRA coverage. If employers cannot control the costs of their own health care plans because Congress mandates certain types of coverage, employers will be forced to drop their coverage altogether.

We urge you to support H.R. 3103, the Health Coverage Availability and Affordability Act.

Sincerely,

ELAINE Z. GRAHAM,
Senior Director, Government Affairs.

CHRISTINA M. HOWARD,
Legislative Representative.

Mr. LOTT. Mr. President, I had an amendment that I drafted, which I will not offer at this time for a variety of reasons. I do want to move this legislation along. But in the House-passed bill, there was a pro-small-business provision, and I think we should include that in any bill that we send to the President. The provision, which the House called the Health Coverage Availability and Affordability Act of 1996, clarifies existing law. It allows small business employers to join together to purchase health insurance for their employees.

This act also included provisions allowing individuals to open the medical savings accounts that we have already dealt with this afternoon. I really do think there is a real justification for small businesses to be able to join pools and provide coverage for their workers. That could be a pool through the Restaurant Association, the National Federation of Independent Business, or within their own corporation.

I realize that it is not as simple as it sounds, but it is something that should be done. I think it would help a lot of people now that work for small businesses—particularly fast food services—be able to get access to insurance through these pools.

So I will be working with the conferees to try to get them to take a look at this and see if we cannot perhaps perfect some of the language that was in the House bill and allow this coverage to be available.

I know of many instances where people are working for hamburger places or pizza places, where most employees have no coverage. They cannot afford it, and the employer cannot provide it. This would give them a way to get it through pools.

I hope we will look at this approach in the conference, since it is in the House bill. If we cannot work it out there, let us see if we cannot find an opportunity to give serious consideration to this at the earliest opportunity.

Mr. KENNEDY. Mr. President, we have some provisions in here to encourage pooling among small businesses. We would be glad to work with the Senator from Mississippi in reviewing that language, since the House has similar language, to find out how we may be able to make that more effective. And we will certainly be glad to visit with him prior to the time of the conference and see if we cannot find ways of making it more effective. He has identified a very important problem and challenge, and we attempted to make some important, modest steps, but very important steps, I think, to encourage this kind of activity and programs. He has additional ideas, and we look forward to talking with him.

Mr. LOTT. I thank the Senator. I will be glad to work with him on this issue.

AMENDMENT NO. 3678

(Purpose: To provide equitable relief for the generic drug industry)

Mr. BROWN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Colorado [Mr. BROWN] proposes an amendment numbered 3678.

Mr. BROWN. 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 in title III, insert the following:

SEC. . EQUITABLE TREATMENT FOR THE GENERIC DRUG INDUSTRY.

(a) SENSE OF THE SENATE.—It is the sense of the Senate that the generic drug industry should be provided equitable relief in the same manner as other industries are provided with such relief under the patent transitional provisions of section 154(c) of title 35, United States Code, as amended by section 532 of the Uruguay Round Agreements Act of 1994 (Public Law 103–465; 108 Stat. 4983).

(b) APPROVAL OF APPLICATIONS OF GENERIC DRUGS.—For purposes of acceptance and consideration by the Secretary of an application under subsections (b), (c), and (j) of section 505, and subsections (b), (c), and (n) of section 512, of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 (b), (c), and (j), and 360b (b), (c), and (n)), the expiration date of a patent that is the subject of a certification under section 505(b)(2)(A) (ii), (iii), or (iv), section 505(j)((2)(A)(vii) (II), (III), (IV), or section 512(n)(1)(H) (ii), (iii), or (iv) of such Act, respectively, made in an application submitted prior to June 8, 1995, shall be deemed to be the date on which such patent would have expired under the law in effect on the day preceding December 8, 1994.

(c) MARKETING GENERIC DRUGS.—The remedies of section 271(e)(4) of title 35, United States Code, shall not apply to acts—

(1) that were commenced, or for which a substantial investment was made prior to June 8, 1995; and

(2) that became infringing by reason of section 154(c)(1) of such title, as amended by section 532 of the Uruguay Round Agreements Act (Public Law 103–465; 108 Stat. 4983).

(d) SUBSTANTIAL INVESTMENT.—For purposes of this Act and section 154(c)(2)(A) of title 35, United States Code, with respect to a product that is subject to the requirements of subsections (b)(2) or (j) of section 505, or of subsections (b)(2) and (n) of section 512, of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(2) and (j), and 360(b)(2) and (n), the submission of an application described in subsection (b), and only the submission of such an application, shall constitute substantial investment.

(e) NOTICE.—

(1) IN GENERAL.—Unless the notice required by this subsection has previously been provided, when an applicant submitting an application described in subsection (b) receives notice from the Secretary that the application has been tentatively approved, such applicant shall give notice of such application to—

(A) each owner of the patent which is the subject of the certification or the representative of such owner designated to receive such notice; and

(B) the holder of the approved application under section 505(b) or section 512(c)(1), respectively, for the drug which is claimed by the patent or a use of which is claimed by the patent or the representative of such holder designated to receive such notice.

(2) CERTIFICATION OF NOTICE.—The applicant shall certify to the Secretary the date that such notice is given. The approval of such application by the Secretary shall not be made effective until 7 calendar days after the date so certified by such applicant.

(f) EQUITABLE REMUNERATION.—For acts described in subsection (c), equitable remuneration of the type described in section 154(c)(3) of title 35, United States Code, as amended by section 532 of the Uruguay Round Agreements Act (Public Law 103–465; 108 Stat. 4983) shall be awarded to a patentee only if there has been—

(1) the commercial manufacture, use, offer to sell, or sale, within the United States of an approved drug that is the subject of an application described in subsection (b); or

(2) the importation by the applicant into the United States of an approved drug or of active ingredient used in an approved drug that is the subject of an application described in subsection (b).

(g) APPLICABILITY.—The provisions of this section shall govern the approval or effective date of approval of all pending applications that have not received final approval as of the date of enactment of this Act.

Mr. BROWN. Mr. President, this is not a new subject for Members of Congress. This is one we have considered before. I will make my remarks very succinct. I know other Members are waiting to speak.

What this does is complete our consideration of GATT. In the GATT agreements, the provisions with regard to exclusive use of drugs was extended. But the GATT provided specifically for exceptions where people have made substantial investments in generic drugs. This goes along with the language in the GATT agreement. It puts us in conformity with what other countries are considering. It allows us to provide the original length of protection that was planned for drugs.

Without action on this amendment, what we stand to have is American consumers lose roughly $5 million a day. The impact on U.S. consumers is roughly $5 million. Every day we delay enacting this means a day in which consumers are denied generic drug alternatives, which can save them $5 million a day. We have already delayed to a point where, by the end of this month, U.S. consumers will have lost over $700 million, and the price tag rises dramatically.

A bill we had up in committee was put off. It is, thus, imperative that we offer this on this vehicle. It is an enormous savings to American consumers.

Mr. President, it is fairness because it gives drug companies the same protection for which they planned on all along. But it does not give them a windfall, or more than what was planned.

Mr. President, I yield the floor at this point.

Mr. PRYOR addressed the Chair.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. PRYOR. Mr. President, I thank the Chair for recognizing me.

Mr. President, I am very pleased and honored to join with my friend from Colorado, Senator BROWN, in the introduction of this amendment. This is the so-called GATT Glaxo amendment. The issue has been presented here on the floor. In fact, this is a simple way of correcting a major mistake that Congress made in adopting the GATT Treaty. It was an oversight. It has been testified to time and time again by Mickey Kantor—our then U.S. Trade Representative who negotiated this particular treaty—that it was a mistake, and that it needs to be corrected. The Patent Office said it was a mistake, and all up and down the line people agree that this was an enormous mistake that we need to correct at this time.

The first time we brought this issue to a vote on the floor was December 7, 1995. On that particular vote, the vote cast in the Senate was 48 to 49. There was one abstention. There was one absent Senator. And since that day, since that particular delay, I think it might be interesting to note that very few—a handful of drug companies—Glaxo specifically, have made a profit, or a gross income, because of this variation in the GATT Treaty giving a particular exception, a particular benefit, to a handful of drug companies. There has been an extra $5 million per day in income to these companies. Since December 7, 1995, we have seen an income of $665 million extra to these drug companies that is being paid out of the pockets of the consumers especially for drugs such as Zantac; $665 million—a windfall profit gift that we have given to these particular companies, and especially to a company called Glaxo.

We also note that Senator HATCH wrote a letter to us, the sponsors of this amendment, on December 13. He said he promised hearings on February 27, 1996. So we waited and waited and waited around for that hearing. According to his promise, the distinguished chairman, Senator HATCH, held a hearing. By that time another $310 million had been given to the drug companies in a windfall profit situation.

We waited another month—until March 28, 1996. The Judiciary markup was scheduled, and it was abruptly canceled. So once again there was a delay.

This morning, on April 18, 1996, another Judiciary markup on S. 1277 to correct this egregious error in GATT was held. And, when the Senators arrived at the markup, it was noted that a Senator had put a hold on the markup, that there would be no actual vote on S. 1277. And, therefore, Mr. President, another $665 million in profits for a very few drug companies.

Now it is noted that the chairman this morning stated that if possible we will have a hearing in the Judiciary Committee next week on the 25th of April, and possibly we could mark this bill up, S. 1277.

But in the meantime, Mr. President, the clock is running. We feel that this is a health bill, that this is the proper way to bring this bill to the attention of our colleagues, and it is the proper measure to attach this correction to the GATT Treaty.

We hope that our colleagues will support this measure.

Mr. President, I thank the Chair for recognizing me. I yield the floor.

Mr. HATCH. Mr. President, although I understand that the Senator from Colorado plans to withdraw his amendment, I want to take this opportunity to express my opposition to both the Brown/Pryor/Chafee amendment and the idea that it should be included as part of the Kassebaum-Kennedy health insurance reform measure.

I said it on December 7, and I say it today: ''Here we go again.''

Four months ago, we considered the Pryor language in this chamber. That time, it was an amendment to the partial birth abortion ban bill the President just vetoed. We agreed then, by a vote of this body, that the Judiciary Committee should hold hearings on the issue.

On December 13, I sent a letter to Senators PRYOR, BROWN, and CHAFEE, and I made a commitment to hold a hearing on February 27 and a markup by the end of March.

In fact, the committee did hold the hearing on February 27, as I promised. I agreed to hold a markup the week of March 25, but had to delay that because of lengthy committee consideration of the immigration bills. I rescheduled the markup at the first opportunity. In fact, it was to have been today, but as my colleague may have heard, we did not get a quorum.

I still intend to press forward expeditiously for consideration of this issue in the committee. It will be on the agenda for the next markup and that is my commitment.

I find it ironic that proponents of this amendment are using the same timetable as I. There is no disagreement here. The process is moving forward.

In sum, I have lived up to my word.

As a matter of fact, I have bent over backwards to accommodate the interests of this body in a full and fair examination of the issue.

We had 10 witnesses at the February 27 hearing, 5 on each side. It was a good session, one during which I believe we all learned a lot.

I plan to go ahead with the markup. We will try to work out a resolution. I hope we will be able to. I don't think that the Brown amendment today meets that test.

The GATT/pharmaceutical patent issue is unquestionably one of the most complicated we have seen, as it involves the confluence of patent law, trade policy and food and drug law and regulations.

Its resolution has potentially enormous consequences, both on the future of biomedical research in this country and on the ability of consumers to have access to the most safe, effective, and low cost drugs possible.

The proponents of this amendment argued today, as they have in the past, that this is a case of Congress making a simple mistake and that now we should act to fix this mistake by adopting this technical mistake.

This is the type of argument that is often made when this body acts through unanimous consent.

I wonder how many times we have debated a purported technical corrections bill for 3 hours—as we did on December 7—then split almost down the middle on a 49–48 vote that cut across party lines.

There is no foundation for the argument that this is a simple perfecting amendment that would achieve a result which is clearly intended by Congress.

Again today we heard the now familiar litany on the issue of intent. We heard about Ambassador Kantor, FDA Deputy Commissioner Bill Schultz, and all the other Administration representatives who attend the school of revisionist history on this issue.

What has become apparent to me during this debate, a fact which has not been revealed today by any of my colleagues, is that the argument on intent has been rejected by the Court of Appeals for the Federal Circuit, which could find no definitive evidence of intent.

In the November, 1995 Royce decision, the Federal Circuit stated:

> The parties have not pointed to, and we have not discovered, any legislative history on the intent of Congress, at the time of passage of the URAA, regarding the interplay between the URAA and the Hatch–Waxman Act.

Perhaps some day my colleagues can explain why it is that the Federal Circuit, a neutral judicial tribunal, is having so much trouble finding any evidence on the question of intent, a question that seems to lie at the center of this debate.

Perhaps some day my colleagues can explain why, in their quest to ''level the playing field,'' they have created a special benefit for one industry. I challenge them to identify any industry that has attempted, let alone succeeded, to use the GATT transition rules to reach the market prior to expiration of the newly extended patents. It just hasn't happened, and it probably will not unless anyone can identify acts that would not have been infringing before we enacted the URAA that continued and became infringing after the URAA was enacted.

It is curious to me that a lawyer for the generic drug industry would argue to the Supreme Court that ''the most obvious intended beneficiary of this statutory licensing system was the generic drug industry . . . In fact, since the adoption of TRIPS and the URAA, no industry other than the generic drug industry has emerged as being potentially affected by the equitable remuneration system.''

I will not prolong my remarks today. I look forward to exploring these and other issues in much greater detail at the markup.

In closing, I want to reiterate my strong opposition to the amendment, and my disappointment that we are considering it here today prior to the Judiciary Committee's scheduled markup.

Mr. DORGAN addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I request to be able to use the 15 minutes that I am allotted under the former UC that was decided by the Senate.

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

MINIMUM WAGE AND SOCIAL SECURITY

Mr. DORGAN. Mr. President, I intend to yield some of that time to the Senator from South Carolina.

Mr. President, everyone has a right to characterize or mischaracterize the activities of the Senate. A colleague of mine during the previous debate on the motion to strike came to the floor and in that debate characterized the series of things that had happened earlier this week—or rather mischaracterized them—and described the certain circumstances as highly partisan, just politics, and so on.

I felt it necessary that I correct the RECORD and not allow this moment to pass without responding. I want everyone to understand that there are times here in the Chamber when amendments are offered that it is not convenient for people, amendments are offered that just are uncomfortable for people. But the way the system works here is sometimes you do not have an opportunity to offer an amendment except in the certain circumstance, and then you must offer it, or you are never going to have a chance to have the Senate consider it.

We had a circumstance earlier this week where a bill was brought to the floor of the Senate. Senator KENNEDY, I, and some others were intending to offer an amendment. Senator KENNEDY was going to offer an amendment on the minimum wage, which I support. That is inconvenient for some people. They do not want to debate the minimum wage. Some in this Chamber say we do not want to deal with the minimum wage issue. Some of us do. Some of us think when you have gone 6 years without a change in the minimum wage that at least those on the lower rung of the ladder have lost one-half dollar of their purchasing power from the minimum wage, and maybe people in this Chamber ought to care a little about that. I know there are no high-paid lobbyists out beyond this Chamber saying, ''Yes, we care about the people at the bottom of the economic ladder.'' If we are working on issues that dealt with the people at the top of the ladder, you can bet the halls would be full of high-paid lobbyists. But not for the minimum wage.

Some of us insist that these are issues that we ought to be debating.

Is it partisan? No. It is public policy.

The second issue which I introduced as an amendment on Monday dealt with the Social Security issue. It is mischaracterized as totally partisan, irrelevant, and a troublemaking amendment.

Let me describe what this issue is. Let me go back to 1983. In 1983 this Congress passed the Social Security Reform Act. I know that because I helped write it. I was a member of the Ways and Means Committee in the U.S. House. If anybody wants to go back to the record of the markup, you will find that I offered the amendment in 1983 during the markup that said let us not

use the Social Security revenues we are going to begin to save to meet our needs when the baby boomers retire. Let us not use them as other operating revenues. Let us truly save them. So let us create a firewall. Let us prevent people from misusing, or taking, the Social Security trust funds and using them for other purposes. In 1983 I offered that amendment. It was defeated in the Ways and Means Committee.

I have tried since repeatedly. The Senator from South Carolina has tried, and in some cases successfully. The fact is we have a law that prevents the Social Security funds from being misused for other purposes, and the law is ignored.

My intention was to bring to the floor on Monday an amendment that I offered that angered some people, an amendment that said, if we are going to consider a constitutional amendment to balance the budget which the majority leader said he will require us to do under reconsideration, a procedure that will allow no amendments and no debate—if we are going to do that—I said let us have the Senate vote on a sense-of-the-Senate amendment to create a firewall between the Social Security trust funds and other revenues because, if we do not do that, what will happen is $600 to $800 billion of Social Security trust funds will be misused. That is not trivial, and is not partisan. It is policy.

I understand that for some it is a nuisance. For some it is inconvenient. For some it is troublesome to have to deal with this.

So the result was people got in a pique and decide to put the Senate into a recess so one person or another cannot speak. It is not the way this place works.

We will vote on that sense-of-the-Senate resolution. We did not on Monday. But we will vote on it. We have the right to offer it, and we have the right to insist on a vote on it.

The same will be true with minimum wage, and the same will be true with several other issues that we think are important matters of policy. This is not about individuals on the Senate floor.

The PRESIDING OFFICER. If the Senator will suspend for a moment, will those Members in the Senate who are having discussions please retire to the Cloakroom, and members of staff as well?

The Senator from North Dakota.

Mr. DORGAN. Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 10 minutes and 20 seconds.

Mr. DORGAN. Let me finish, and then I will yield to the Senator from South Carolina under the 15 minutes.

My only point is this: I respect any Member who stands up and ascribes motives to others, but if they are motives that, in my judgment, do not comport with what we are trying to do, then I think we have a right to say that is not the case.

With respect to Social Security, Social Security is going to have problems beginning in the year 2018. That is the point at which the surplus discontinues accumulating. From 2019 down to 2029 or so we run out of surplus. The fact is in order to accumulate that surplus, we must set the surplus trust funds aside.

That is what the Senator from South Carolina and I have been trying to do for a long while. I encourage those who wonder about motives to go back to 1983 and the Ways and Means records and see who was making those motions 13 years ago on this very issue, and then call them political today, if you will. But you are wrong.

The Senator from South Carolina has been on this floor many times and I have been on the Senate floor and the House floor many times in the last 13 years on this subject, and I will continue to do so. It might be inconvenient to have offered the sense-of-the-Senate resolution last Monday, but we will vote on it at some point. I said then I would agree to a 20-minute time limit; it does not matter to me. I just want this Senate to go on record on those issues. Maybe that is partisan in the minds of some. To me it is a very important public policy.

Mr. President, I yield the remaining time to the Senator from South Carolina [Mr. HOLLINGS].

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. HOLLINGS. Mr. President, I thank my distinguished colleague from North Dakota. We have been working in the vineyards together in trying to end the practice of applying Social Security surpluses toward the deficit. Everyone is interested in balancing the budget. But what happens in all of these budgets, both the Republican and the administration budgets, is that they use Social Security trust funds to obscure the size of the deficit.

This minute, we owe $502 billion to Social Security. Over the next 6 years, we will borrow another $600 billion from that trust fund. So even if we succeed in enacting these so-called balanced budget plans, by 2002 we will have destroyed the Social Security program; we will owe Social Security over $1 trillion. No one is going to raise taxes some $1 trillion to make good on the Social Security trust fund.

The time to stop that nonsense is here and now. In order to do so, 98 Senators in this Chamber, as the Senator from North Dakota stated, voted for the Heinz-Hollings-Moynihan amendment on October 18, 1990. President George Bush, on November 5, 1990, signed section 13301 of the Budget Enforcement Act into law.

Republicans charge that offering the Dorgan amendment is delaying action on the immigration bill. But what is good for the goose is good for the gander. On yesterday afternoon, in the middle of the terrorism bill, the distinguished majority leader saw fit to come to the floor to talk about balancing the budget through spectrum auctions. Fine. That is his privilege and no one disrespects it. But we should not cry foul when other members talk about Social Security and balancing the budget.

The truth of the matter is that we are in a Catch-22. This Senator has produced balanced budgets. I had a AAA credit rating as the South Carolina's Governor. I voted for a balanced budget in 1968–69. Since that time, as chairman of the Budget Committee, I have proposed freezes, Gramm-Rudman-Hollings, and, yes, tax increases to try and balance the budget. So this is not a casual political maneuver to get high ground in any political campaign. It is done in an attempt to get us to keep our word—to not use Social Security trust funds in calculating the deficit. We cannot keep it when the leadership, in considering the constitutional amendment to balance the budget, which this Senator has voted for already three times——

The PRESIDING OFFICER. If the Senator will suspend, let the Chair try to get order in the Senate. If those Members who are having discussions, please, could retire to the cloakroom. The Senator is entitled to be heard.

Mr. HOLLINGS. I thank the distinguished Chair.

I voted for a balanced budget. I wish to vote for a balanced budget amendment to the Constitution. But I will not vote to repeal the firewall that we have in the law for the Social Security trust fund. Let us have really truth in budgeting.

I commend the distinguished Senator from North Dakota in bringing his amendment up in this particular fashion. It is unfortunate that we had no other option. We are not trying to delay the immigration bill. I commend the Senator from Wyoming and the Senator from Massachusetts on their leadership on immigration. I am ready to vote for their bill. We are ready to agree to a time agreement. But we want to vote on this issue to really fix into the conscience of the body that when we say it is a trust fund, we mean to protect it and not dip into those surpluses. That is what the chairman of the Budget Committee on the House side said they did last evening. They dipped once again into our children's piggy bank.

That piggy bank is there to protect retirement. Senator THURMOND and I, we are going to get ours. In fact, we are getting ours now. But I can see some young folks around here; when their time comes, they are never going to be able to receive it. Why? Because we have got this nonsense about a unified budget.

Here is the budget law. If you can find the word unified in there, I'll jump off the Capitol dome. There is no such thing as a unified budget in the budget law, but the administration goes along with it; the Congress goes along with it. They violate the law. Let us join with the distinguished Senator from North Dakota and stop violating the law.

I yield back the remainder of my time.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I am just going to take one moment and then yield the floor. We have a measure that is before us, and I see the Senator from Vermont, who has an amendment, who had spoken to us earlier today and is waiting to move towards that amendment.

We are going to, in just a few moments, ask unanimous consent to finalize the list of amendments. We have been able to work through many of them. So we are expecting probably some votes that will be continuing along until we are able to hopefully get this concluded. We can do that in a period of time, but I hope that our membership will not be coming to us at 7, 7:15 asking for windows and other kinds of things, because we were able to really move this and follow the admonition of both the majority and minority leaders. So we are going to ask for a consent that we have received all the amendments in just a few moments. So if any of the Members are interested, this is really the last call.

Mr. SIMPSON addressed the Chair.

The PRESIDING OFFICER. The Senator from Wyoming.

BALANCED BUDGETS AND SOCIAL SECURITY

Mr. SIMPSON. Mr. President, I just want to speak for a few moments on this issue of Social Security and balanced budgets. I have the greatest respect for Senator Fritz HOLLINGS and my colleague Senator Kent CONRAD, who sits there, and his friend and mine BYRON DORGAN. They are a very remarkable duo from North Dakota, and they have been working hard on this issue a good long while, and so has my old friend Senator HOLLINGS.

If we are going to debate this issue of Social Security, we are going to have to deal with reality. The reality has come to me and should come to everyone in this Chamber simply by studying the work of the entitlements commission, the Bipartisan Entitlements Commission, where Senator BOB KERREY and Senator JOHN DANFORTH of Missouri sat for a year and presented to 32 Americans, including many of us in this Chamber, what is going to happen to Social Security.

There is no way to duck it. There is no way to finesse it. There is no way to demagog it. That is no way to go. Because if you are going to talk about something that is worth $360 billion and leave it ''off the table'' in a fashion that no one in this body is supposed to touch it or say a word about Social Security while the senior citizens groups beat your head in and my head in and not allow us to even touch a system and keep telling us, and warning us, ''Oh yes, it will need to be corrected'' and, ''Oh yes, we have a way to tell you how to do that''—and their solutions always have to do with raising the payroll tax, ladies and gentlemen, and guess who pays the payroll tax? Not the senior citizens.

Now, if we are going to deal with this issue, then I am going to begin to come to the floor each and every time we come to this issue of Social Security and balanced budgets concepts and begin to get one singular thing across. Hear it. There is no Social Security trust fund, ladies and gentlemen. There is no Social Security trust fund. None. And the reason there is none is because, when Franklin Delano Roosevelt and the Congress put this package together, they said that if there is any surplus in the Social Security system it will be invested in the securities of the United States Government, secured by the full faith and credit of the United States. And every shred of this surplus—and it is big and it is going to get a lot bigger—every shred of it is invested in the securities of the United States Government in a series of IOU's.

You know that and I know that. But, better yet, the trustees know that. And who is this group of people telling us about this? They are called the trustees of the Social Security system, three of whom are in the President's Cabinet: Robert Rubin, Donna Shalala, and Robert Reich; one Republican, one Democrat, and the Commissioner of Social Security. And they are the stewards of Social Security. There are no other designated stewards of it.

In the trustees little booklet of their annual review which is about that thick, and I hope you will read it, it says that in the year 2029, without doing something for Social Security, it will go broke. It will be out of business. But, more important, in the year 2012, when the payments coming in will not cover the payments going out, you are going to start cashing in the bonds. And then you begin to use up the interest. And between the year 2012 and the year 2029, it is history.

So, every time we hear this old saw, I want to be right here too and tell the American people, just as the trustees would if they were here—I will speak for them—that there is no Social Security trust fund. It is a floating pile of IOU's. You know it and I know it. So, when we come here to this Chamber to talk about cooperation, coordination, subjugating our own obsessions or our own agenda's to the body work of this then let us talk about that fact every time.

I have been through this plenty of times in this Chamber. I do not keep score of how many times I may have come to the floor on any issue. But I can tell my colleagues I do know how many times some people have come to the floor on this singular issue—time after time after time; and fully knowing that there is no trust fund.

We were just involved in a bill, talking about a rather interesting issue called illegal immigration reform. Several years ago—and I have done this too long, remember for 17 years—my dearest friend, Senator John Heinz, proposed an amendment on—guess what? Social Security. What was it that time? Listen to this one. I said to John Heinz, my old friend—and remember, we put together a package that said that the COLA would always be paid out, but if the inflation was ever 3 percent or less that we would not increase the COLA. If it was less than 3 percent we would not give a COLA on Social Security.''

It was that year at 1.5 percent or something, or perhaps 2. And we came to the floor and Senator Heinz, who really was spectacular—in fact—if he were here today we would not be in the health care conundrum we are in. He was that good. He could have led us out of that.

I said, ''John, you know it will pass. All you have to do is mention Social Security or a COLA and you know it will pass—or if you mention veterans, you know it will pass.'' We have all been there. We are all bright people. We know this.

So, there it was. An impasse. And finally he removed it from the immigration bill, placed it on another one, and so it is much like this one. We all know what this is. There is not a soul in this building, a soul in this city, a soul who follows this, like BOB KERREY and JACK DANFORTH did, who does not know that there is no Social Security trust fund—zero—zip—nothing. To hear it continued to be bandied about is an extraordinary adventure in fantasy.

Mr. HOLLINGS. Will the distinguished Senator yield?

Mr. SIMPSON. I will yield for a question.

Mr. HOLLINGS. With respect to Senator KERREY and Senator Danforth's recommendations, fine—I support their particular report. It is not a question of fixing Social Security. It is a question of not using the surpluses to obscure the size of the deficit and using them for Social Security.

I am sure the Senator was with me, on October 18, 1990. And I am sure he supports that law.

You and I act like there is some difference. There is no difference in our belief that changes will have to be made to protect the integrity of social security. But the law says thou shalt not use the Social Security moneys to obscure the size of the deficit? That is the law, 13301. The chairman of the Budget Committee is here, he is totally familiar with it. Isn't that correct?

Mr. SIMPSON. Mr. President, I do not think anybody would try to obscure anything—at least this Senator is not. The obfuscation and the obscuring is to tell the American people that there is a trust fund that we are using moneys from. There is not any trust fund there to be using. It is not there. It is a series of IOU's. So, when we say, ''Oh, you are doing a terrible thing. You are hiding something or you are using the money that should have been there for us,'' that is simply not the case.

Let me just review just for the body in 4 more minutes eight rather recent votes on this issue. I can only find eight in the last 30 minutes, since I knew that this would come up on the floor. The amendments are not always offered up by the same Senator. They are offered by different people each time. It is kind of like we do with a ''rolling hold.'' You kind of fire the one barrel and then you fire another barrel. So here it all is, of recent vintage.

On January 26, 1995, Senator HARKIN offered an amendment. Senator KEMPTHORNE made a second-degree amendment on it. The Kempthorne amendment said that implementing legislation should not cut Social Security. We all agree with that. You cannot miss on that one. If you simply, each time, want to talk about the balanced budget and add to it that we will never ''cut'' Social Security, that is a snapper in here—except for a few of us who will cast that opposite vote and know very well that it just does not fit.

Then Senator REID tried to table that. That failed. Senator KEMPTHORNE's amendment then passed. Then Senator HARKIN tried a perfecting amendment to add his language back, saying that the balanced budget itself should exempt Social Security. That was tabled.

On February 10, 1995, Senator DOLE offered the amendment to ask the Budget Committee to report instructions not affecting Social Security. That passed 87 to 10, like we all knew it would. Then it was done.

Then Senator REID presented an amendment, February 14 of 1995, saying Social Security is now counted in the balanced budget amendment. And Senator DOLE tabled that, 57 to 41.

On February 28, 1995 Senator FEINSTEIN offered a substitute for the balanced budget amendment with the exclusion of Social Security. That was tabled 56 to 39.

On February 28, 1995, Senator GRAHAM put forward an amendment to eliminate ''held by the public'' from the debt limit, so as to get the balanced budget to exclude Social Security. That was tabled 59 to 40.

Another Graham amendment was tabled 57 to 43.

This issue has been voted on time and time and time again. I think it is time that it not be voted on again, especially for this issue, on either illegal immigration or health care. Find a new line of work.

Several Senators addressed the chair.

Mr. DORGAN. Will the Senator yield for one brief question? I wonder if the Senator will yield for a brief question?

The PRESIDING OFFICER. The Senator from Wyoming has the floor.

Mr. SIMPSON. I yield for a question.

Mr. DORGAN. I appreciate that. I guess it is the Senator's contention that there is no Social Security trust fund. I just ask this question.

We were told early on that the Social Security trust fund was not being used for any other purpose. Then we were told by those who wanted an affirmative vote on the constitutional amendment to balance the budget that the Senator supported that, even though they had argued that it was not being used to balance the budget, they would stop using it to balance the budget by the year 2008.

How does one reconcile that if there is not a trust fund? If there is not a trust fund, how can you stop using it in the year 2008?

Mr. SIMPSON. Mr. President, I say to my friend from North Dakota that the travesty is that it is not being used. It is a series of IOU's. There is no Social Security trust fund. And the money is being invested.

You can say we will cut it back. You cannot. It is in T-bills. Some people here own T-bills. Banks own T-bills. There is no Social Security trust fund. I have never gone to my people and said we are stealing from the Social Security trust fund because I just stepped up to the plate and said there is none. So, when you bring that up, you are bringing up a fiction.

Mr. HOLLINGS. Mr. President, how would it be if we had IOU's for the same time, I ask the Senator?

The PRESIDING OFFICER. The Senator from Wyoming has the floor.

Mr. HOLLINGS. How can it be invested and become an IOU? If it is invested, it is presumably going to be paid back? That is our problem, it is being spent on the deficit. That is my point.

Mr. SIMPSON. Mr. President, not only the fiction of it, but since 1938, by law, the trust fund buys T bills which are IOU's that the Government must pay back. FDR did that, and that is what it is. There is no mystery to it. It is a series of IOU's, and when those are outstanding and then the revenue from Social Security will not cover—it is a pay-as-you-go, do not forget, Social Security is pay-as-you-go, and if it does not cover, you have to cash in the IOU's and you have to get more money through the payroll tax, or reducing benefits or issuing some new kinds of securities.

Mr. HATCH. Will the Senator yield for a unanimous consent request?

Mr. SIMPSON. Yes.

HEALTH INSURANCE REFORM ACT

The Senate continued with the consideration of the bill.

Mr. HATCH. Mr. President, I understand the pending business is the BROWN amendment. It is my understanding that he will make his arguments and then withdraw the amendment; am I incorrect on that?

Mr. BROWN. Mr. President, the Senator is correct.

Mr. HATCH. I am correct.

Mr. SIMPSON. I yield the floor.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, prior to returning to Senator BROWN's amendment, if I may propose a unanimous consent request on behalf of Senator DOLE.

Let me yield and say, evidently, this has not been cleared fully on both sides, so we will return to Senator BROWN's amendment.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, we want to try and accommodate the greatest number of Members. We have several Senators who are here with their amendments ready to address them and ready to act on them. We believe that if we are able to do that, we can afford, whoever wants to speak, as much time as they want to speak on other kind of matters. But we are here to deal with this legislation.

We have been urging Senators to come over here and offer their amendments. They are here now, and we can either do this later—I plan to stay here until it is done, but the greater numbers of Members would like to have at least some finality to the legislation. I believe we can do it. It is 6 o'clock now and we had the chance for general discussion during the course of the day. Many of our colleagues have come over here to address these issues and to vote on them, and they have been waiting as well.

I hope we will urge our colleagues who are not going to talk on these matter—we know they can; people can get up and address any other matters—but out of consideration of other Members, please try and see if we cannot focus on the matter that is at hand, and that is the Kassebaum-Kennedy bill, which is of enormous importance to many American families.

I see other Members here, and I am sure they will do what they have to do, but we are trying to conclude this and then to let others speak so that at least others will not be here tomorrow. We are going to end up being here tomorrow as sure as I am standing here unless we are able to make progress. That is fine with me, if that is what it is. But with some cooperation of the Members, we have a very good chance of finishing this. Otherwise, Members ought to understand we are going to be here late tonight voting and end up starting the votes later this evening and tomorrow.

We are just about to ask for the final list so that we can agree with that. But in the meantime, we have the Senators who are here who are prepared to move ahead. Senator BROWN is here, and Senator JEFFORDS was here just a few moments ago to deal with an extremely important measure and has been here now for an hour and a half trying to gain the floor.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

AMENDMENT NO. 3678

Mr. CHAFEE. Mr. President, I am going to address the amendment that is before us, the Brown amendment,

but I say to the managers of the bill, I join with them in their enthusiasm to finish it up. I do not see why we do not seek time agreements, in case we get off on another Social Security argument, whatever it might be. But that is up to the managers.

Mr. President, I have a statement that I wish to make that deals with the subject Senator BROWN has been addressing, and Senator PRYOR, likewise, and which I joined in the past.

All I can say, Mr. President, is I just wish we would address this matter, both in the committee, and I understand Senator BROWN has been trying to achieve that, but also on the floor of the Senate. We have had one vote. It was a one-vote margin difference. Perhaps people's minds have been changed since then. Nonetheless, I support the efforts of Senators BROWN and PRYOR.

Congress and the administration made a simple—but costly—error in drafting the Uruguay Round Agreements Act of 1994. That inadvertent error is costing consumers, State governments, and the Federal Government millions of dollars, while providing an unintended windfall to a handful of drug companies. I don't believe we should let that error stand.

What happened? The facts of the case are straightforward. Back in 1994, Congress was drafting omnibus trade legislation designed to bring the United States into conformity with the important new global trade agreement known as the GATT. As part of our commitment to fulfill our new GATT obligations, the United States pledged to increase patent protection for future patents. In addition, the United States also pledged to boot protection for patents already in existence—a key point that goes to the heart of the issue before us today.

Accordingly, the trade bill that Congress wrote, boosted existing patent terms by up to 3 years, giving current patentholders a valuable extension on their patents. To be fair to generic manufacturers who had been preparing to go to market on the old patent expiration date, Congress fashioned a compromise: generic companies who had made a substantial investment in preparing for market would be allowed to proceed as planned, but would have to pay equitable remuneration—that is, a royalty—during the extended term. This carefully balanced compromise became law as part of the 1994 Uruguay Round Agreements Act.

However, in drafting this 653-page bill, Congress and the administration made a small—but very costly—mistake. A simple conforming amendment to an FDA statute was omitted. Yet the impact was enormous: the omission singlehandedly prevented the generic drug industry from going to market during the extended term. The result is that a handful of brand-name drug companies have received a staggering $4.3 billion windfall, at the expense of consumers, that Congress, United States trade officials, and even the brand-name companies themselves, neither intended nor expected.

The cost to consumers is enormous. The drugs that are covered by the windfall are widely prescribed, and are used for everyday ailments that affect millions of Americans. Keeping the generic version off the shelf for up to 3 years means that Americans—including and especially older Americans—are paying far more than was ever intended for their medications.

Not only are consumers paying for this error, but so are State governments and the Federal Government—in the form of higher reimbursements for prescription drugs for the elderly, veterans, and low-income Americans.

This is not right. We made a mistake. We should fix it. In this case, the solution is obvious and easy: simply enact the missing conforming amendment. That is exactly what Senator PRYOR, Senator BROWN, and I—and many others—have been working to do.

Let me take a moment to put to rest a few red herrings. Our amendment would not affect our GATT commitments or our efforts to promote patent protection worldwide. Our amendment would not upset the balance in U.S. drug patent laws, nor impede research and development of new drugs. If any of these misrepresentations were true, we simply would not be sponsoring this amendment. It is that simple.

It is time to correct this injustice—an injustice to consumers in our Nation, an injustice to the Federal and State governemnts that are paying extra and needless sums into Medicaid and Medicare and an injustice to the generic manfuactures who made the investment in reliance on the law as it was supposed to be.

It is time we fixed this unfairness.

Mr. BROWN addressed the Chair.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. BROWN. Mr. President, it is my intention to try and expedite the deliberations here tonight. In that regard, my thought would be to make a statement, hopefully, shedding some light on this amendment. I know Senator PRYOR has worked so hard in this area. He wants to make a statement, and then it will be my intention to withdraw the amendment. I withdraw it reluctantly, because I think it needs to be considered and dealt with as soon as possible. But I am persuaded that we will not have some votes that we need to adopt it if we insist on attaching it to this measure.

Having said that, let me simply outline the issue that is before us. It is well described in a New York Times editorial of February 28. I will quote a portion of that, because I think it is quite succinct and to the point:

> Congress finds it hard to remedy the simplest mistakes when powerful corporate interests are at stake. In 1974, when Congress approved a new trade pact with more than 100 other countries, it unintentionally handed pharmaceutical drug companies windfall profits. More than a year later, Congress has yet to correct the error. The trade pact obliged the United States to change its patent laws to conform with those of the rest of the world. They had the effect of extending some American patents for up to 20 months.

Mr. President, those are the opening lines of the editorial.

The simple fact is this. We had people research drugs and put the investment into it and receive the full length of their exclusivity that this Congress has supported and put into statute. The GATT agreement gave a serendipitous extension to that. In other words, under the GATT agreement and the conforming changes of law that this Congress adopted, people who had invested in and relied on our laws got a longer period of patent protection than they have ever planned for. But the GATT agreement also had a provision, an exception for that extended protection when someone had made a substantial investment in reliance on our laws in providing competitive products.

In other words, what we propose in this amendment is nothing more than absolutely the process that was contemplated and planned for under GATT. And, I might mention, Mr. President, many countries have done exactly the same thing. As a matter of fact, this country has done a similar kind of thing with other products.

What this amendment simply suggests is that where we have given someone an unexpected, unplanned extension in their patent protection, that we make an exception for that extension where someone else has made a substantial investment in producing and providing a competitive product—in this case, a generic drug.

If we do not adopt this, we will have said to people who produce products in reliance to our laws, ''After you have made the investment, after you have put the money into it, after you have made under the terms of what will be the statute a substantial investment on reliance of our laws, we are going to pull the rug out from under you and change the rules retroactively.''

Mr. President, that is not right. That is not honest. That is not fair. That is not a good way to do business. We have talked about the horrible damage—and it is enormous damage—done to consumers by this unjustified quirk of the ratification document.

But I want to focus the Members' attention on what is unfair to business. I believe it is unfair to business to say, ''Look, here are the laws. Here is how long you have for patent protection. And by the way, we're going to change the law retroactively, and even though you made substantial investment in producing a competing product, we're not going to let you compete.'' Now, that is what has happened.

If we do not pass this bill as it is in committee or the amendment as we offer it on the floor, what you are going to do is not only impact consumers to the tune of billions of dollars, but you are going to say to businesses that have relied on the law, that it is tough luck, you should not have believed us. You should not have relied on what we did.

Why is it important to pass it on this bill or pass it quickly? I think that is a fair question. I must tell the Members, I am disappointed I have not been able to persuade all the other people who support the concept that it is important to pass it on this measure.

It is important because the impact of this, if it goes uncorrected, could be over $2 billion, according to the Washington Post. It is important because this costs consumers up to $5 million a day while we delay. Mr. President, let me repeat that because I am not sure people have focused on the impact of delay. It costs up to $5 million a day to consumers in this country if we do not act. Some estimates indicated it may have cost consumers already $700 million.

Mr. President, this is not anything other than fairness. This is not anything other than saying the patent protection that was planned in the law ought to be delivered as it was planned in the law.

Mr. President, I will not prolong the argument. I know the distinguished Senator from Arkansas has worked on this and has some remarks, but I ask unanimous consent to have printed in the RECORD the editorial from the Washington Post, a letter from The Seniors Coalition, a letter from the National Committee to Preserve Social Security and Medicare, a letter from the National Women's Health Network, a letter from the Citizen Action, a letter from the Gray Panthers, a letter from the Generic Drug Equity Coalition, a letter from the Consumer Federation of America, and a letter from the Citizen Advocacy Center, all pertaining to this subject and advocating the position of this amendment. I ask unanimous consent that all of these letters be printed in the RECORD.

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

[From the Washington Post, Dec. 4, 1995]

THE ZANTAC WINDFALL

All for lack of a technical conforming clause in a trade bill, full patent protection for a drug called Zantac will run 19 months beyond its original expiration date. Zantac, used to treat ulcers, is the world's most widely prescribed drug, and its sales in this country run to more than $2 billion a year. The patent extension postpones the date at which generic products can begin to compete with it and pull the price down. That provides a great windfall to Zantac's maker, Glaxo Wellcome Inc.

It's a case study in legislation and high-powered lobbying. When Congress enacted the big Uruguay Round trade bill a year ago, it changes the terms of American patents to a new worldwide standard. The effect was to lengthen existing patents, usually by a year or two. But Congress had heard from companies that were counting on the expiration of competitors' patents. It responded by writing into the trade bill a transitional provision. Any company that had already invested in facilities to manufacture a knock-off, it said, could pay a royalty to the patent-holder and go into production on the patent's original expiration date.

But Congress neglected to add a clause amending a crucial paragraph in the drug laws. The result is that the transitional clause now applies to every industry but drugs. That set off a huge lobbying and public relations war with the generic manufacturers enlisting the support of consumers' organizations and Glaxo Wellcome invoking the sacred inviolability of an American patent.

Mickey Kantor, the president's trade representative, who managed the trade bill for the administration, says that the omission was an error, pure and simple. But it has created a rich benefit for one company in particular. A small band of senators led by David Pryor (D-Ark.) has been trying to right this by enacting the missing clause, but so far it hasn't got far. Glaxo Wellcome and the other defenders of drug patents are winning. Other drugs are also involved, incidentally, although Zantac is by far the most important in financial terms.

Drug prices are a particularly sensitive area of health economics because Medicare does not, in most cases, cover drugs. The money spent on Zantac is only a small fraction of the $80 billion a year that Americans spend on all prescription drugs. Especially for the elderly, the cost of drugs can be a terrifying burden. That makes it doubly difficult to understand why the Senate refuses to do anything about a windfall that, as far as the administration is concerned, is based on nothing more than an error of omission.

THE SENIORS COALITION, PROTECTING THE FUTURE YOU HAVE EARNED,
Washington, DC, April 17, 1996.

Hon. HANK BROWN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BROWN: The Seniors Coalition urges you to support legislation offered by Senator Brown in the Judiciary Committee to correct an egregious mistake made in the implementation of the GATT treaty. This mistake has cost the consumers, and primarily the elderly, of this nation millions of dollars. This loophole has allowed a few drug companies to take advantage of a situation that was unintended and to line their pockets with unearned money from American citizens.

I ask you to read the article ''What you don't know about brand name drugs is costing you millions'' (pp. 4–5) in our latest edition of The Senior Class which outlines the problem and then to vote to support the correction. Your support for this effort is critical to the financial well being of thousands of senior citizens.

I submitted testimony to the Senate Judiciary Committee on this issue when the committee held hearings on this issue in February. At that time I called for the Congress to correct the mistake and reject the efforts of brand name companies to thwart the correction. The so-called ''compromise'' that has been drafted by Glaxo and may be offered by a member of the Judiciary Committee is nothing more than a thinly veiled effort to codify the mistake that was made. A careful reading of the language will find that it does even more damage to the ability of consumers, especially seniors, to find safe and affordable pharmaceutical products in the marketplace.

Again, please support Senator Brown and his effort to correct this mistake. Now is the time for the Congress to do something for the American public.

Sincerely,

THAIR PHILLIPS,
CEO.

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,
Washington, DC, March 27, 1996.

Honorable HANK BROWN,
Senate Judiciary Committee, U.S. Senate, Hart Senate Office Building, Washington, DC.

DEAR SENATOR BROWN: We understand the Senate Judiciary Committee plans to mark-up legislation addressing and General Agreement of Tariff and Trade (GATT) patent pharmaceutical issue tomorrow. We urge you to support legislation (S. 1277) sponsored by Senators Chafee, Pryor, and Brown to correct an oversight in the GATT implementing legislation that will save consumers and taxpayers billions of dollars in prescription drug costs. We urge you to oppose any alternative measures that would maintain this costly and unintended loophole under GATT.

As you know, because of an oversight in patent changes approved under the GATT treaty implementing legislation, the availability of lower-priced generic versions of more than 25 widely-prescribed drugs must be delayed for up to an additional three years. As a result, seniors and other consumers will wait longer for access to less-costly generic drugs.

Every day Congress delays in correcting this oversight costs consumers $5 million dollars in additional prescription drug costs. In fact, the delay has already cost consumers an additional $500 million dollars. The biggest losers among U.S. consumers are senior citizens, as older Americans consume about one-third of the prescription drugs sold in the United States. On fixed incomes and with no pharmaceutical coverage under Medicare, three out of four seniors cite prescription drugs as their largest out-of-pocket expense.

On behalf of our millions of members and supporters, the National Committee to Preserve Social Security and Medicare urges you to support and report out of Committee the Chafee/Pryor/Brown generic drug legislation.

Sincerely,

MARTHA A. MCSTEEN,
President.

NATIONAL WOMEN'S HEALTH NETWORK,
Washington, DC, March 21, 1996.

DEAR JUDICIARY COMMITTEE MEMBER: In this time of federal, state and local budget-cutting, threats to Medicare and Medicaid, and continually rising medical costs, health care savings are more important than ever to the American public. Given the seriousness of skyrocketing health care costs, it is unconscionable that Congress has so far failed to address an error that needlessly increases the cost of health care for millions of Americans, and unnecessarily boosts costs to the federal government, as well.

More than a year ago, Congress discovered that the legislation implementing the GATT Treaty contained an unintended loophole for some pharmaceutical drug companies. An error of omission granted the manufacturers of brand-name drugs treatment unique in all of American industry.

By failing to include generic drugs in its rules concerning transition to new patent terms under the GATT Treaty, Congress has done a disservice to women's health, specifically, and to consumers and taxpayers, generally. While the mistake was unintentional, the consequences are grave. Each day that passes without Congressional action to correct this error costs millions of dollars; the total cost is expected to exceed $2 billion.

The beneficiaries of the current situation are the handful of giant pharmaceutical corporations that will enjoy windfall profits for three additional years. Their glee at this unanticipated windfall is evidenced by the fierceness with which the lobbyists for these companies are fighting to preserve their protected status.

The exemption of drug companies from the GATT transition rules was a mistake. It

would be intolerable to compound this mistake by failing to correct it. Please support the solution proposed by Senators BROWN, CHAFEE and PRYOR.

Sincerely,

CYNTHIA PEARSON,
Program Director.

CITIZEN ACTION,
Washington, DC, March 26, 1996.

DEAR JUDICIARY COMMITTEE MEMBER: On behalf of Citizen Action and our three million members, I would like to ask your support for a proposal which will shortly be offered by Senators Brown, Chafee and Pryor. This proposal would undo a legislative error which, if not corrected, will cost U.S. consumers hundreds of millions of dollars in unnecessary prescription drug costs.

When Congress passed new patent terms under the GATT Treaty, it failed to include prescription drugs under its transition rules. GATT extends patent terms of U.S. products from 17 to 20 years. Because many manufacturers had already invested millions of dollars in competing products in expectation of the 17-year limit, Congress adopted transition rules to allow those companies to introduce generic alternatives on the date that the 17-year patent would have expired.

The omission of prescription drugs in the transition rule means that makers of lower-cost generic drugs will be unable to bring their products to market until the full 20-year term of patent protection has expired. This loophole will allow a few large pharmaceutical companies to reap more than $2 billion in windfall profits. Because lower-cost generics will be kept off the market, consumers will be forced to pay higher prices for more than a dozen drugs, including big-sellers Zantac and Capoten.

Without a correction, taxpayer-funded federal and state health programs, as well as individual purchasers of prescription drugs, will be forced to pay higher than necessary costs. The Department of Veterans Affairs estimates that it alone will spend $211 million in additional costs over the next three years.

The Judiciary Committee has an opportunity to correct a provision that will have grave consequences for consumers. Again, Citizen Action urges that you act now to remove this unique loophole which rewards certain large pharmaceutical companies at the expense of taxpayers and consumers.

Sincerely,

CATHY L. HURWIT,
Legislative Director.

GRAY PANTHERS PROJECT FUND,
AGE AND YOUTH IN ACTION,
Washington, DC, February 29, 1996.

Hon. HANK BROWN,
U.S. Senate, Senate Hart Office Building, Washington, DC.

DEAR SENATOR BROWN: Attached please find copies of Tuesday's ABC World News Tonight news story focusing on the negative impact that the GATT loophole will have on American consumers like Eleanor Black and her mother Sally. In addition, attached are copies of the testimony submitted to the Judiciary Committee from Ms. Black and myself, as well as Wednesday's New York Times editorial on the issue.

With the Senate Judiciary Committee hearings on GATT now behind us, Senators Chafee, Brown, and Pryor have vowed to introduce legislation within the next few weeks that will correct this loophole and bring relief to millions of consumers like the Blacks who rely on the savings that generic pharmaceuticals offer.

In December, an effort to bring the Chafee-Brown-Pryor amendment to the Senate floor was narrowly defeated by one vote. When the Chafee-Brown-Pryor amendment is introduced in the near future, I urge you and your colleagues to do the right thing and correct this Congressional oversight and save American taxpayers from a costly mistake.

Please support the Chafee-Brown-Pryor amendment and close the GATT loophole.

Sincerely,

DIXIE D. HORNING,
Executive Director.

GENERIC DRUG EQUITY COALITION,
Washington, DC, March 29, 1996.

To: Members, United States Senate
FR: Generic Drug Equity Coalition
RE: No More Delays, Pass Chafee/Pryor/Brown

When the Senate adjourns today for the Spring recess, consumers and taxpayers will have paid $580 million more for prescription drugs than they should have because of a mistake Congress and the administration made in December 1994, $580 million. Everyday that passes costs consumers and taxpayers $5 million more.

By the time you return in two weeks, the cost to consumers and taxpayers will have reached $650 million.

Yet, despite written commitments to markup a bill to close the GATT loophole in the Senate Judiciary Committee in March, nothing has happened.

A few companies continue to reap unintended windfall profits at the expense of American consumers, taxpayers and generic drug manufacturers.

While you are away observing the Easter and Passover Holidays be sure to think about Americans like 69-year old Eleanor Black and her 89-year old mother Sally who spend $339 a month, one quarter of their monthly income, for Zantac because of the GATT loophole.

The Generic Drug Equity Coalition urges you to support the Chafee/Pryor/Brown proposal and close the GATT loophole.

The Judiciary Committee leadership has missed its own, self-imposed deadline. It is time for a vote on the Senate floor.

CONSUMER FEDERATION OF AMERICA,
Washington, DC, March 27, 1996.

DEAR SENATE JUDICIARY COMMITTEE MEMBER: The Senate Judiciary Committee plans this week to examine the loophole in the General Agreement on Tariffs and Trade (GATT) which exempts the pharmaceutical industry from patent transition terms. We urge you at this time to support the efforts of Senators BROWN, CHAFEE, and PRYOR to redress this unintended and potentially costly, effect of the GATT Treaty.

As you know, an error of omission in the legislative language implementing the GATT Treaty has exempted the pharmaceutical industry from the patent transition terms. As a result, the pharmaceutical drug industry—alone among all industries—enjoys a 20-year patent term, and generic manufacturers are unable to market long-planned products.

The unintended effects of the patent extension include diminished market competition, an undeserved windfall to pre-GATT patent holders, and further inflated costs to millions of Americans. The Congressional Budget Office (CBO) has estimated that this simple mistake will cost consumers and taxpayers as much as $2 billion as drug companies reap windfall profits in the absence of competition. This windfall was not intended by Congress, nor envisioned in the GATT treaty itself.

Senators, BROWN, CHAFEE, and PRYOR have proposed closing the loophole, thereby protecting consumers' health and taxpayers' wallets. This solution would not convey special status on the generic drug industry; instead, this amendment provides for equal treatment, and would compel brand-name drug manufacturers to live under the same rules as every other American industry.

In the interest of consumers, taxpayers and fairness, we urge you to support the efforts Senators, BROWN, CHAFEE, and PRYOR have made to redress this costly error.

Sincerely,

MERN HORAN,
Legislative Representative,
Consumer Federation of America.

CITIZEN ADVOCACY CENTER,
Elmhurst, IL, March 25, 1996.

DEAR JUDICIARY COMMITTEE MEMBER: An oversight in the legislation implementing the GATT Treaty has granted the pharmaceutical industry a privileged status at the expense of consumers and taxpayers. More than a year after the implementing legislation was adopted, Congress has yet to correct this windfall benefit. Now, Senators Brown, Chafee, and Pryor have developed a solution that is fair and reasonable and deserving of your support.

GATT is premised on opening world markets to competition. Under our implementing legislation, however, manufacturers of generic drugs, alone among all industries in the United States, are prohibited from bringing products to market until the full twenty-year patent term has expired for brand-name drugs. This anticompetitive windfall is estimated to be worth two billion dollars in profits. Health care consumers are thus forced to pay higher costs, as will taxpayers, who fund drug purchases through a number of government programs. The City of Elmhurst has a high percentage of Senior Citizens, a group that is disproportionately harmed by high health care costs, and the adverse effects of the as yet uncorrected legislation.

Congress did not intend to bestow this windfall on drug companies when it adopted the transitional rules for GATT. We urge you, in the interest of consumers, seniors, and taxpayers, to correct this oversight and to not be lulled into inaction by the multimillion dollar lobbying blitz of the companies enjoying this windfall daily.

Senators Brown, Chafee and Pryor have proposed a simple solution that would protect the balance of interest between generic and brand-name manufacturers envisioned in the Hatch-Waxman Act of 1984. It's time to support their proposal.

Very truly yours,

THERESA AMATO,
Executive Director,
Citizen Advocacy Center.

Mr. PRYOR addressed the Chair.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. PRYOR. Mr. President, my apologies to the Senator from Colorado. Has the Senator from Colorado finished his statement?

Mr. BROWN. Yes.

Mr. PRYOR. Mr. President, I will take but a few moments of the Senate's time this evening. We need to move on. The distinguished managers have requested that we move to final resolution of this very important measure. But I would like to take, Mr. President, in opening, a few moments to discuss our particular concerns over this uncorrected error in our laws which has led to unnecessarily high drug prices.

I would like to quote from my good colleague who is departing the Senate and is a great friend, Senator PAUL SIMON of Illinois. Senator SIMON recently spoke on the issue of correcting

this problem in the GATT treaty. I quote from Senator SIMON when he said, ''This is a classic example of special interests versus the public interest.''

Mr. President, that is what this debate, I am afraid, has boiled down to. I know my friend from Colorado, Senator BROWN, in his eloquent statement has placed into the RECORD a recent editorial of December 4, 1995 from the Washington Post. I will read a paragraph from that editorial:

All for lack of a technical conforming clause in a trade bill, full patent protection for a drug called Zantac will run 19 months beyond its original expiration date. Zantac, used to treat ulcers, is the world's most widely prescribed drug, and its sales in this country run to more than $2 billion a year.

I continue quoting from the Washington Post editorial:

The patent extension postpones the date at which generic products can begin to compete with it and pull the price down. That provides a great windfall to Zantac's maker, Glaxo Wellcome, Inc.

That is the beginning paragraph, Mr. President, of the Washington Post editorial. To conclude from that editorial, let me read:

That makes it doubly difficult to understand why the Senate refuses to do anything about a windfall that, as far as the administration is concerned, is based on nothing more than an error of omission.

Well, once again, this issue is with us. We failed by one vote back on December 7 to rectify this mistake. Since that time, a few companies like Glaxo Wellcome have earned more than $600 million in extra revenues because of a congressional error. It also means that the Veterans Administration, the Medicaid programs, the consumers of America, and especially the elderly of America are having to pay double for Zantac than what they would be paying had we allowed a generic to come into the marketplace and compete.

This is not fair, Mr. President. We know that this is not fair. The Judiciary Committee this morning had scheduled a markup, one which has already been delayed from last month. They continue to promise that they are going to mark up S. 1277, the measure offered by Senator BROWN and Senator CHAFEE and myself to correct this mistake in the GATT treaty.

But, once again, this morning an unnamed Senator objected to the Senate Judiciary Committee marking up this measure, and, once again, it means more and more windfall profits for undeserving companies at the expense of consumers. These delays are completely unacceptable and unwarranted. The American public simply cannot abide further delays on behalf of special interests.

What is at stake? Back on November 27, 1995, an editorial in the Des Moines Register stated that:

A month's supply of Zantac ordinarily sells for around $115; the generic price—meaning the same drug without the Zantac label—would be around $35, the generic makers contend.

Mr. President, I ask unanimous consent that a copy of that Des Moines Register editorial be printed in the RECORD.

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

[From the Des Moines Register, Nov. 27, 1995]

A COSTLY OVERSIGHT

FINE PRINT IN GATT LAW COULD COST ZANTAC USERS MILLIONS

The nation's prescription drug makers are at war again, with a $1 billion-plus purse going to the winner. If the brand-name drug manufacturers win, the losers will include the millions of Americans who suffer from ulcers or heartburn, and take the drug Zantac regularly to combat the problem. It's going to cost each of them about $1,600.

Zantac is made by GlaxoWellcome, the biggest in the business.

Here's what started the current war:

When a new prescription drug hits the market, generic drug manufacturers await the patent expiration so they can enter the market with the same drug. They offer it for sale without the brand name, usually at a fraction of the brand-name price.

The new international GATT treaty signed by the United States and 122 other countries sets the life of a patent at 20 years from the date of application. Former U.S. law provided patent protection for pharmaceuticals for 17 years from the date of approval. Because the difference could have a significant impact on the number of years a firm could market its patented drug without competition. Congress made special provisions for drugs under patent at the time GATT was approved last summer.

But when the legal beagles got done reading all the fine print, it turned out that Zantac was granted a 19-month extension of its patent life—and it is such a hugely popular drug that that translates into a multi-million-dollar windfall.

Generic drug makers call the windfall a congressional oversight, and estimate the difference is worth $2.2 billion to Glaxo, because the generics can't enter the market for 19 more months. Glaxo counters that Congress made no mistake, that the extension was part of the compromise with generics. It won't wash. Nothing in the GATT treaty was intended to further enrich the happy handful of brand-name drug makers who hold lucrative patents—or to personalize the users of the drugs.

A month's supply of Zantac ordinarily sells for around $115; the generic price—meaning the same drug without the Zantac label—would be around $35, the generic makers contend. Unless Congress changes the wording of the law regarding transition to GATT provisions, Zantac users will pay the difference for 19 months longer.

Some generic drug manufacturers had already spent a bundle preparing to enter the market before the GATT treaty took effect. They lose. So do taxpayers, who pay for Medicaid prescriptions. The Generic Drug Equity Coalition estimates that the higher costs of Zantac and some other drugs affected by the mistake (such as Capoten, for high blood pressure) will cost Iowa Medicaid $3.5 million. Further, say the generic drug makers, it will tack another $1.2 million onto the cost of health-insurance premiums for Iowa state employees.

Glaxo's political action committee has doubled its contributions to Congress in recent months. Glaxo wants the mistake to stay in the law. Generic drug manufacturers want it out.

So should ulcer sufferers. So should taxpayers. So should Congress.

Mr. PRYOR. Mr. President, finally, let me say we all know what this issue is about. We have debated this issue to some extent on the floor of the Senate and to a great extent in the Judiciary Committee. We heard our U.S. Trade Representative, Ambassador Kantor conclusively explain the situation, and I quote:

The provision was written neutrally because it was intended to apply to all types of patentable subject matter, including pharmaceutical products. Conforming amendments should have been made to the Federal Food, Drug and Cosmetic Act and section 271 of the U.S. Patent Act, but were inadvertently overlooked.

One other quote from Ambassador Kantor:

We intended to apply this grandfather provision to the pharmaceutical area. S. 1277 would result in a level of protection that is consistent with our original intent.

Mr. President, let me say, Senator BROWN, Senator CHAFEE and myself have tried to proceed in good faith. There are Members on each side of the aisle that have stated their concern about, and in some cases their objection to, certain language that we had in this legislation. We have attempted to meet with them. We have attempted to compromise. We have certainly gone to the negotiating table and attempted to bargain in good faith and see what their concerns are.

Truly, Mr. President, I believe that we now have come together and crafted an amendment that is acceptable to all those concerned with doing what is right for consumers, businesses which have relied upon the law in good faith and for our compliance with a very important treaty. The amendment represents the simplest and best means for us to correct the egregious flaw that persists today because of unconscionable delays and the efforts of special interests.

Mr. President, I want to say in conclusion that I have thoroughly enjoyed working with Senator BROWN of Colorado and Senator CHAFEE of Rhode Island, my colleagues on the other side of the aisle. I hope we can bring this matter to a resolution in the very near future.

The PRESIDING OFFICER (Mr. GORTON). The Senator from Colorado.

Mr. BROWN. Mr. President, the vote on this measure was close, as has been noted. Since that time, I believe we have persuaded others to join us in advocating this amendment. The amendment has been compromised to the point that specifically we have spelled out in the compromise version that is before the Senate right now a very clear, bright-line test of what substantial investment is. It is easy and clear to work with. I think we have addressed the problems. I am confident we have the votes.

However, because of the urgency of the particular underlying measure that is here, some Members whose votes we need and count on are unable to support this amendment because they fear

it would bring controversy to the bill. It is, therefore, necessary for me to reluctantly withdraw this measure.

I must mention, Mr. President, it does seem to me this is the appropriate kind of thing that ought to be considered on a prompt basis. Literally, to fail to act costs consumers $5 million or more a day, and literally if we fail to act very promptly, the issue becomes moot because the time simply runs out. I believe in fairness to companies that have reinvested, and, in fairness to consumers, we should and must act quickly.

I simply want to serve notice that we will be looking for other vehicles to offer on this floor in a rather prompt fashion.

With that, I reluctantly withdraw the amendment.

The PRESIDING OFFICER. The Senator has the right to withdraw the amendment.

So the amendment (No. 3678) is withdrawn.

Mrs. KASSEBAUM. Mr. President, I very much appreciate the sponsors of the amendment withdrawing it. Senator BROWN and Senator PRYOR are very persuasive in their arguments, as Senator CHAFEE was as well. I am sympathetic to the purpose of the amendment.

As was noted by the sponsors, it is controversial. For that reason, we would have to oppose it on the health insurance reform bill. I appreciate the thoughtfulness in their withdrawal.

UNANIMOUS-CONSENT AGREEMENT

Mrs. KASSEBAUM. Mr. President, I put forward on behalf of the majority leader a unanimous-consent agreement.

I ask unanimous consent during the remainder of the Senate's consideration of S. 1028, the following amendments be the only first-degree amendments in order, that they may be subject to relevant second-degree amendments, and following the disposition of the listed amendments and the committee substitute, the bill be advanced to third reading, and the Senate then proceed to the House companion bill, that all after the enacting bill be stricken, the text of the Senate bill be inserted, the bill be advanced to third reading and the Senate proceed to vote on passage of H.R. 3103, as amended, without any intervening action or debate.

The list that I have of the amendments would be: Nickles, relevant; Jeffords, lifetime caps; Thomas, rural health; McCain, biological medical devices; Gramm, relevant; Coats, medical volunteer liability coverage; Domenici, mental health; Specter, public health; pecter, public health; Specter, public health; Gregg, choice care; Helms, study of access by HHS; Senator BROWN has withdrawn his amendment; McConnell, medical malpractice; Bond, administration simplification; Pressler, CRNAS; D'Amato, fair tax treatment; Kassebaum, relevant; Dole, relevant; Roth, relevant; Simpson, commission; Bennett relevant; Burns, telemedicine; Boxer, ban HMO gag rules; Conrad, nurse practitioner, nurse anesthetists, advance nurse practitioner; Feinstein, nonprofit insurance; Graham-Baucus, Medicare fraud; Harkin, fraud and abuse; Harkin, fraud and abuse; Kennedy, relevant; Pryor relevant; Wellstone, two domestic violence; Simon is a sense-of-the-Senate resolution; Dorgan, organ donations; Lieberman, MM data banks; Kennedy, nursing care; Daschle, relevant; Boxer, biomed devices.

Mr. KENNEDY. Would the Senator add Wellstone, relevant, sense of the Senate.

The PRESIDING OFFICER. Is there objection to the unanimous consent request?

Without objection, it is so ordered.

Mrs. KASSEBAUM. Mr. President, I believe Senator JEFFORDS has been waiting, and I believe he is next to be recognized.

Mr. JEFFORDS. Mr. President, I yield to the Senator from Arkansas.

Mr. PRYOR. Mr. President, if we could ask a question, Mr. President, while the two distinguished managers are on the floor. It is 6:15; I did not realize there were quite as many amendments.

Mrs. KASSEBAUM. Neither did we.

Mr. PRYOR. Are we planning to go on into the evening?

Mrs. KASSEBAUM. Yes, Mr. President, I say to the Senator from Arkansas, I think it is the hope not only of the managers but also of the minority leader and the majority leader that we finish tonight.

Mr. PRYOR. Good night, Mr. President, thank you.

AMENDMENT NO. 3679

(Purpose: To establish a minimum amount that may be applied as an aggregate lifetime limit with respect to coverage under an employee health benefit plan or a group health plan)

Mr. JEFFORDS. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Vermont [Mr. JEFFORDS] PROPOSES AN AMENDMENT NUMBERED 3679.

Mr. JEFFORDS. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

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

At the end of section 103, add the following new subsection:

(g) LIMITATION ON LIFETIME AGGREGATE LIMITS.—

(1) IN GENERAL.—Except as provided in paragraph (2), an employee health benefit plan or a health plan issuer offering a group health plan may not impose an aggregate dollar lifetime limit of less than $10,000,000 (such amount to be adjusted for inflation in fiscal years subsequent to the fiscal year in which this subsection becomes effective) with respect to coverage under the plan.

(2) SMALL EMPLOYERS.—Paragraph (1) shall not apply to a group health plan offered to or maintained for employees of a single employer that employs 25 or fewer employees.

(3) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed as prohibiting the application by an employee health benefit plan or a health plan issuer offering a group health plan of any limits, exclusions, or other forms of cost containment mechanisms with respect to coverage under the plan other than the aggregate limit permitted under paragraph (1).

(4) DISCLOSURE.—Any limits, exclusions, or other cost containment mechanisms permitted under paragraph (3) shall be disclosed as provided for in section 105(c).

(5) APPLICATION OF SUBSECTION.—This subsection shall not apply to a health maintenance organization that meets the requirements of title XIV of the Public Health Service Act.

(6) EFFECTIVE DATE.—This paragraph shall become effective with respect to health plans on the date that is 2 years after the date of enactment of this Act.

At the end of section 105, add the following new subsection:

(c) DISCLOSURE OF LIMITS AND EXCLUSIONS.—An employee health benefit plan or a health plan issuer offering a group health plan shall disclose, as part of its solicitation and sales materials and in a form and manner that is conspicuous and understandable to a reasonable individual, any limits, exclusions, or cost containment mechanisms with respect to coverage provided under the plan.

Section 3711 of title 31, United States Code, is amended by adding at the end the following new subsections:

''(g)(1) If a nontax debt or claim owed to the United States has been delinquent for a period of 180 days—

''(A) the head of the executive, judicial, or legislative agency that administers the program that gave rise to the debt or claim shall transfer the debt or claim to the Secretary of the Treasury; and

''(B) upon such transfer the Secretary of the Treasury shall take appropriate action to collect or terminate collection actions on the debt or claim.

''(2) Paragraph (1) shall not apply—

''(A) to any debt or claim that—

''(i) is in litigation or forelosure;

''(ii) will be disposed of under an asset sales program within 1 year after the date the debt or claim is first delinquent, or a greater period of time if a delay would be in the best interests of the United States, as determined by the Secretary of the Treasury;

''(iii) has been referred to a private collection contractor for collection for a period of time determined by the Secretary of the Treasury;

''(iv) has been referred by, or with the consent of, the Secretary of the Treasury to a debt collection center for a period of time determined by the Secretary of the Treasury; or

''(v) will be collected under internal offset, if such offset is sufficient to collect the claim within 3 years after the date the debt or claim is first delinquent; and

''(B) to any other specific class of debt or claim, as determined by the Secretary of the Treasury at the request of the head of an executive, judicial, or legislative agency or otherwise.

''(3) For purposes of this section, the Secretary of the Treasury may designate, and withdraw such designation of debt collection centers operated by other Federal agencies. The Secretary of the Treasury shall designate such centers on the basis of their performance in collecting delinquent claims owed to the Government.

''(4) At the discretion of the Secretary of the Treasury, referral of a nontax claim may be made to—

''(A) any executive department or agency operating a debt collection center for servicing, collection, compromise, or suspension or termination of collection action;

''(B) a contractor operating under a contract for servicing or collection action; or

''(C) the Department of Justice for litigation.

''(5) nontax claims referred or transferred under this section shall be serviced, collected, or compromised, or collection action thereon suspended or terminated, in accordance with otherwise applicable statutory requirements and authorities. Executive departments and agencies operating debt collection centers may enter into agreements with the Secretary of the Treasury to carry out the purposes of this subsection. The Secretary of the Treasury shall—

''(A) maintain competition in carrying out this subsection;

''(B) maximize collections of delinquent debts by placing delinquent debts quickly;

''(C) maintain a schedule of contractors and debt collection centers eligible for referral or claims; and

''(D) refer delinquent debts to the person most appropriate to collect the type or amount of claim involved.

''(6) Any agency operating a debt collection center to which nontax claims are referred or transferred under this subsection may charge a fee sufficient to cover the full cost of implementing this subsection. The agency transferring or referring the nontax claim shall be charged the fee, and the agency charging the fee shall collect such fee by retaining the amount of the fee from amounts collected pursuant to this subsection. Agencies may agree to pay through a different method, or to fund an activity from another account or from revenue received from the procedure described under section 3720C of this title. Amounts charged under this subsection concerning delinquent claims may be considered as costs pursuant to section 3717(e) of this title.

''(7) Notwithstanding any other law concerning the depositing and collection of Federal payments, including section 3302(b) of this title, agencies collecting fees may retain the fees from amounts collected. Any fee charged pursuant to this subsection shall be deposited into an account to be determined by the executive department or agency operating the debt collection center charging the fee (in this subsection referred to in this section as the 'Account'). Amounts deposited in the Account shall be available until expended to cover costs associated with the implementation and operation of Governmentwide debt collection activities. Costs properly chargeable to the Account include—

''(A) the costs of computer hardware and software, word processing and telecommunications equipment, and other equipment, supplies, and furniture;

''(B) personnel training and travel costs;

''(C) other personnel and administrative costs;

''(D) the costs of any contract for identification, billing, or collection services; and

''(E) reasonable costs incurred by the Secretary of the Treasury, including services and utilities provided by the Secretary, and administration of the Account.

''(8) Not later than January 1, of each year, there shall be deposited into the Treasury as miscellaneous receipts an amount equal to the amount of unobligated balances remaining in the Account at the close of business on September 30 of the preceding year, minus any part of such balance that the executive department or agency operating the debt collection center determines is necessary to cover or defray the costs under this subsection for the fiscal year in which the deposit is made.

''(9) To carry out the purposes of this subsection, the Secretary of the Treasury may prescribe such rules, regulations, and procedures as the Secretary considers necessary.

''(h)(1) The head of an executive, judicial, or legislative agency acting under subsection (a)(1), (2), or (3) of this section to collect a claim, compromise a claim, or terminate collection action on a claim may obtain a consumer report (as that term is defined in section 603 of the Fair Credit Reporting Act (15 U.S.C. 1681a)) or comparable credit information on any person who is liable for the claim.

''(2) The obtaining of a consumer report under this subsection is deemed to be a circumstance or purpose authorized or listed under section 604 of the Fair Credit Reporting Act (15 U.S.C. 1681b).''.

Mr. JEFFORDS. Mr. President, I know that we have had a difficult day today. We are having a difficult time trying to face the facts of life that the bill we are amending is a very important one, one which I have been an original cosponsor and one which part of the bill is mine. It is something that I worked very hard on. I believe it is an excellent job.

However, I also believe that it has a very serious flaw in it. Thus, at the time the committee was meeting—and I want to point out that we have already made an exception today—the Finance Committee came and said, ''Hey, we have a bunch of amendments.'' Most of them have been accepted. So we have already made several exceptions to the nonamendment rule. I want to remind people of that.

Now, I submitted this amendment, which I have before this body, at the committee. I am a member of the committee, ranking Republican on the committee. At that time it was said, ''Hey, we want to get out of here a unanimous bill. We may have problems.'' So I said, ''OK, I will wait until the floor.'' So I come to the floor to offer an amendment, which I think about everybody agrees ought to be on it, and they said, ''No. No amendments—except for the Finance Committee amendments.''

I understand that the ranking Republican and the chairman of the committee are bound by their commitment to no amendments, but nobody else is. Nobody else is in this body. So I hope Members would say he deserves to be heard. He has told me I could raise this amendment on the floor, and here it is.

Now we will talk about what the amendment is and why we are here. The bill is one which provides, if a person is working for a business and changing jobs, or whatever else, has a health problem, that they are guaranteed an issuance of a policy or a continuance of a policy, notwithstanding the fact that they are sick. That is very important. This is an important breakthrough. That is why I supported the bill.

However, what we were not aware of at the time and I brought to the committee's attention, but perhaps there was too little time to consider it, is the fact that there is no requirement now under the Federal law for any kind of a certain level of cap.

Now, what could happen to us is, OK, we require the insurance company to take a sick person, but then the insurance company has the right to change its benefits, or it can say, ''OK, we will lower the lifetime cap. So when we take you on, as soon as we pay whatever level of funds we reduce the limit to, you are gone, finished, you have no more coverage.''

Well, this amendment would rectify that and say we have to put—as a nationwide standard, with the exception, we admit it could cause some problems with small businesses, so we exempt 25 and under. We say you have to have $10 million of coverage. Why the $10 million? The $10 million lifetime cap is because the standard for the industry for many years was a million dollars. But that was 20 years ago. That million dollars is worth about $100,000 now. So we say, let us go back to the standard of 20 years ago and put on that cap.

I want to point out that when we do this, we are obviously going to cause some costs. I will explain that later. But let us take a look at who we are talking about when we are talking about those covered under this provision. We are talking about those that are working for businesses, as I say, that get sick. All of a sudden they have some pretty big bills. Remember, some of the lifetime caps out there on these insurance plans are $50,000. That is one day in a hospital sometimes. So you go in there sick, and all of a sudden you have no coverage. We are trying to correct that.

Now, let me point out to you, again, what we are talking about from a national policy perspective. What happens now to that sick person? That person is sick. They have been allowed to be covered and then chopped off because they have reached the lifetime limit of, say, $50,000. What happens? Under the law right now, in order for them to qualify for Medicaid, they cannot have resources beyond a certain level. So what we are talking about—and I will give some examples in a minute—is middle income people, or even higher income people, who suddenly are placed in a position where the only way they can get care for their loved one is to get rid of all of their assets and then they will qualify for Medicaid. So the household has to go through that—getting rid of its assets—and then they qualify for Medicaid. Should our policy in this Nation do that? I say no, and I am sure you will, too. This is not good policy.

Let me talk a little about some of the people involved. I think all of you have probably heard the ads of Christopher Reeve, or watched them on television, or read the editorials in the newspapers and the stories that have covered this. If you want an example as to whether or not it could happen to you, here is ''Superman,'' who was involved in a very serious accident. He was thrown off his horse and he becomes a C–2, which is a broken neck. He has lost the functions below the neck level, without some assistance. He has a cap of $1.2 million, and it is costing him $400,000 a year. In 3 years, he will be past that cap.

Let us take Jim Brady, who is another one—not an example of the lifetime cap, because he is on worker's compensation, but he had a head injury caused by a bullet when he was with President Reagan. He would be far beyond a million-dollar cap, to say nothing of a $50,000 cap at this time.

Let me talk about some of the people that do not have the resources of a Christopher Reeve, or the protection of the law with respect to worker's comp, like Jim Brady. Let me go through some of these so that you understand better what kind of people we are talking about.

This story is about Donelle and Kyle Meniketti, from the Washington Post. For 4 years, Donelle Meniketti waged a tremendous fight to save her son Kyle from suffering death or severe brain damage as a result of a rare breathing disorder that struck when he was 18 days old. It says:

When he sleeps, said the Livermore, CA, woman, his airway collapses and his brain does not tell him to breathe. He needs a breathing machine at night and an oxygen monitor. When he sleeps, he must have someone there all the time to make sure he is breathing.

Home nursing care costs alone can be $10,000 a month, and even though Mrs. Meniketti has spent sleepless nights watching over her son rather than pay for a nurse, his medical care is making constant claims on the health insurance plan of her husband Keith. As these claims mounted, they face the terrible prospect of the child's expenses soon reaching the million-dollar cap.

He is 4 years old. So far he has escaped it. But they will be forced into Medicaid if this amendment does not succeed.

Then there is Heather Fraser. I wish you would have seen her. She appeared at our press conference the other day. She is 23 years old and suffers from cystic fibrosis. She has suffered already many times. She does not know from one day to the next whether she is going to have one of these respiratory infections. She has had chronic problems of all different kinds and will continue to do so. She graduated from college, is 23, and is looking forward to the future. What is going to happen? The average cost per year to treat a moderate case of cystic fibrosis is $46,000. More severe cases cost roughly $79,000. To date, Heather's medical expenses have exceeded $800,000. Research is going on, but right now she will be beyond the cap and on Medicaid.

Another one is Lauren Yandell of Williston, VT. Her policy has a cap of $1 million. Lauren has a son who has suffered from a chronic and very rare neurological disease since birth. Because of medications and frequent surgery and personal care, his medical expenses are extremely high—last year alone, over $70,000. He is only 5 years old. At this rate, Lauren believes her son will exhaust the limit within 10 years.

Barbara Church, in Shelburne, VT—these are Vermonters, but there are people like this all over the Nation. Barbara has a 12-year-old son who was in a car accident 3 years ago. He has a very similar condition to Christopher Reeve. Since the accident, medical expenses have ranged from $20,000 to $50,000 annually. Her policy through her employer does not have a cap, and she is wary because if she loses her job, as it is under this law now, and she tries to go somewhere, she will not have the cap, or it may be only $50,000. There is no protection for her.

These are the kinds of real-life situations. Is it appropriate for us to say that the way these people should get their continuous care is to get rid of all their assets and live in poverty for the rest of their lives, as long as their child survives? No, that is not what the policy of this Nation ought to be. This amendment would make sure that those occurrences do not occur.

I hope that people will take into consideration that this is an amendment which will correct the deficiencies in the bill before us by saying that there will be a cap out there, which will be sufficient to take care of the expenses of these people to whom we are saying, ''You have a good deal because you can continue your coverage.'' Right now, the expectations are not there, and they can be changed at any moment.

So I want to urge you to consider that this is something that is important to the bill before us. It is an amendment to the bill before us. It is to correct the serious problem in the bill before us. What we are talking about here, as far as the impact, is, obviously, if somebody is paying some money, somebody is going to have to shell out some money somewhere else. If they are being paid to have their health taken care of—first of all, let me review for a moment the kinds of costs involved with these actions.

Look at this chart. It will show you about children with hemophilia. There are about 7,000 children with hemophilia, not many in terms of 250 million. The average cost per year per person is $100,000. Life expectancy is 40 years. Lifetime cost per person for hemophilia is $4 million. Do you want to put them all under Medicaid?

Cystic fibrosis, the case I talked about earlier; the prevalence is about 4,000 in this country. That is not many relative to the huge population. It is easy to spread around the cost. The average cost per person per year is $18,000, and the average life expectancy is 30 years; $2.5 million.

This is the kind of situation which we are talking about.

Let us take a look. There are other examples. Spinal injury and head trauma, you can also see where the costs are—around $5 million for a lifetime situation.

Now let us review the question of why this is going to be a reasonable cost with respect to the existing situation. Again, insurance—the main purpose of insurance is to spread costs over a larger population so that the cost is small to the employer and to the employee with the insurance policy. But because of the huge number for which we spread it, it makes it reasonable for a family to afford.

Let me remind all of my colleagues that we all have no lifetime cap. None of the Federal employees have anything to worry about. We are all covered, whatever the costs are. In addition to that, as this chart shows, we are one of the 20 percent in this country that have no limits whatsoever. There are those that have more than $1 million, about 6 percent. The biggest group is that one that has been carrying the $1 million forward for the last 20 years as long they have been in business. That is 46 percent. So already we are at over 70 percent. Then we go on down.

I will be candid with you. The lower, of course, your lifetime caps, especially when you get to the really low levels, you obviously start covering more things than normally, and you end up with more cost. But the thing I am trying to make sure you understand is the cost that is spread around is not that high.

Let us take a look at what some of the people say about what those costs would be. First of all, let me run through some of these that have given us some costs.

The American Academy of Actuaries, for instance, has given us a cost analysis which demonstrates what we are talking about. Let me go to Price Waterhouse first. Price Waterhouse is a noted accounting firm, which we often look to give us accurate information, estimates that the Jeffords amendment would save $7 billion in Medicaid costs—$7 billion—over 7 years. And more importantly, the cost to businesses would be somewhere in the area of—especially those in the larger areas—would be somewhere around 1 percent of their premiums.

Let us go to another one. We have several on this.

Also the National Taxpayers Union; let me tell the people on my side of the aisle what the National Taxpayers Union says. They are supporting it. They say it will be scored as a direct spending reduction in the Medicaid Program by approximately $2.8 billion over a 5-year period. In addition, $2.1 billion may be saved through State and local Medicaid Programs.

How can you say that this is not something that should be done when we know what it is going to do to help us address the budget problems which we have? Do you know what that amount of money means? That is going to be replaced by the insurance premiums? But it does not even cover the money that is drained out of all those families that went out for expenditures on health care.

The Consumers Union, the other side of the aisle usually looks forward to the lifetime cap amendment which would significantly benefit consumers. The Consumers Union agrees that, if

health insurance policies have lifetime caps, it would be no lower than $10 million to the people exposed. They say it is important and essential.

Then, of course, we have to look to the Congressional Budget Office and we have CBO's estimates. This came to us today. The Congressional Budget Office says the amendment would increase the Federal deficit. They are the only ones who say it is a cost after you balance out the deductions for taxes—$120 million. So by the worst-case scenario we have an offset for this. You could have a tiny, itty-bitty negative impact of $120 million over 5 years.

So it is almost a no-brainer. It is hard to find out why anybody is against it.

This is the Congressional Budget Office again. The proposal would initially raise private insurance premiums by 0.4 percent. You want to keep in mind that, if you are an employer, you have options. You can increase your premiums, or you can increase your deductibles.

So it may not even cost the businessman anything. So again, the Congressional Budget Office says that we have something here which either costs nothing or something which is going to save the Treasury billions of dollars over 7 years.

So it is just hard for me to figure out why there can be any opposition to do this. Not only that. But Senator KENNEDY, and I think Senator KASSEBAUM, have suggested that this is a great amendment and that it ought to be on some other bill. What other bill? Why not the one it is most relevant to? Why not on the one with which we are trying to make sure is helping people with their transfer from job to job?

I understand the complexity of trying to get a bill through without any amendments on it. But I remind everyone that we have already granted exceptions to the Finance Committee, and I asked the committee that be one of those exemptions because I offered it at the committee level, and they said, ''No way. Take it to the floor.'' I come to the floor. They say, ''Sorry. No amendments even though it is relevant to the bill.'' It will save the middle-income people billions of dollars. It will not cost employers hardly anything, and it will establish for the first time a good policy in this situation so that we do not drive people through poverty to qualify for Medicaid.

Mr. President, I yield the floor.

Mr. SIMON addressed the Chair.

The PRESIDING OFFICER. The Senator from Illinois.

PRIVILEGE OF THE FLOOR

Mr. SIMON. Mr. President, I ask unanimous consent that Jayson Slotnik, a fellow on my staff, be permitted to be on the floor during the action on S. 1028.

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

Mr. SIMON. Mr. President, I rise in support of Senator JEFFORDS' amendment. I am blessed to be a cosponsor of that. He mentioned the case of Christopher Reeves. Christopher Reeves and an actor named Robin Williams, when they were students, made a pact that they would support one another if they ever faced this kind of an emergency. Robin Williams, as an actor who makes a great deal of money, is able to help Christopher Reeves. But what about the thousands of Americans who do not have a Robin Williams?

It is very interesting. Senator JEFFORDS talked about the cost. We changed the Federal insurance. In other words, all Federal employees, including everyone here in the Senate right now—all of us—had some changes. We had two major changes. The most costly was adding mental health coverage for all Members—not only Members but all Federal employees. Do you know what that cost? It costs 27 cents each pay period. That is the additional mental health coverage cost. Twice a month we pay 27 cents. I tried to find out what taking the $1 million cap off cost us, and nobody knows what it cost. It is such a small amount.

My guess is, if you took that chart that Senator JEFFORDS has there of companies that have a $1 million limit and the 22 percent that do not have any limit, that you would find really no difference in the rates charged; no pattern of difference. You are talking about something that does not affect very many Americans. So the total cost is very limited.

I talked earlier today—four reporters stopped me out here, as they stop all of us. I said to the reporters, when they were asking me about this, ''Do you know what kind of limits you have on your insurance?'' Well, Adam Clymer of the New York Times knew, but the other three reporters did not know. I think very few Americans have any idea what kind of limit they have. They just know they are covered by insurance or they are not.

We should not impoverish people before we protect them. That is what we do with Medicaid. I think the Jeffords amendment makes a great deal of sense, and I am proud to support it and proud to be a cosponsor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, it grieves me greatly to rise to indicate my reservation about this amendment on this particular bill. I know how hard the Senator has worked on this project, and in any other forum I would be a strong supporter. I am very familiar with Chris Reeves. He is a resident of my State out in the Berkshires. He was a strong supporter of mine in the last campaign, a personal friend as well. I am very familiar with the real challenges—first of all, the extraordinary courage of this absolutely incredible human being. It is what I think of first when I think of Christopher Reeves. As he has pointed out so well, the human tragedy of others who are facing these kinds of situations is incredible and incredibly difficult, and all of us are familiar with stories of families being bankrupt because of these ceilings which are out there. Most of them were about $1 million just until very recently, some of them as high as $2 million.

I agree with the Senator, and it pains me to oppose him on this particular measure. I was mindful of that during his presentation.

I ask the Senator what his disposition is, whether he might take a voice vote here. Does he prefer that we make a tabling motion, or is he willing to take——

Mr. JEFFORDS. That, of course, is the Senator's option. I cannot stand here representing 100 groups who support this amendment and taking into consideration the tremendous effort that Christopher Reeves has put into this personally to try and convince this body to do this reasonable thing, and not, unfortunately, from the Senator's perspective, ask for a recorded vote. I do not mean to embarrass the Members on this, but I just remind them that I was told I could come to the floor and offer it, and I am being precluded. But I understand that all got changed as we went along the way, and I do not hold any grudges against anybody. I understand you have to stand by that no amendment outside of the Finance Committee. I just would suggest to my colleagues that they are not bound by any such thing and would urge them to vote in favor of the amendment.

Incidentally, I have now heard something which occurs when you get people nervous here, that there has been a rush to find a new cost from CBO, and apparently they are ready to rush over and claim I do not have enough money.

Well, I am always ready for those circumstances, and we are rushing over with an amendment which will put a sufficient amount of money in it so I do not get into a budget problem. If they are not around, if we can just get the yeas and nays without going through the necessity of me amending the amendment, that is fine, too.

Mr. SIMON. Will my colleague yield?

The PRESIDING OFFICER. The Senator from Massachusetts has the floor.

Mr. KENNEDY. I want to be very clear. I had joined with the chairman of the committee in indicating I would oppose amendments on this that virtually were not unanimously accepted. I should like very much to accept it.

As I mentioned earlier in the day, there are many different features which I should like to add.

I can remember very well I had a son who was in an NIH program, and they terminated the NIH support. It was $3,200 for the treatment they had to give those children every 3 weeks for 3 days for 2 years, and I was able to afford it. Mothers and families were out there saying, well, my child only gets 5 months, 6 months. What chance does that child have to live?

I am very mindful of these situations. I feel very strongly about them,

and I feel very sympathetic, too. But I am also mindful that we need this legislation, and we have made a commitment at the time which I hope the Senator from Vermont will understand. I joined with the chairman of the committee to that effect. But I will be glad to join with him at another time. But we are going to abide at least by the assurances we gave to the other members of the committee. At the appropriate time I will, or the chairman of the committee can, make a motion to table.

Mr. SIMON. Will the Senator from Massachusetts yield?

Mr. KENNEDY. I will be glad to yield.

Mr. SIMON. I cannot speak for the chief sponsor, but when you ask for a voice vote, the Senator from Massachusetts has a strong voice. If he will be fairly silent in that voice vote, I would be willing to take a voice vote, but I cannot speak for the Senator from Vermont.

Mrs. KASSEBAUM. Mr. President, if I may, I, too, am very sympathetic to the issue that Senator JEFFORDS is addressing. I think we all recognize—I believe the figures are almost 1,500 Americans at least that would benefit from this legislation. It is more than just the enormous financial cost. It is an emotional and difficult issue.

However, our agreement was not just with the Finance Committee. Unless there is a consensus of support on both sides of the aisle, then we have to oppose the amendments. I think the Senator from Vermont knows there are many in the business community, particularly the small business community, that have been opposed to this, who worry a great deal about the implications of it and have said they would oppose the whole bill if amendments like this one would be added. We felt that the underlying amendment offered so much that we then had to also oppose those other amendments which I think have much merit, and it is with regret that I would, too, have to oppose it. I certainly am willing to have a rollcall vote. I think it will be up to the sponsor of the legislation to determine that.

Mr. KENNEDY. I make a motion to table the Jeffords amendment.

Mr. JEFFORDS. I would like to amend my amendment first to have plenty of money in there so nobody can——

Mr. KENNEDY. I am not going to make that argument. That is fine.

Mr. JEFFORDS. All right.

Mr. KENNEDY. If it is all right with Senator KASSEBAUM. I have no objection to either doing it—we are not making a point of order on the money or questioning it at this time.

AMENDMENT NO. 3680 TO AMENDMENT NO. 3679

(Purpose: To reduce delinquencies and to improve debt-collection activities government-wide, and for other purposes)

Mr. JEFFORDS. I want to preclude that objection from being registered, so, Mr. President, I have an amendment to my amendment.

The PRESIDING OFFICER. The Senator has the right to modify his amendment.

Is this an amendment to the amendment?

Mr. JEFFORDS. Mr. President, it is an amendment to the amendment. I will ask to have it reported.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Vermont [Mr. JEFFORDS] proposes an amendment numbered 3680 to amendment No. 3679.

Mr. JEFFORDS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with or we will be here the rest of the evening.

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. JEFFORDS. What this does, Mr. President, is take an amount of money which has been verified by CBO, which has yet to be utilized and also verified by OMB, that will cover any conceivable cost of this bill, to make sure someone does not come back and say I failed to cover any cost of that.

I understand there will be maybe a motion to table. Let me just urge my colleagues to please remember what we are trying to do here. You have 100 disability groups of people who are in favor of this amendment. You have estimates which indicate that we have eliminated all the small businesses 25 or under. We have not pulled lifetime caps. We have gone to $10 million, which is exactly the value of what they were many years ago when the million dollar cap was in fashion.

What we are trying to do is prevent people going into bankruptcy in order to qualify for Medicaid in order to take care of their sick ones. It also improves this bill because this bill would allow an insurance company—although they are forced to take somebody on the policy, they can lower the lifetime caps and chop them off after a year again, and then they are back out on the street looking for care and back onto Medicaid.

With that, I would suffer the indulgence of a tabling motion at this time.

The PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 3680) was agreed to.

Mrs. KASSEBAUM. Does any Senator wish further debate on the amendment, as amended?

If not, I move to table the amendment of the Senator from Vermont.

The PRESIDING OFFICER. The Senator from Kansas has moved to table the amendment of the Senator from Vermont, as amended.

Mr. JEFFORDS. 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.

Mrs. KASSEBAUM. Mr. President, I ask if there could be about a 5-minute delay to notify everybody to come.

Mr. JEFFORDS. 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.

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. BENNETT). Without objection, it is so ordered.

Mrs. KASSEBAUM. Mr. President, I ask that we now proceed to vote on the motion to table the amendment of the Senator from Vermont. The yeas and nays have been ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to lay on the table the amendment of the Senator from Vermont, No. 3679.

The yeas and nays have been ordered. The clerk will call the roll.

The bill clerk called the roll.

Mr. LOTT. I announce that the Senator from Colorado [Mr. CAMPBELL] and the Senator from Florida [Mr. MACK] are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 56, nays 42, as follows:

[Rollcall Vote No. 74 Leg.]

YEAS—56

Abraham	Ford	Kyl
Akaka	Frist	Lieberman
Ashcroft	Gorton	McCain
Bennett	Gramm	Mikulski
Bond	Grassley	Moseley-Braun
Bradley	Gregg	Moynihan
Breaux	Hatch	Murkowski
Brown	Hatfield	Murray
Bryan	Heflin	Nickles
Chafee	Hollings	Nunn
Coats	Hutchison	Pressler
Cochran	Inhofe	Reid
Cohen	Inouye	Rockefeller
Coverdell	Johnston	Sarbanes
Craig	Kassebaum	Simpson
Daschle	Kempthorne	Thomas
Dodd	Kennedy	Thompson
Exon	Kerrey	Thurmond
Faircloth	Kohl	

NAYS—42

Baucus	Feinstein	Pell
Biden	Glenn	Pryor
Bingaman	Graham	Robb
Boxer	Grams	Roth
Bumpers	Harkin	Santorum
Burns	Helms	Shelby
Byrd	Jeffords	Simon
Conrad	Kerry	Smith
D'Amato	Lautenberg	Snowe
DeWine	Leahy	Specter
Dole	Levin	Stevens
Domenici	Lott	Warner
Dorgan	Lugar	Wellstone
Feingold	McConnell	Wyden

NOT VOTING—2

Campbell	Mack

So the motion to lay on the table the amendment (No. 3679) was agreed to.

Mr. KENNEDY. Mr. President, Senator DOMENICI has been seeking recognition, and I believe he is willing to enter into a time agreement.

Mr. DOMENICI. Senator WELLSTONE, how much time?

Mr. WELLSTONE. I think I need about 15 minutes.

Mr. DOMENICI. From the standpoint of proponents, we will settle on 35 minutes. You all can take whatever you would like.

Mr. KENNEDY. Mr. President, I ask that we have 40 minutes on the Domenici-Wellstone amendment, 35 minutes to be under the control of Senators DOMENICI and WELLSTONE, and 5 minutes under the control of Senator KASSEBAUM.

Mr. JOHNSTON. Does the Senator from Massachusetts know how many amendments and when we might expect to finish tonight?

Mr. KENNEDY. On our side there would probably be—we have Senator BOXER's amendment, which I think will take a very short period of time. We have Senator CONRAD on visa, which I think we can work out. We are waiting for the report of the chairman on the immigration control. Senator SIMON, a sense-of-the-Senate which I think will be very short. We are on the Domenici-Wellstone now. There is one by Senator DORGAN on the organ cards, which hopefully we can accept.

I do not think we have any amendments here that would require very much time to deal with.

Mrs. KASSEBAUM. Mr. President, if the Senator from Massachusetts would yield, there may be some amendments offered that will be withdrawn—not all have been agreed to or cleared. I think we are moving forward. We wish to complete this by 9:30 or 10 o'clock tonight at the latest. We need to know exactly who will be wanting a rollcall vote on their amendments. I think that is what everyone would like to know.

Senator DOMENICI's amendment will be next. There will be a rollcall vote I believe. At that point, we should know how many more votes would actually be ahead of us.

Mr. JOHNSTON. Will the Senator yield for a question?

Mrs. KASSEBAUM. I am happy to.

Mr. JOHNSTON. Would it be out of the question to stack some votes tonight?

Mrs. KASSEBAUM. We thought not. We thought it best to move forward. After the next vote, we will be able to tell you exactly how many more rollcall votes there will be.

Mr. DOMENICI. When you ask the Senator from Kansas a direct question, she gives you a direct answer, right?

The PRESIDING OFFICER. There is no unanimous-consent agreement before the Senate. The Senator from Massachusetts was propounding one, but it was not formally propounded.

UNANIMOUS-CONSENT AGREEMENT

Mr. KENNEDY. Mr. President, I ask unanimous consent that on the Domenici amendment that there be 40 minutes, with 35 minutes under the control of Senators DOMENICI and WELLSTONE, 5 minutes under the control of Senator KASSEBAUM and the Senator from Massachusetts, and that there be no second-degree amendments in order to the Domenici amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DOMENICI. 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.

AMENDMENT NO. 3681

(Purpose: To ensure that parity is provided under health plans for severe mental illness services)

Mr. DOMENICI. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI], for himself and Mr. WELLSTONE, proposes an amendment numbered 3681.

Mr. DOMENICI. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. DOMENICI. Mr. President, I yield myself 10 minutes and ask that I be advised when I have used 9 minutes of that time.

Mr. President, it is with a degree of regret that I have to bring this amendment to the floor on this bill because I understand that Senators KASSEBAUM, KENNEDY, and the committee of jurisdiction have worked very hard on the basic bill that is before us. They have made some commitments, which I gather, based on the last vote, that they take very seriously. They are going to try to keep this bill clean.

I have to say to my fellow Senators that when you are involved and understand what is going on out there in America with reference to the mentally ill people and their inability to get adequate insurance coverage, which I will explain in a little more detail to the Senate, you have to take every opportunity you can to try to effect some major change.

The country, in terms of insuring people for various physical disabilities has come a long way. But this country, in terms of insuring mentally ill people, is going backward instead of forward, because as insurance costs go up, insurance company after insurance company is finding a way to try to write cheaper and cheaper insurance, and they look for ways to drop groups of people from coverage by saying they are not covering them, or are covering them so inadequately that they are left back in the arms of their parents or relatives. So this is happening dramatically across America. When it comes to mental illnesses, I submit that I know a little bit more about severe mental illnesses because I have worked actively in committees on that issue for a long time.

But if you happen to be a parent of somebody who has schizophrenia, a very serious mental disease, and not some figment—it did not come because somebody's mother did not take care of them properly; it is a severe disease of the brain. If you happen to have one of those kinds of persons in your family and you have an insurance policy that is typical in America, it will, for the most part, not cover very much, it will have a cap that is very insignificant, and it will be very distinct from the rest of the policy coverage. In other words, they will go out of their way to cover mental illness differently and with less coverage than the basic coverage they are giving to physical ailments, diseases that we all understand.

The time has come—and we can wait once again, but I believe it is tonight—to send a signal that while we have a bill before us that is going to alter some serious shortcomings in insurance coverage in America—and we understand what they are and we compliment the committee for taking one good bite at this problem—but those of us who are worried about the problem of mental health and mental illness, including severe mental illnesses, like manic depression, severe depression, bipolar or serious depression, we understand that there is medication available, there is treatment available. But, occasionally, they have to be treated in an atmosphere that costs a lot of money, in an environment that costs a lot of money.

This amendment is very simple. I am offering it with my friend, Senator WELLSTONE. Essentially, Mr. President, it prohibits insurers and health plans from imposing treatment restrictions or financial requirements on services for the mentally ill that it does not impose on services for the physically ill.

We offer this today, although this country has come a long way in understanding and recognizing the special problems of people suffering from mental illness. We understand that structural and institutional discrimination continues and persists in our society. Stigmas are rampant in this area, and I am referring to another kind of discrimination—that is, the way health insurers and health plans treat these individuals, and I believe this situation represents one of the real continuing injustices in America today.

Although we now understand that mental illnesses are, in fact, for the most part, physical illnesses, they are still treated differently than other physical conditions. The only difference between the other physical ailments and mental illness is that mental illness is a disease of the brain, and it may be more complicated, but we are making excellent strides at understanding it. Because this disease manifests itself in our centers of thought, reason, and emotion, many find it easy to deride those problems and to deride those who are afflicted, or turn their back on the problem, or act as if the problem does not exist. Mental illness is not due to sinful behavior. It is not due to a weakness, or frail character. These illnesses are real, and they are

debilitating, and there are many who suffer from them. Nearly 5 million Americans suffer from severe forms of mental illness. I will repeat just a few of them.

Schizophrenia affects about 2 million adults a year. And I repeat, nobody is at fault because somebody has schizophrenia and acts differently and reasons differently. They are just as sick as your neighbor who has cancer.

Yet only 2 percent of all individuals with mental illnesses are covered by insurance which provides benefits equal to the coverage for physical illnesses. I stated that in generalities a while ago. Now, here is the objective number. Through narrowing down the definitions through caps that are irresponsible but save money so insurance companies do it in their own self-interest, only 2 percent of Americans with mental illness are covered with the same degree of coverage as if they got tuberculosis or cancer instead of manic-depression or schizophrenia.

You can walk down any street in urban America and you will find them. It is time to give these people access to care they need, and as you see them in urban America sleeping on grates and other things, you should realize that they probably started out as wonderful teenage children in some beautiful family. And when the costs got prohibitive and the behavior uncontrollable, they are abandoned. In fact, you find more of them in jails than in the institutions which we ought to have to help them. Most studies reveal that most of the severely mentally ill are in prisons or county or city jails because of misbehavior than in places we put together to treat them. Part of that is because resources are not applied, and part of the reason resources are not applied is because the insurance companies—I am not here angry at them, I am not here fighting with insurance companies. Because what they say is, ''How do we make money? So if we lessen the coverage for mental health, we get a better bargain for people who want coverage for the other things.'' But I am submitting that sooner or later we have to say to them that you all have to cover them. If you are covering physical illness and they get 6 months of hospitalization, you have to do the same for mentally ill people. If not, nobody is going to care for them.

Let me tell you, I have seen purposely and intentionally how this destroys families. I have been to the National Alliance for the Mentally Ill meetings with 1,000 of the finest people in America who are there talking about their children, and in many cases they are lost because they could not afford to pay for them when they were 19 and 20, and they do not even know where they are. Somebody in this society is paying for that. For the most part, the ill are paying for it, for they are not getting taken care of right.

I thought a bill that was aimed at correcting the lack of coverage in the private insurance industry of America—because you choose and pick insurance companies to cover what you want and what you do not want you do not cover—we came today to the Senate and in 1 day or 2 are going to pass a marvelous bill that says, in two areas, you are all going to cover something. I am just asking tonight that, in three areas, you say you are going to cover something.

I know the motion to table will be made, and the argument will be made that this is not the right time. And, of course, I am taking a gamble, because with that kind of power, I might lose this amendment. But let me suggest, if we do—and I hope we do not—you can count on it, we are going to be back here, and we are going to find and look until we find a vehicle that sets this thing straight.

Mr. President, when that bill was sent to the desk, I saw some Senators watch it go up there and they saw this very thick bill. I do not want you to think there is all kinds of language in there about mental illness. What we have to do is pay for this.

So much of that bill is to defer the cost in the first 5 years of this bill, and we have used offsets that are acceptable, which Senator WELLSTONE and I have used at other times here but have not become law. So we have offset it as best we could. That is what most of that is.

It is a rather simple bill. We could narrow it down. We chose not to. We talk about mental illness. That includes all of the severe ones, but it includes more, and it says as part of treatment, no more discrimination, no more treating them differently.

We have cost estimates. If it was done across the board in all policies, it would add about 1.6 percent net to the insurance coverage across the land. It obviously would not happen overnight. It would take some time. But, essentially, we want to give the Senate an opportunity to vote on this tonight.

That is my explanation for now. I want to say thanks to Senator WELLSTONE. He has been kind of my friend working on this for a long time. There are some other Senators on board.

I want to yield to him now 7 minutes of my time for him to tell us his version of why we ought to do that.

Thank you very much.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I am very pleased to be here with my colleague, Senator PETE DOMENICI, to introduce an amendment on an issue that I feel very strongly about. Our amendment deals with one issue, and we hope that we have our colleagues' vote tonight: equitable health care coverage for mental illness services.

Mr. President, let me say it has been a real honor to work with Senator DOMENICI on this issue. He has been a real leader, as has his wife, Nancy, and I personally appreciate all of their efforts.

I am proud to cosponsor this amendment, which would require that health plans to provide coverage for mental health services commensurate with what is provided for other physical illnesses.

For too long, mental health has been put in parenthesis; we did not want to talk about it, and we did not take it seriously as a country. The stigma of mental illness has kept many in need from seeking help, and it has prevented policymakers from providing it. And for too long, persons in need of mental health services who reach private coverage discriminatory limits have been dumped onto Government-funded programs.

Mr. President, I support a universal health coverage plan, and comprehensive benefits for mental health services. While we failed to enact legislation to achieve this during the 103d Congress, we did increase awareness. But now we are talking about parity, and awareness is not enough.

Our amendment would require health plans to provide parity in their coverage of physical and mental health. Plans would be prohibited from requiring copays, or deductibles, for mental health benefits, or establishing lifetime limits for mental health benefits, or establishing visit limitations for mental health services unless the same restrictions apply to other health services.

All we ask for is equitable treatment. That is all this amendment does. All this amendment does is say, please let us stop this discrimination.

Mr. President, many people, or most people's instinctive reaction is to assume that this amendment would be expensive. This is not the case. As a matter of fact, in my State of Minnesota, where we have already passed legislation requiring full parity for mental health and substance abuse services, this was implemented August 1, 1995, and the cost of the parity mandate was estimated to be 26 cents per member provided. Minnesotans who were unable to work full time either because they were too sick or they were forced to impoverish themselves in order to qualify for Medicaid benefits, are now able to work and pay taxes and be productive. Because of this discrimination, all too often people cannot work so that they can receive medical assistance. People are forced to impoverish themselves in order to qualify for the medical assistance they need.

Now, in Minnesota—this is what we propose to do for our Nation, because we have parity and we have ended this discrimination—these same Minnesotans are now able to work, to live a life with dignity, and to pay their taxes.

Mr. President, we have a tremendous body of evidence, new evidence, proving that, without a doubt, mental health disorders can be diagnosed and treated in a cost-effective manner.

In fact, we can show that within a very short period of time it costs less

to treat those disorders directly and appropriately than not treat them at all. We can say that this is true based upon studies of every sector of our population—insured and employed, uninsured and unemployed, people who now use the private system and those who now use the public system.

Mr. President and colleagues, there are several arguments for requiring parity for mental health services. First, we now have cost-effective treatments for mental illnesses and high rates of success are being achieved across the spectrum of diagnosis. For example, 80 percent of individuals with depression respond to treatment. Second of all, mental illness results in physical illness, inability to work, impaired relationships, and sometimes crime and homelessness.

Would it not be better to end the discrimination and have less of the homelessness? Would it not be better to end the discrimination and enable people to work and be productive citizens? And finally, Mr. President, mental health services are already part of health delivery in the United States.

Let us have no doubt about it, this amendment leaves all decisions about the delivery of services to the private marketplace. The amendment does not require the provision of mental health services to employees, specify what care should be provided, interfere with the discretion of employers and health plans to negotiate reimbursement rates as they see fit, or mandate the use of any particular kind of delivery of needed care.

What this amendment calls for is just parity. Mental illness has touched many of our families and many of our friends. It is for this reason and many others that it is not a partisan issue. Mental illness is a problem affecting all sectors of American society. It shows up in both the rural and urban areas. It affects men and women, teenagers and the elderly, every ethnic group and people in every tax bracket. It can be effectively treated just like heart disease or diabetes. Treatment not only saves lives but it also saves dollars. That is why this amendment is so important.

I look forward to the adoption of this amendment and to continuing to work with Senator DOMENICI to end discrimination against this very vulnerable population and their families. It is only old data and old ideas that keep us from covering mental health, the same way we cover any other real illness, whether it is acute or chronic.

I know there has been some agreement on amendments, but I plead and implore my colleagues to please vote for this amendment. Senator DOMENICI is right. Tonight is just the beginning. If we do not win tonight—and I hope we get a very significant vote, and I hope we do win—then, of course, we will come back.

Colleagues, please support us. Please end the discrimination. That is what this amendment is all about.

I do not usually do this on the floor of the Senate, but I would like to dedicate my remarks to my brother who has struggled with mental illness almost his whole life. He is doing great now.

I yield the floor.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. How much time does the Senator from New Mexico have?

The PRESIDING OFFICER. The Senator has 13 minutes and 5 seconds.

Mr. DOMENICI. My good friend, Senator SIMPSON, desires to speak, and I yield him 5 minutes. And then, I say to the Senator from North Dakota, I will yield him some time.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. SIMPSON. Mr. President, I hope that all Members will read the amendment. I know sometimes we forget to do that from time to time, it is perhaps one of our failings. It is a very simple amendment. It is described as ''parity.'' I think the Senator from New Mexico and the Senator from Minnesota have covered it very well.

The important thing that you want to hear regarding it is about the rule of its construction. It is just one construction because people say that it is going to be tremendously costly; or that this is going to ''open the doors'' or that this is the first step toward incurring tremendous cost. But what the amendment says is this:

> Nothing in [the subsection previous] shall be construed as prohibiting an employee health benefit plan, or a health plan issuer offering a group plan, or an individual health plan from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary.

I think that is a very important thing. That is a very critical part of this.

Let me just tell you that about 4 years ago a most beautiful girl in our family, the niece of my wife—my wife's twin sister's daughter, whom we had watched grow and mature from her birth—left our midst. She was a dancer; she was an artist; she was a poet; she was a guitarist; she was a singer; she was the rainbow of life.

We did not get or understand the signals in time, and the signals were very clear as we all look back now out of sheer guilt and anguish. She was tough minded, independent, loving, strong, and forceful. She would come into your kitchen and just cook up a batch and leave the stuff in the sink, and family would say, ''Why doesn't Susan clean up afterwards?'' And then, ''Why doesn't Susan work? How old will she be before she ever works?''

She began to withdraw, and then she went into some religious and almost cultish activities, and she had a child. And that is a beautiful child. I know that child. That is the wonderful part of it now—because Susan is gone. And after years of reaching out to us in her way and us not hearing and us not knowing, she one day decisively purchased a pistol and a few hours later purchased the ammunition and went to an isolated field, removed her shoes, sat in a the crouched position in Bowling Green, KY, and blew her chest away.

That is what sometimes happens to these people, and we think, ''well, but they should have tried to do something for themselves.

We thought we were doing something for her. We thought she was finally doing it for herself. She was taking medication, and it was working. But then something, something unknown, entered her mind and her life and she decided not to take the medication—knowing what would happen if she did not—and then her tragic plan of ultimate rejection came to pass.

There is a group of humans—a particular vulnerable group in society that the mental health workers and professionals tell us about who now are in their 37th to their 45th year, who somewhere along the line were perhaps those involved in the early experimentation with drugs, yes. Yes, of course, but that penalty should not be something visited upon them forever. So I say there is not a soul in this Chamber that has not been grievously affected in some way by these things. It is time for healing. It is time for understanding more than anything. It is time to minister. It is time to love and to be compassionate and time to learn so much more about these tragic things. For these are the people who you know and see every day, and they are making it, and they never did before, but they are now. If we can put this in this bill in this way with this language, I think it would be a tremendous benefit to them—and they are our first charge—and to the rest of us in society.

I thank the Chair.

Mr. DOMENICI. How much time do we have remaining, Mr. President?

The PRESIDING OFFICER. The Senator has 8 minutes and 50 seconds.

Mr. DOMENICI. Mr. President, I yield 5 minutes to Senator CONRAD.

Mr. CONRAD. Mr. President, I personally thank Senators DOMENICI and WELLSTONE for bringing this amendment to the Chamber tonight.

I rarely take the time of my colleagues, in the evening hours, to speak, because I often feel that it is an imposition on their time. Tonight, I think this amendment is so important that it requires all of us to speak. This amendment simply asks that mental illnesses be treated on a parity basis with other illnesses. It is inescapable: An illness is an illness. There should be no differentiation between how we treat those who have a mental illness and a physical illness.

When I was the assistant tax commissioner in North Dakota, Senator DORGAN was the tax commissioner. We had a young woman who was our receptionist. She was a beautiful and vibrant young woman. She was somebody

who absolutely lit up an office. One day, she just went off the deep end with a mental illness that none of us knew that she had. Pictures were speaking to her. She had all kinds of aberrant thoughts. It led to her institutionalization. It led to her attempting to take her own life. That was a young woman, because of a suicide attempt, who did enormous damage to herself from which she will never fully recover.

That young woman had a mental illness, and that illness deserved to be treated like any other illness. She is not alone. There are millions like her all across America. As we sought to reach out and help this young woman, I became somewhat educated about what was happening in our communities. One thing I learned is that we actually treat differently those with a physical illness and those with a mental illness, and it is a tragedy.

In our State, we have taken the step to recognize that there should not be discrimination between illnesses. What we have found is it does not cost more money. Oh, it does as you begin, but as you go forward, it does not cost more money, and it does not cost more money because, if you fail to treat, the physical ailments mount and become much more expensive.

I would say to my colleagues, we passed this amendment. We passed this in the Finance Committee on Medicaid, during reconciliation. I offered the amendment. It was adopted. It passed here on the floor of the U.S. Senate. It was only taken out in conference.

We passed it in the Finance Committee based on the best evidence that shows over time this will not cost money. I submitted detailed studies from North Dakota that demonstrate that.

I hope my colleagues will vote for this amendment tonight. It is the right thing to do. I hope my colleagues will agree to the Domenici-Wellstone amendment. They will be proud the rest of their lives that they did.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield myself 2½ minutes.

I have difficulty in not commending, which I do, my good friends and colleagues with whom I have worked over a very considerable time on the issues of mental health. This is obviously an awkward position for me to have these amendments come up and to be fighting these issues. One of the first pieces of legislation passed during President Kennedy's administration was the community health programs which got people out of institutions, and into the community. I worked with Senator DOMENICI and Senator WELLSTONE in 1990 to move the whole mental health research out to NIH, against strong opposition at that time. In the health insurance bill that we passed last year, we had effective equivalence between mental health and physical health, though there were some aspects of hospitalization that were phased in over a period of time.

So I am strongly sympathetic. I just regret this. Hopefully, it will be defeated. Maybe we are going to continue to have these votes so people are able to speak to them. Once again, I can understand the frustration because we have not gone ahead on it.

It is painful for many of us who are strongly committed to the whole issue of eliminating preexisting condition and our strong commitment to that, to have to go on record in opposition to these amendments. But if that is the cost, and Members of the Senate feel that is what they want to do to many of us who have been out there working on precondition year in and year out, we are prepared to do it.

I will join in urging that the Senate table this at the first opportunity.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, how much time do I have left?

The PRESIDING OFFICER. The Senator from New Mexico has 4 minutes 26 seconds.

Mr. DOMENICI. Mr. President, I certainly do not intend by my action tonight to make it painful for Senator KENNEDY, who has been a staunch advocate. I hope that is not what he said tonight. I just believe very, very sincerely that the time is now to get something done.

I want to explain one more time in just a brief, few words what this amendment does not do, because I think there could be some confusion. Let me clear up what it does not do. It does not provide an open-ended entitlement to whatever mental health services an individual wants. It does not limit the ability of an insurer or health plan to limit services to only those who are medically necessary. It does not institute a service-by-service equivalency between physical and mental illness. It does not mandate a benefit package.

It simply makes the following common situations illegal. Let me cite a few:

Policies that allow 365 days in-patient care for physical illness allow only 45 days for in-patient psychiatric care.

Policies that provide a lifetime cap of $1 million for physical care have a $50,000 cap for mental illness.

Policies providing unlimited outpatient visits for physical care allow only 20 outpatient visits for mental illnesses.

Mr. President, 90 percent of employer-sponsored plans impose such limits, despite the proven efficacy of treatments for mental illness. Treatment for schizophrenia has a 60 percent success rate; manic depression, 80 percent; major depression, 65 percent. Yet commonly reimbursed procedures such as angioplasty and arthrectomy have only a 41-percent and a 52-percent ratio, and nobody seeks to treat them with limitations that are imposed on mental illnesses.

The era of managed care is upon us, making tight management of patient care the norm, and artificial cost measures to reduce utilization are a thing of the past.

I have a number of examples of companies that have covered with parity of treatment and, believe it or not, they have saved money and added to their work force in ways that are measurable and objectively beneficial to the companies that have so seen fit.

So, from my standpoint, from the standpoint of the Senator from New Mexico, I do not seek to kill this bill. I think it is a marvelous step in the right direction. But I ask my fellow Senators when, if not tonight, will we ever get around to this issue? If I thought there was another bill coming down this year, I would probably have made an agreement so that I could have the full support of my friend from Massachusetts and my colleague and friend from Kansas, Senator KASSEBAUM. But I do not see that coming.

I believe there is plenty of evidence that the discrimination continues. It grows more rampant. The stigma, since that discrimination is rampant, is growing instead of diminishing, in an era when knowledge is beginning to grow almost exponentially.

So, now is the time. Tonight is the time to send this to conference. Deny the motion to table. Let our Senate colleagues take this to conference. Let us work on the various interests that will be part of that conference and see if we cannot make this a better bill because it would have this amendment attached than it would if it fails tonight.

I yield the floor.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I know that many here would like to vote in favor of this amendment offered by Senator DOMENICI, and Senator WELLSTONE is one. It has been carefully crafted.

There is no greater dedication to this legislation than from those who have spoken to us, as well as Senator KENNEDY who, for a long time, has been a great supporter.

So it is with real disappointment, if all debate is over, that I will have to move to table, as it is not an amendment that has consensus of support. And so for that reason, I only hope we can find some other avenue later through which we can address this.

I move to table the Domenici-Wellstone amendment, and 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.

Mr. DOMENICI. Has all time expired?

The PRESIDING OFFICER. The Senator from New Mexico has 14 seconds remaining. The Senator from Kansas has 2 minutes.

Mr. DOMENICI. I yield back my time.

Mrs. KASSEBAUM. I yield back my time.

The PRESIDING OFFICER. The question is on agreeing to the motion to lay on the table amendment No. 3681.

The yeas and nays have been ordered.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. LOTT. I announce that the Senator from Colorado, [Mr. CAMPBELL] and the Senator from Florida [Mr. MACK] are necessarily absent.

The PRESIDING OFFICER (Mr. JEFFORDS). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 33, nays 65, as follows:

[Rollcall Vote No. 75 Leg.]

YEAS—33

Ashcroft	Faircloth	Kempthorne
Bond	Ford	Kennedy
Breaux	Frist	Kohl
Brown	Gorton	Kyl
Bryan	Gramm	McCain
Chafee	Grams	Nickles
Coats	Gregg	Reid
Cohen	Hollings	Rockefeller
Craig	Inhofe	Roth
Daschle	Johnston	Smith
Dodd	Kassebaum	Thompson

NAYS—65

Abraham	Glenn	Moynihan
Akaka	Graham	Murkowski
Baucus	Grassley	Murray
Bennett	Harkin	Nunn
Biden	Hatch	Pell
Bingaman	Hatfield	Pressler
Boxer	Heflin	Pryor
Bradley	Helms	Robb
Bumpers	Hutchison	Santorum
Burns	Inouye	Sarbanes
Byrd	Jeffords	Shelby
Cochran	Kerrey	Simon
Conrad	Kerry	Simpson
Coverdell	Lautenberg	Snowe
D'Amato	Leahy	Specter
DeWine	Levin	Stevens
Dole	Lieberman	Thomas
Domenici	Lott	Thurmond
Dorgan	Lugar	Warner
Exon	McConnell	Wellstone
Feingold	Mikulski	Wyden
Feinstein	Moseley-Braun	

NOT VOTING—2

Campbell	Mack

So the motion to lay on the table the amendment (No. 3681) was rejected.

Mr. DOLE. Mr. President, I move to reconsider the vote.

Mr. SANTORUM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. DOLE. Mr. President, I think we are making progress. I wonder if the managers might be able to identify those amendments that would require rollcall votes and have the debate on those amendments, and then we can advise our other colleagues that did not have amendments that we would probably be voting, say, at 10 o'clock or 9:30, or whatever it might be. That would save everybody from having to stay on the floor. When you stay on the floor, sometimes you get excited and talk.

Mrs. KASSEBAUM. Mr. President, I say to the majority leader, on our side, I understand that Senator SPECTER would like to have a vote. He has two amendments.

Mr. DOLE. En bloc?

Mrs. KASSEBAUM. I would assume we could vote en bloc.

Mr. SPECTER. I am right here and ready to go, madam manager.

Mrs. KASSEBAUM. All right. I am not sure about Senator THOMAS, whether he will want a vote on his, and Senator GRAMM. I believe those are the only amendments that I have listed that would require—Senator BURNS, I believe, has one on telemedicine.

Mr. COATS. I have one, also.

Mrs. KASSEBAUM. I thought we were going to try to work that out.

Mr. COATS. We are not able to work that out, so we are going to have to have a vote on it.

Mr. DOLE. How many from the Senator from Massachusetts?

Mr. KENNEDY. We have the Conrad amendment on J–1 visas, which is acceptable. We have one other amendment where somebody wants to introduce it, speak, and withdraw it. Senator DORGAN's amendment on organ donor, which, I believe, has been accepted, with Senator FRIST. We have Senator HARKIN's, and we are waiting to see whether Senator WELLSTONE wants to work out an exchange of language or a vote. And there is a Senator Boxer sense of the Senate.

Some of those, as I mentioned—the Conrad visa amendment, and the organ donor amendment—have been worked out. I think they will just take very brief comments.

Mr. DOLE. So that will be two votes?

Mr. KENNEDY. Potentially, four. I hope we get it down to three.

Mr. DOLE. Let me encourage my colleagues, if there is an opportunity to work these out on either side, we hope we can do that and not require a rollcall vote. If you are going to work out your amendment and it is accepted without rollcall votes, I will look very kindly on those amendments. I will be a conferee.

Mr. DOMENICI. Mr. President, I ask that the yeas and nays be vitiated on the Domenici amendment.

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

The amendment is agreed to.

So the amendment (No. 3681) was agreed to

Mr. DOMENICI. Mr. President, I move to reconsider the vote.

Mr. EXON. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. DOLE. Mr. President, I think the distinguished Democratic leader wanted to add a word.

Mr. DASCHLE. Mr. President, I ask the majority leader whether or not, to accommodate a couple of our colleagues, who, I think, were working under the understanding that we might be able to stack votes, whether or not it may be possible to stack the next two or three votes so as to accommodate some of those who may have left with that understanding. Would that be possible?

Mr. DOLE. I am satisfied with that. I think it is a good idea.

Mrs. KASSEBAUM. As long as there are so few left.

Mr. DOLE. We can stack three or four votes back to back, accept the rest of them, and have final passage.

Mr. LEAHY. Will the majority leader yield for a question?

Mr. DOLE. Yes.

Mr. LEAHY. If we are going to stack them, do we know approximately when the votes will start?

Mr. DOLE. How much time will the Senator from Pennsylvania take?

Mr. SPECTER. Mr. President, responding to the majority leader's question, I think it can be disposed of in 20 minutes, 10 minutes a side.

Mr. DOLE. Each amendment, or both?

Mr. SPECTER. I am going to start with the first amendment.

Mr. KENNEDY. We would take 5 minutes.

Mr. DOLE. Let us say an hour from now.

Mr. LEAHY. Votes will start then, an hour from now?

Mr. DOLE. Yes.

AMENDMENT NO. 3682

(Purpose: To reauthorize and expand the healthy start program to target areas in need and to implement community driven strategies to reduce infant mortality)

Mr. SPECTER. 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 Pennsylvania [Mr. SPECTER] proposes an amendment numbered 3682.

Mr. SPECTER. 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 in title III, insert the following new section:

SEC. . REAUTHORIZATION OF HEALTHY START PROGRAM.

(a) AUTHORIZATION OF APPROPRIATIONS.—To enable the Secretary of Health and Human Services to carry out the healthy start program established under the authority of section 301 of the Public Health Service Act (42 U.S.C. 241), there are authorized to be appropriated $100,000,000 for each of the fiscal years 1997 through 2001.

(b) EXISTING PROJECTS.—

(1) IN GENERAL.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary of Health and Human Services shall reserve $30,000,000 for such fiscal year among demonstration projects that received funding under the healthy start program for fiscal year 1996.

(2) ELIGIBILITY.—To be eligible to receive funds under paragraph (1), an existing demonstration projects shall demonstrate to the satisfaction of Secretary of Health and Human Services that such project has been successful in serving needy areas and reducing infant mortality.

(3) USE OF PROJECTS.—A demonstration project that receives funding under paragraph (1) shall be utilized as a resource center to assist in the training of those individuals to be involved in projects established

under subsection (c). It shall be the goal of such projects to become self-sustaining within the project area.

(c) NEW PROJECTS.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary of Health and Human Services shall allocate the remaining amounts for such fiscal year among up to 35 new demonstration projects. Such projects shall be community-based and shall attempt to replicate healthy start model projects that have been determined by the Secretary of Health and Human Services to be successful.

Mr. SPECTER. Mr. President, this is an amendment which provides for reauthorization of Healthy Start. This amendment would reauthorize the Healthy Start program for an additional 5 years at $100 million a year. It is important that the reauthorization occur on this bill because, given the Senate calendar, it is highly doubtful that this issue will be raised on any other bill.

In my capacity as Chairman of the Appropriations Subcommittee for Health and Human Services, I can say with some authority that we need the authorization so that we are prepared to make the appropriate appropriations.

Healthy Start is a program which is designed to provide prenatal care to infants. I saw my first 1-pound baby more than a decade ago at the Alma Ellery Clinic in Pittsburgh and, at that time, I saw a baby about as big as my hand, weighing a pound. Some babies weigh as little as 12 ounces, and they are human tragedies, carrying scars for a lifetime, and they are very expensive for our society, costing as much as $250,000 each.

In my position on the Appropriations Committee, I worked to start this program of Healthy Start, and it has had a really remarkable success. It has been in existence for 5 years, which is a relatively short period of time. But we already have statistics available that show the success of the program.

The 1994 statistics received from the projects demonstrated that from 1984 to 1988, baseline statistics in Philadelphia show that infant mortality had decreased some 28 percent. In Pittsburgh, the infant mortality rate decreased 20 percent since the start of the Healthy Start Program in 1993.

The Maternal and Child Health Bureau reports that for the State of New York, between 1990 and 1994, infant mortality rates decreased by 38 percent in the Healthy Start project area, compared to a 22 percent decline citywide.

Without going into any greater demonstration of statistics, Mr. President, I think it is apparent that Healthy Start is an important program. Dr. Koop commented that with these minimal four prenatal visits, women carrying children would not give birth to low-birthweight babies. It, obviously, has been a very important program. It exists in some 22 cities at the present time: Boston; New York; Philadelphia; Pittsburgh; Baltimore; Washington, the DCPD region; South Carolina; Birmingham, AL; Cleveland, OH. I read these listings so that my colleagues will know how many of these units are in existence in their locales. Troy, IN; Chicago, IL; New Orleans; the Northern Plains Indian Reservations; communities in South Dakota, North Dakota, Iowa; Oakland, CA; and special projects in Dallas, TX; Essex County, NJ; the Florida Panhandle; Milwaukee, WI; the Mississippi Delta; Richmond, VA; and Savannah, GA.

The plan is to expand these projects from the 17 projects which are now—from the 22 projects which are now in existence, to an additional 35 projects.

Mr. President, I think the value of this program is apparent on its face. It has been in existence for 5 years. It has been very successful and does not encumber or impede this bill in any way.

It is a little hard to understand why it is not accepted, but I think it ought to command the attention of this House and the House of Representatives. And I urge its adoption.

The PRESIDING OFFICER. Is there further debate?

Mr. SPECTER. 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.

Mrs. KASSEBAUM. Mr. President, is the Senator from Pennsylvania going to offer a second-degree amendment at this time?

Mr. SPECTER. I am not.

Mrs. KASSEBAUM. Is the Senator going to wait until quarter of 10 to speak on that? We are stacking the votes.

Mr. SPECTER. I understand we are stacking the votes. At this time I am offering this amendment and speaking about this amendment.

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. I understand the floor is open for amendments.

The PRESIDING OFFICER. There is a pending amendment which needs to be set aside by unanimous consent.

Mr. HARKIN. I understand, if I am not mistaken, that we are going to stack these votes. Is the Senator getting a vote right now under the regular order? The yeas and nays were ordered.

Mr. SPECTER. As I understand it, we are stacking the amendments. But I am not prepared to set the amendment aside at this point. I would like to see if the managers have contrary argument.

Mrs. KASSEBAUM. Mr. President, yes. This is not acceptable. The reason is that it is authorizing legislation which I believe needs to come through committee and the committee procedure before we would authorize this on this bill regarding health insurance reform.

That would be the objection of the managers of the bill.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SPECTER. Mr. President, in response to the comments of the Senator from Kansas, it is my strong view that a healthy start program is directly germane and directly relevant to the pending legislation on health care and that it is a jurisdictional question. I do not quite understand the argument. This program has been in existence, has been a success, and there has been no denial by the managers that it is in existence and has been a success. It is hardly the kind of program which is going to require additional hearings. It seems to me that it is right for disposition. That is why I am offering the amendment.

The PRESIDING OFFICER. Is there further debate on the amendment?

Mrs. KASSEBAUM. Mr. President, I stated the reasons why we have an objection. It is a program that has had some success. That is very true. And healthy start is very important. It is part of other programs in the public health sector to which that is directed. As I say, I think it should be really reviewed in oversight so we can analyze what is being done and what should be done. I just feel strongly that in this instance it needs to be handled through the authorizing process rather than an amendment.

The PRESIDING OFFICER. For clarification, there is no unanimous consent to stack the votes at this time. So the pending business is the amendment of the Senator from Pennsylvania.

Mrs. KASSEBAUM. Mr. President, just so I understand, I thought the majority leader asked that votes would be stacked until 9:45. Did I misunderstand?

The PRESIDING OFFICER. My understanding is that it was not posed as a unanimous consent request.

Mr. DOLE. I now make that request.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

AMENDMENT NO. 3683 TO THE COMMITTEE SUBSTITUTE, AS AMENDED BY NO. 3675

(Purpose: To reduce health care fraud, waste, and abuse)

Mr. HARKIN. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Iowa [Mr. HARKIN], for himself and Mr. BAUCUS, proposes an amendment numbered 3683.

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 text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. HARKIN. Mr. President, this is offered on behalf of myself and Senator BAUCUS.

Mr. President, this amendment deals with the continuing problem of waste,

fraud, and abuse in the Medicare system. Over the last several years we have had numerous IG investigations, reports, GAO investigations, and GAO reports. The data is overwhelming. No one can dispute the findings. The Director of HCFA himself has testified before the Labor, Health and Human Services Appropriations Subcommittee as to the validity of these findings. No one disputes that there is tremendous waste, fraud, and abuse in Medicare. The GAO has estimated that up to 10 percent of Medicare funds are lost to waste, fraud, and abuse every year.

Out of a $180 billion program, 10 percent, that is up to $18 billion lost to waste, fraud, and abuse. That is $500 per beneficiary per year.

I know that we are not going to be able to get all of it out. I understand that. But at least we can make some important strides in saving a lot of this money. The amendment that was adopted earlier—the Dole-Roth amendment—had some provisions in it to combat fraud and abuse that I have pushed and supported for a long time, including increased resources for the HHS Inspector General and increased resources for Medicare contractors to fight fraud and abuse, and tougher penalties for fraudulent activities. These were in the amendment adopted.

I say that these are positive and long overdue steps. As I said, they are steps that I have pushed and promoted for years. However, they are inadequate. There is much, much more that needs to be done and can be done right now to really make a dent in the massive amounts of waste and abuse in the system.

Mr. President, every time I go to town meetings in Iowa and I meet with the elderly—or just basically anyone that has been involved in the Medicare system, like people who have had parents or grandparents who have received Medicare help and assistance—whenever you talk about waste and abuse you get an immediate response. They know it exists all too well. When you talk about looking at their bills and ask if they ever look at a bill and see an item on there that they did not really think they received, or maybe paid too much for—you watch the heads nod—they all have, and they are outraged about it. But what they will show you is they will hold up the form that they got from Medicare, and it will have stamped on the front of it, ''This is not a bill.''

A couple of years ago a woman by the name of Shirley Pollock from Atlantic, IA, got hold of me. She had received one of these for her mother-in-law who had been in a nursing home.

For something short of 5 weeks' time, she was billed over $5,000 for bandages. She was outraged, because she knew there was no way her mother-in-law had used that many bandages. But on the front it said, ''This is not a bill.'' So Shirley Pollock complained to the Medicare payor about this and was told: Do not worry about it. You do not have to pay it anyway.

Well, as Shirley later told me, ''I got so mad because I knew somebody's got to pay it. Obviously taxpayers or people paying into Medicare are paying for it. Someone is paying for it. I know we didn't receive $5,000 in bandages, and I want to do something about it.''

So she contacted my office, and we worked it through and found out, indeed, that she was absolutely right. Her mother-in-law had never received $5,000 in bandages—maybe $500 worth but not $5,000, and yet the bill was paid. The bill was just paid as if nothing had happened.

So we know this is going on. And like I said, you can ask any person in a town meeting about this, especially those who have been in Medicare, and they will tell you that they know what we are talking about, too.

So I am offering this amendment to add what I believe are a few more important commonsense weapons in this fight against waste and abuse.

Now, I will for the benefit of my colleagues state at the outset that there is one provision I have been pushing for for some time that I do not have in this amendment because I know there is opposition to it on the floor. I have offered it before. And that is the idea of competitive bidding. I am not offering that as part of this package because I know they want to get the bill through, and I am for this bill; I am a cosponsor of it. I wish to get it through. But, obviously, unbelievable as it may seem to me and to others, there are some who do not believe that Medicare should adopt competitive bidding when it comes to medical supplies so that seniors and the taxpayers get the best price possible.

So I did not include it. I took it out because I know that that some have said it's too controversial. But I am going to be offering that again to get us to competitive bidding, just like the Veterans Administration has been doing for years. It's an outrage Medicare is losing millions because its payment system is prone to abuse and waste. Over a period of years I've compared like bills, like items between Medicare and the Veterans Administration, same city, same supplier. Medicare is often paying 30 to 50 percent more than what the Veterans Administration is. Why is that? Because the Veterans Administration engages in competitive bidding and Medicare does not. But as I said, I have not included that in this amendment. I wanted to make that clear.

All of the provisions in this amendment that I have offered are the result of extensive hearings held by the Labor, Health and Human Services Appropriations Subcommittee over the past several years. They are all recommendations of the General Accounting Office, the inspector general of the Department of Health and Human Services or other private sector medical experts. All of them are commonsense steps, and I just want to review very briefly what they are.

First, this would provide for improved information to seniors to allow them to better help in the fight against Medicare fraud, waste, and abuse. Seniors would be guaranteed the right to receive itemized bills instead of a summarized report from which it may be difficult to detect billing errors or abuses. Every Medicare payment statement would also have to include a toll-free hotline number to report suspected cases of fraud, waste, or abuse.

Now, to those who may say this is a burden, let me just point out that those who are sending in the bills have to keep an itemized record. But when they send it to the beneficiary, they can just summarize it. So the beneficiary can look at it, and a lot of times not even know what they are paying for and a lot of times Medicare does not know what it is paying for. They just pay it, but they really do not know what the itemized bill is.

The reason I know that you can go back and find the itemized bills is that the investigations we have done by the General Accounting Office have gone after some of these summarized bills, gone back to the claimant, back to the hospital or the nursing home or the doctor or whoever it might be and said, OK, what made up this summarized statement? Well, they had to produce the itemized bill so that the General Accounting Office could look at it. So they do have that itemized bill. I am saying it is no more of a problem for them just to print that out on the bill they send to Medicare. This amendment would guarantee seniors that they could get an itemized bill so that they know exactly what they were being charged for and how much they were being charged for it. And, as I said, it would also require Medicare to put on each explanation of Medicare benefits a toll-free hotline number so that a person could report any suspected case of fraud or abuse.

That is the first part of my amendment. The second part of my amendment establishes rewards of up to $10,000 for those providing information that leads to a health care fraud conviction. Again, it is to get people to step forward, to provide the information that we need, and if it leads to a health care fraud conviction they would be entitled to a reward up to $10,000.

The third part of my amendment prohibits Medicare payments for wasteful and unnecessary items such as sports cars for corporate executives, lucrative gifts to executive families and friends, tickets to sporting and other entertainment events, and other items not related to medical care.

In one of the most infuriating cases of abuse we found that health care executives were padding Medicare bills with all sorts of outrageous items identified as indirect costs. For example, we found the following items charged to Medicare: $2,433 for a trip to Italy to inspect a piece of sculpture; $10,215 billed to Medicare for clocks, watches,

and bowls for employees and friends; thousands of dollars for a golf tournament that was only held for executives; a $4,200 bill for a sporting event, all billed to Medicare as indirect costs. That is outrageous.

Now, Medicare did take one step after I prodded them at hearings. No longer will they pay for alcohol or for lobbying expenses as indirect costs. Well, that was a good first step, but they still have not specifically excluded these other items. My amendment would change that.

Next, my amendment says that we would reduce Medicare waste by giving the private companies that administer Medicare the authority to reduce payments for items they identify as grossly overpriced. Currently this can only be done on a national basis by HCFA and has only been done once, a process that took HCFA 3 years.

I am familiar with that because I initiated it several years ago. We found a blood glucose monitor, a little device that you can buy at Kmart or any discount store; it is for people who have diabetes. They can get an accurate check on what their blood glucose level is. It is a little pocket device with a battery in it. We found that Medicare was reimbursing up to $200 for each one of those. I sent my staff down to the local Kmart. They bought one for $49.99—50 bucks. Medicare was reimbursing up to $200 for it.

So I went to Medicare, to HCFA. I said, ''Okay, we have to stop it. You can go down and buy it for 50 bucks. Why are you paying $200?''

Believe it or not, from that moment to the day that they actually reduced the price to $50 took 3 years—3 years for them to do that. Well, this amendment would give a private company that administers Medicare the authority to reduce payments on items that they identify as grossly overpriced. So if they found something like a blood glucose monitor that they were reimbursing $200 for and they could buy it for 50 bucks, they could reduce the price down themselves. Again, right now, it takes HCFA over 3 years just to do one simple thing like that. This is a change that has been praised both by Medicare and the HHS Inspector General.

Next, my amendment would better assure that rapidly growing home health services are not subject to abuse by requiring that Medicare payments are not inflated by bills being filed in a higher payment area outside of where the service was provided, by establishing a fine for knowingly providing a false certification that a patient meets Medicare home health coverage criteria and by requiring that bills submitted for surgical dressings are itemized.

I will just read a little bit from this GAO report that covered excessive payments for medical supplies. Here is what happens. It says:

Fiscal intermediaries pay medical supply claims without knowing specifically what they are being asked to pay for on behalf of beneficiaries. The claims submitted by providers have no detailed information that would allow fiscal intermediaries to assess the claims' reasonableness. This lack of detail exists because HCFA guidance allows providers to bill all medical supplies under 10 broad codes. Billed items are not listed by type or amount. A code frequently used to record medical supplies is code 270, that is medical/surgical supplies, which we found included many different items such as a $21,437 pacemaker, a 75 cent sterile sponge, and even daily rental charges of $59 for an aqua pad. Consequently, unless fiscal intermediaries identify these claims for review and request additional documentation before payment, they will pay for the claims without knowing what the specific purchase was or whether it was covered or medically necessary.

Again, my amendment would address that and allow them to get that necessary information so that they would know exactly what they were paying for. That change was recommended and drafted by the General Accounting Office.

Next, my amendment would require Medicare to replace its outdated computer systems with state-of-the-art private sector computer software to detect and stop billing abuse. The General Accounting Office found that this simple change would save about $600 million a year. Again, this provision carries out their recommended changes to save seniors and taxpayers money.

GAO found, in fact, that a number of the private companies that process Medicare claims use the more sophisticated computer software on their private sector business but are not allowed to use it on their Medicare claims. They actually have to have two computer systems. They have their own that they submit claims to. Then they have another set that they have to have and another set of software just for Medicare.

As I said, the General Accounting Office said that just by making this one change, this one change would save $600 million a year, and the cost for doing that was about $20 million. So, again, it would require Medicare to replace its computer systems with state-of-the-art private sector computer technology, just what most private companies are using today to detect and stop billing abuse. As the GAO said, the private sector ones were so much better at detecting fraud and abuse than the Medicare ones were. We have been after Medicare. They say they are going to do this; maybe by the end of 1999 they might have it changed. We could change it right now and, as GAO said, save up to $600 million a year.

Last, my amendment saves money and reduces hassle by cutting excessive Medicare and Medicaid paperwork. There would be a uniform application and benefit claims form that would be established and would eliminate duplicative forms.

Mr. President, these are really modest steps. Again, these are all steps that the GAO, the inspector general's office, and other private sector health care experts have said are necessary to at least stem this tremendous hemorrhaging of waste and abuse that we have in Medicare. When you are talking about up to $18 billion a year, even if we cannot get all of it, if we could just get half of it, that is $9 billion a year. That is a lot of money. I see no reason why we could not get at least half of it with these modest steps that I am proposing here.

As I said, I did not include the one on competitive bidding. We will revisit that at another time. But I thought in the spirit of moving this legislation along and offering something that I thought was modest, that would move us in the right direction, that is why I took out competitive bidding.

I offer this amendment to enhance this bill and hopefully make it a better bill for health care in America. That is what this bill is about, is to help us in health care reform. You cannot have real health care reform until you stop the waste, fraud and abuse in Medicare. It is in that spirit I offer this amendment.

I thank the Senator from Montana for his strong support over the years, trying to weed out this waste, fraud and abuse in Medicare. He has been a leader on this subject. I am happy to have him as a cosponsor on this amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I hope my colleagues listened very closely to the Senator from Iowa. The big debate here is how to save Medicare. Senators on one side of the aisle say we have to cut Medicare to save it. We had this big debate over whether we should cut $270 billion out of Medicare in the next 7 years. We spent a lot of time debating this issue. Unfortunately, the majority Members in this body ended up deciding that, yes, we should cut that much money out of Medicare over 7 years. I think every Member on this side of the aisle voted against that.

Obviously, if we are going to save Medicare, we ought to first look at waste. It is clear there is waste in Medicare. We all know there is waste in Medicare. The General Accounting Office has documented the waste. The Senator from Iowa has listed all the Federal agencies that documented the millions of dollars lost to waste. Each of us, at home, talks to senior citizens, to providers and others who, on an anecdotal basis, tell us about waste in Medicare. We all know there is waste in Medicare.

We also know it takes a long time to get something done around here, way too long. Too many times we debate issues, not months but years. It takes way too long to get something meaningful accomplished around here. I think tonight we are debating a very important bill. We are going to pass this bill, hopefully tonight, that will take solid steps to provide better insurance coverage for millions of Americans and thousands of Montanans. This

is important and I strongly support this bill. At the same time, we have the chance to take the steps necessary to cut some of the waste in Medicare.

Tonight, let us pass this amendment. It is not perfect. There will be a lot of opportunities to work with it, during the conference committee, but let us get started. Let us pass this. We all know we should. Let us just do it. It might not be perfect, but we should not let perfection be the enemy of the good. Every Senator here tonight knows that this is a good amendment. We all know it is on the right track. I, for the life of me, do not understand why we just do not accept it tonight, work on it in the conference committee, maybe fix it up a little bit, get it enacted into law, and begin to attack a lot of the waste that exists in Medicare.

I hope Senators listened to the examples the Senator gave tonight. There are many more. They are outrageous—trips to Italy, sports cars. You would be amazed what waste, fraud, and abuse occurs in our Medicare program. It is outrageous. So, let us begin to do something about it; just begin. We heard the figures. GAO says up to 10 percent. That is $18 billion.

Let us be honest, we are not going to get a full $18 billion recovered. We know that. But, as the Senator from Iowa says, let us at least make a start. Let us not say we are not going to do it tonight because we have a no-amendments policy. We have already adopted one amendment, and another one, already tonight. Certainly this is in the category of amendments that we know should be passed. Otherwise, we run the risk that nothing will happen to fight fraud and abuse in the Medicare program this year.

What is going to happen next year? We do not know, as we attempt to address the waste that exists in Medicare.

I am not going to belabor the issue. It is getting late tonight. The Senator from Iowa has listed all the various provisions of his amendment. I just hope we can leave the partisan fighting and political rhetoric behind and do something which we know the people at home whom we represent want. Let us begin to take some very critical and concrete steps to address the waste and fraud that does exist in Medicare. That is where we should begin, rather than just cutting Medicare. First, let us cut the waste out of Medicare and the fraud out of Medicare before we cut Medicare services and programs that help millions of seniors nationwide.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas, the majority manager, is recognized.

Mrs. KASSEBAUM. Mr. President, I am speaking somewhat on behalf of Senator COHEN from Maine. He has worked many years on this issue, and has worked with Senator HARKIN as well, trying to address the issues of fraud and abuse.

The language that Senator COHEN had worked on is now part of the bill. It is an important issue, and the very things that Senator HARKIN raised are issues Senator COHEN raised. But there have also been some concerns, and we have to be careful, if there are some problems, to see if we cannot get them worked out or else it poses a problem for the underlying bill.

I yield time to the Senator from Maine.

Mr. KENNEDY. Mr. President, I wonder if we can possibly get a time understanding. We have several Members here. I know people want to address this, and Senator COHEN wants to speak on it. I am wondering if the proponents of the amendment are willing to agree to a time limit.

Mrs. KASSEBAUM. There is very little time we need, Mr. President. My guess is, if Senator COHEN says 5 minutes, that is fine.

Mrs. BOXER. I am sorry, this is a time agreement?

Mr. KENNEDY. Just with regard to the Harkin amendment, can we agree that there be 10 minutes evenly divided? I ask unanimous consent that there be 10 minutes equally divided.

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

The Senator from Maine.

Mr. COHEN. Mr. President, if I can be as brief as I can within the 5-minute limitation, the fraud and abuse provisions that we adopted in the leadership amendment is something that I have worked on now for over 3 years. It passed both the House and the Senate last year as part of the budget reconciliation act. It was included in the administration's budget reconciliation proposal.

So the legislation we have passed and adopted is something that has been completely vetted; it has been negotiated through a lengthy process; it has been through the hearing process; it has been on the floor on several occasions—in fact, numerous times.

Additionally, it has received the endorsement of the administration, the Attorney General, Secretary of Health and Human Services, the Finance Committee of the House and Senate, as well as many private groups. The Harkin legislation has not gone through any such review or scrubbing; it has not received these endorsements, to my knowledge. In fact, I am sure we do not know of all the objections to his provisions. I do believe that there are several that are the subject of controversy.

I am not here to argue the merits of each of the items I am about to raise, but I know that both Health and Human Services and HCFA, the Health Care Financing Administration, object to the section that requires HCFA to acquire commercial software technology for Medicare claims processing. I know HCFA has concerns with the Harkin section that requires Medicare payments for certain items.

Again, I am not here to argue the merits of these particular items tonight. I merely say to my colleagues, they are not without controversy. If our objective is to pass the Kassebaum-Kennedy bill because we want to see legislation that guarantees access, affordability and portability, it seems to me the best thing we can do is stay with the legislation we adopted. That is why it was included in the leadership amendment.

So we have adopted it on several occasions. There may be some merit to Senator Harkin's proposal, but I think because of the items that are in controversy, it is only going to jeopardize the legislation. I believe the fraud and abuse provisions we have adopted are an enormous step forward. CBO has scored the amendment we adopted as saving some $3 billion, and that is going to pay for a number of items in the bill itself.

So, Mr. President, I hope that my colleagues, when the appropriate time comes, will move to table the Harkin amendment, that we will enjoy the support of our colleagues, because I believe the Harkin amendment does raise controversial issues, and the last thing we need at this time is more controversy on this bill.

Mr. KENNEDY. I yield myself 2 minutes.

Mr. President, I have worked very closely with the Senator from Iowa, and I admire all of his extraordinary work in all of this area. I think it is very commendable, and I do not think we have really ensured that a number of the recommendations have been enacted. So I am, again, very sympathetic and supportive of the concept.

This is a matter really for the Finance Committee, and there has been an objection raised on that vote in support of tabling the amendment. But I give assurances to the Senator, as a member of the conference and given the fact the whole issue of fraud will be a matter of conference, I will do the best I can to see that we are able to include some of those measures in the conference. That is the best at least I can do, but I admire his work and look forward to joining with him on another occasion.

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I appreciate Senator KENNEDY's comments, and I hope we can get some of these adopted in conference. I say, again, I appreciate what the Senator from Maine has done over the last few years. He has done a great job of going after these issues of waste and abuse. I have no major objections to what was adopted earlier. Overall, I think it is a great step in the right direction.

We probably have been working along parallel paths. I am on the Appropriations Committee and the Senator is on another committee, but I first started having hearings on this 6 years ago, so we have been working on parallel tracks. I do not think there is any need to debate that.

I was just saying I do not know that it is necessary before we pass anything

around here that we have to have the approval of the administration. I find that kind of an odd concept at this time in the Senate that we have to have that kind of approval. We are the legislative branch.

I point out that every single item I just mentioned has gone through a process of hearings. We have had numerous hearings on this. We have had the approval of the inspector general's office and the GAO.

The Senator from Maine did mention one item. Out of all of these, there is only one item that HCFA opposes, and that is the provision in there that mandates they use state-of-the-art computer technology. That is because HCFA has been trying to develop its own. I have had some pretty fair battles with HCFA on this. I guarantee the Senator from Maine is right that they do not want that provision.

I am going to tell you they are wrong. There is high quality computer software out in the private sector that Medicare can adopt right now. They are wasting money developing their own. And I'm afraid by the time that the system they are developing won't solve the problem. The GAO study and investigation showed that. I have had Medicare intermediaries say that they have the software that Medicare could adopt, and, in fact, I say to the Senator from Maine that Medicare did adopt some changes of the type I've advocated in January of this year. They adopted a little bit of it. It will save some money, but much more could be saved.

Lastly, let me just say the amendment of the Senator from Maine does save $3 billion over 7 years. We do not have an estimate on how much this would save. All I know is, just on the computer software alone, that was $600 million in savings. I believe this amendment would save much, much more.

Again, I do not see anything here that is controversial but for that one item where HCFA says they are opposed to adopting private sector computer technology. As I said every single item in this amendment is a direct recommendation from the Inspector General, the General Accounting Office or other experts as effective methods to stop waste, fraud and abuse in Medicare.

This should be a completely noncontroversial amendment. I hope, again, as the Senator from Montana said, that we will not get caught up in jurisdictions.

Let us do what is right. What is right is to adopt this and start saving some money in the Medicare system. The amendment of the Senator from Maine is going to save some money. Darn right it is going to save some money. But we can save much more by adopting these other provisions.

The PRESIDING OFFICER. The Senator's time has expired. The minority manager is recognized

Mr. KENNEDY. I was going to make the tabling motion and then set that aside. What we had tried to do before is have the few amendments that we have here incorporated.

But I am reminded by my chairman that we had one over here and that it would be reasonable and fair to do one over there, and then we would come back to try and do all three of these here.

Mr. CONRAD. I wonder if we can get at least an order that would be acceptable so that those of us who have been waiting for an extended period might get a timeframe so that we will not just be waiting around and then find the list somehow gets altered and we wait some more.

Mr. KENNEDY. I was prepared to accept Senator CONRAD's amendment. It is going to take a minute.

Mr. KASSEBAUM. We are accepting it. So if the Senator wants to proceed—Senator COATS has been waiting too, but that is fine. It is acceptable.

Mr. KENNEDY. Mr. President, I make a motion to table the Harkin amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is sufficient second.

The yeas and nays were ordered.

Mr. KENNEDY. Mr. President, I ask that the Harkin amendment be temporarily set aside.

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

AMENDMENT NO. 3684

(Purpose: To extend State requested waivers of the foreign country residence requirement with respect to international medical graduates, and for other purposes)

Mr. CONRAD. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from North Dakota [Mr. CONRAD] proposes amendment numbered 3684.

Mr. CONRAD. Mr. President, I ask unanimous consent that further 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 in the bill, insert the following:

SEC. . WAIVER OF FOREIGN COUNTRY RESIDENCE REQUIREMENT WITH RESPECT TO INTERNATIONAL MEDICAL GRADUATES.

(a) EXTENSION OF WAIVER PROGRAM.—Section 220(c) of the Immigration and Nationality Technical Corrections Act of 1994 (8 U.S.C. 1182 note) is amended by striking ''June 1, 1996'' and inserting ''June 1, 2002''.

(b) CONDITIONS ON FEDERALLY REQUESTED WAIVERS.—Section 212(e) of the Immigration and Nationality Act (8 U.S.C. 1184(e)) is amended by inserting after ''except that in the case of a waiver requested by a State Department of Public Health or its equivalent'' the following: ''or in the case of a waiver requested by an interested United States Government agency on behalf of an alien described in clause (iii)''.

(c) RESTRICTIONS ON FEDERALLY REQUESTED WAIVERS.—Section 214(k) (8 U.S.C. 1184(k)) is amended to read as follows:

''(k)(1) In the case of a request by an interested State agency or by an interested United States Government agency for a waiver of the two-year foreign residence requirement under section 212(e) with respect to an alien described in clause (iii) of that section, the Attorney General shall not grant such waiver unless—

''(A) in the case of an alien who is otherwise contractually obligated to return to a foreign country, the government of such country furnishes the Director of the United States Information Agency with a statement in writing that it has no objection to such waiver; and

''(B)(i) in the case of a request by an interested State agency—

''(I) the alien demonstrates a bona fide offer of full-time employment, agrees to begin employment with the health facility or organization named in the waiver application within 90 days of receiving such waiver, and agrees to work for a total of not less than three years (unless the Attorney General determines that extenuating circumstances exist, such as closure of the facility or hardship to the alien would justify a lesser period of time); and

''(II) the alien's employment continues to benefit the public interest; or

''(ii) in the case of a request by an interested United States Government agency—

''(I) the alien demonstrates a bona fide offer of full-time employment that has been found to be in the public interest, agrees to begin employment with the health facility or organization named in the waiver application within 90 days of receiving such waiver, and agrees to work for a total of not less than three years (unless the Attorney General determines that extenuating circumstances exist, such as closure of the facility or hardship to the alien would justify a lesser period of time); and

''(II) the alien's employment continues to benefit the public interest;

''(C) in the case of a request by an interested State agency, the alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than three years only in the geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

''(D) in the case of a request by an interested State agency, the grant of such a waiver would not cause the number of waivers allotted for that State for that fiscal year to exceed 20.

''(2)(A) Notwithstanding section 248(2) the Attorney General may change the status of an alien that qualifies under this subsection and section 212(e) to that of an alien described in section 101(a)(15)(H)(i)(b).

''(B) No person who has obtained a change of status under subparagraph (A) and who has failed to fulfill the terms of the contract with the health facility or organization named in the waiver application shall be eligible to apply for an immigrant visa, for permanent residence, or for any other change of nonimmigrant status until it is established that such person has resided and been physically present in the country of his nationality or his last residence for an aggregate of at least two years following departure from the United States.

''(3) Notwithstanding any other provisions of this subsection, the two-year foreign residence requirement under section 212(e) shall apply with respect to an alien in clause (iii) of that section who has not otherwise been accorded status under section 101(a)(27)(H)—

''(A) in the case of a request by an interested State agency, if at any time the alien practices medicine in an area other than an area described in paragraph (1)(C); and

''(B) in the case of a request by an interested United States Government agency, if at any time the alien engages in employment for a health facility or organization not named in the waiver application.''.

Mr. CONARD. Mr. President, this is very simple. It is an extension of the popular J–1 visa program for 6 years. If we fail to do this, the authority runs out June 1. Mr. President, the J–1 visa waiver permits each of our States to extend 20 waivers a year. And 21 of our States have already done it. More are interested in doing it. They will not have a chance if the authority runs out June 1.

Mr. President, the amendment I am sponsoring would extend what has become known by some as the ''Conrad State 20 Program.'' In 1994, I added a provision to the visa extension bill that allows state health departments or their equivalents to participate in the process of obtaining J–1 visa waivers. This process allows a foreign medical graduate (FMG) who has secured employment in the United States to waive the J–1 visa program's 2 year residency requirement.

As a condition of the J–1 visa, FMGs must return to their home countries for at least 2 years after their visas expire before being eligible to return. However, if the home countries do not object, FMGs can follow a waiver process that allows them to remain and work here in a designated health professional shortage area or medically underserved area. Before my legislation became law, that process exclusively involved finding an ''interested federal agency'' to recommend to the United States Information Agency (USIA) that waiving the 2 year requirement was in the public interest. The law now allows each State health department or its equivalent to make this recommendation to the USIA for up to 20 waivers per year.

This law as necessary for several reasons. Despite an abundance of physicians in some areas of the country, other areas, especially rural and inner city areas, have had an exceedingly hard time recruiting Americans doctors. Many health facilities have had no other choice but turn to FMGs to fill their primary care needs. Unfortunately, obtaining J–1 visa waivers for qualified FMGs through the federal program is a long and bureaucratic process that not only requires the participation of the ''interested federal agency'' but also requires approval from both the USIA and the Immigration and Naturalization Service.

Finding a federal agency to cooperate is difficult enough, considering that the Department of Health and Human Services does not participate. States who are not members of the Appalachian Regional Commission, which is eligible to approve its own waivers, have had to enlist any agency that is willing to take on these additional duties. These agencies, such as the Department of Agriculture or the Department of Housing and Urban Development, often have little or no expertise in health care issues. Once an agency does agree to participate, the word spreads quickly and soon that agency can be flooded with thousands of waiver applications from across the country.

Because states can clearly determine their own health needs far better than an agency in Washington, DC, my legislation now allows states to go directly to the USIA to request a waiver. It also is relieving some of the burden that participating federal agencies have incurred in processing waiver applications.

The Conrad State 20 Program is still very new, and not every state has yet elected to use it. But the program is beginning to work exactly as I had hoped. At least 21 States have reported using it to obtain waivers. More states are expected to participate in the coming months. Unfortunately, the Conrad State 20 program is scheduled to sunset on June 1, 1996, unless Congress approves an extension. The amendment I am offering would extend the program for 6 more years. This is not a permanent extension. The amendment would sunset the program on June 1, 2002.

My amendment also puts new restrictions and conditions on FMGs who use the federal program. As a condition of using the Conrad State 20 program to acquire a waiver, FMGs must contract to work for their original employer for at least 3 years. Otherwise, their waiver will be revoked and they will be subject to deportation. My amendment would apply the same 3-year contractual obligation for those who obtain a waiver through the Federal program.

We all know that State empowerment has been a major issue of the 104th Congress. The Conrad State 20 Program is one way of giving States more control over their health care needs. States that are using the program want to keep it operating for a few more years. They understand that this program does not take away jobs from American doctors, but instead is one more valuable tool to help serve the health care needs of rural and inner city citizens. The Senate passed my original legislation with strong bipartisan support. I am hopeful the Senate will agree that creating the Conrad State 20 program was very worthwhile, and will agree to accept this modest, 6-year extension.

I hope we can accept this amendment.

Mr. KENNEDY. Mr. President, we have talked to the chairman of the Immigration Committee, Senator SIMPSON. And I, as the ranking minority member on that committee, say this makes sense. It is targeting doctors in underserved areas. We welcome this. This is effective. It is time sensitive in terms of the reauthorization. We urge the adoption of the amendment.

The PRESIDING OFFICER. Is there further debate?

The question occurs on agreeing to the amendment.

The amendment (No. 3684) was agreed to.

Mr. SIMON. Mr. President, I recognize Senator COATS is going to have his amendment next. But Senator CONRAD's point that we would like some kind of knowledge as to what order we are going to come in here—some of us have been waiting a long time. And it will take a few minutes. I wonder if there can be some agreement following the Coats amendment as to who is going to be up here with their amendments.

Mrs. KASSEBAUM. After the Coats amendment there are only two amendments I know of at this point that will require votes on this side, one is a Gramm amendment and, I believe, perhaps a Burns amendment.

Mr. KENNEDY. Mr. President, I ask Senator COATS, how long does he expect to take?

Mr. COATS. There are one or two people that may want to speak on it. They are not on the floor. I do not intend to take all that long, 15 minutes or so, 10, 15 minutes.

Mr. KENNEDY. All right. The Senator from Illinois was just trying to get through this. He has been here and has been prepared, and Senator BOXER. I ask unanimous consent that at the conclusion of the consideration of Senator COATS' amendment, Senator BOXER be recognized, and at the conclusion of Senator BOXER, Senator SIMON be recognized.

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

Mr. KENNEDY. Could we get a time, for the benefit of our colleagues here? Could we set a time for the Senator's amendment?

Mr. COATS. Well, it is difficult for me to determine how much opposition there will be to this amendment.

Mr. KENNEDY. I think the opposition will not take very much time. We would request maybe 4 minutes for the opposition.

Mr. COATS. I think we can do this then in a total of 15 minutes equally divided.

Mr. KENNEDY. Mr. President, I ask unanimous consent that there be an allocation of 20 minutes, 15 minutes for the Senator from Indiana, and 5 minutes for this Senator.

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

Mr. COATS addressed the Chair.

The PRESIDING OFFICER. The Senator from Indiana is recognized.

Mr. COATS. I thank the Chair.

Mr. KENNEDY. Mr. President, I ask unanimous consent that we vitiate that unanimous consent request until I get agreement on our side.

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

AMENDMENT NO. 3685

(Purpose: To encourage the provision of medical services in medically underserved communities by extending Federal liability coverage to medical volunteers)

Mr. COATS. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Indiana [Mr. COATS] proposes amendment numbered 3685.

Mr. COATS. Mr. President, I ask unanimous consent that further 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 in title III, insert the following new section:

SEC. . MEDICAL VOLUNTEERS.

(a) SHORT TITLE.—This title may be cited as the ''Medical Volunteer Act''.

(b) TORT CLAIM IMMUNITY.—

(1) GENERAL RULE.—A health care professional who provides a health care service to a medically underserved person without receiving compensation for such health care service, shall be regarded, for purposes of any medical malpractice claim that may arise in connection with the provision of such service, as an employee of the Federal Government for purposes of the Federal tort claims provisions in title 28, United States Code.

(2) COMPENSATION.—For purposes of paragraph (1), a health care professional shall be deemed to have provided a health care service without compensation only if, prior to furnishing a health care service, the health care professional—

(A) agrees to furnish the health care service without charge to any person, including any health insurance plan or program under which the recipient is covered; and

(B) provides the recipient of the health care service with adequate notice (as determined by the Secretary) of the limited liability of the health care professional with respect to the service.

(c) PREEMPTION.—The provisions of this section shall preempt any State law to the extent that such law is inconsistent with such provisions. The provisions of this section shall not preempt any State law that provides greater incentives or protections to a health care professional rendering a health care service.

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

(1) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means a person who, at the time the person provides a health care service, is licensed or certified by the appropriate authorities for practice in a State to furnish health care services.

(2) HEALTH CARE SERVICE.—The term ''health care service'' means any medical assistance to the extent it is included in the plan submitted under title XIX of the Social Security Act for the State in which the service was provided.

(3) MEDICALLY UNDERSERVED PERSON.—The term ''medically underserved person'' means a person who resides in—

(A) a medically underserved area as defined for purposes of determining a medically underserved population under section 330 of the Public Health Service Act (42 U.S.C. 254c); or

(B) a health professional shortage area as defined in section 332 of such Act (42 U.S.C. 254e);

and who receives care in a health care facility substantially comparable to any of those designated in the Federally Supported Health Centers Assistance Act (42 U.S.C. 233 et seq.), as shall be determined in regulations promulgated by the Secretary.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of the Department of Health and Human Services.

Mr. COATS. Mr. President, the amendment I offer extends the Federal tort claim coverage to a health care professional if that health care professional volunteers his or her medical services to a medically underserved person. This is the same type of coverage—this is not new. We are not breaking new ground here. We extend that same type of Federal tort coverage for medical services provided in Indian health care facilities, in Federal community, migrant, homeless, and public housing health centers.

What I am attempting to do here is extend it to those volunteer efforts—not paid—but volunteer efforts on the part of health care professionals if those medical services are provided to people from underserved areas that are deemed by the Secretary of Health and Human Services as medically underserved or medically needy.

We have built into this significant patient protection, indicating that the patient must receive notice before providing the care, and that the provider has agreed not to charge the party for any health care that is provided, and that the medical malpractice liability is shifted to the Federal Tort Claims Act.

We are not in any way limiting the plaintiff's right to receive compensation for negligence or for a successful award in a suit. We are just simply shifting it from the provider's insurance coverage to the Federal Tort Claims Act. The provider is deemed, for the purposes of providing that voluntary service, an employee of the Federal Government and therefore covered under the act.

The providers have to be licensed in the State in which the care is provided. The care must be covered under Medicaid in that State. In addition, the patient must receive the care in a health care facility that is substantially comparable in nature to the Federal migrant and community health centers that provide care to underserved populations. This is the protection that is needed in order to ensure that the care is provided in adequate facilities. So those facilities that are deemed by the Secretary of Health and Human Services as federally certified—if they are provided in substantially comparable facilities—the coverage will qualify.

What we are attempting to do here is to provide a way that medical personnel can provide medical services to people who otherwise cannot afford them, people who are uninsured but where doctors and professionals and providers in the community come together and volunteer their time.

We all know the horrendous cost of medical liability insurance. In many instances these medical providers cannot pay or do not choose to pay the additional liability cost. One of the primary reasons for this is that many of these individuals are retired. They are retired doctors or dentists or health care providers. So they do not have umbrella liability policies because they are not necessarily practicing on a full-time basis. But we want to encourage these individuals—as many of them already do—to engage in providing medical services.

I think the amendment is pretty straightforward. There has been a question about the cost. It is interesting to note that when we provided this liability coverage for community health centers, the Congress set aside $10 million a year to cover potential liability costs. It is important to note that none of this money has been used in the 2 years that this has been in operation.

People receiving free health care from professional providers generally are very grateful for the care and obviously are not looking to sue, yet we have protected their rights to do so if negligence occurs or if any liability occurs under the services. That is provided. It just simply is that the coverage comes under the Federal tort claims procedure rather than under the private insurance liability coverage of the medical provider.

Again, the purpose here is to encourage the provision of free medical services to people who either live in underserved areas—and who of us do not represent a State that has underserved areas—or to those people of such income level that do not have insurance or do not have the personal wherewithal to purchase the medical service that is needed.

This is widely supported. The American Medical Association supports this, the Catholic Health Association, the Christian Medical and Dental Society. Senators FRIST and KASSEBAUM have been cosponsors of this bill. And it is supported by professionals throughout our States and throughout our communities.

I have seen some marvelous examples of efforts where community medical professionals gather together, provide an acceptable clinic, volunteer their time and provide very needed services to people that need these free services in order to receive medical care.

I hope that our colleagues could support this amendment. I thought this was something that we might be able to work out. We were not able to do that. I will address any questions that might be raised in opposition to this. I reserve the balance of my time.

Mr. KENNEDY. Mr. President, I yield myself 2 minutes.

This idea is a good idea. As the author of the community health centers, we had the Tort Claim Act covering all the medical personnel in there. Then there was a downsizing of service corps, we had other doctors that came in there, and we had an increase in the insurance costs for the neighborhood health centers as a result of that.

About 4 years ago, again, we worked out with the Treasury and the administration an indemnification program for those doctors in the neighborhood health centers. It has worked very well. The reason that has worked well

is because there is supervision and accountability at the neighborhood health centers.

That aspect is missing in this program. That is why I will vote to table this measure. Then we will come back, one, on the issue of what the funding level would be in terms of it; and second, whether an overall program can be worked in terms of the accountability. Without an accountability, without some ideas of funding, this is not the place, the time. It is a good idea.

I commit to working with my friend from Indiana to try and see if we cannot make it a reality in the very near future.

Mr. COATS. Mr. President, I appreciate the offer of the Senator from Massachusetts to work with us on this. I hardly think this needs additional work.

First of all, it is important to understand that the bill itself addresses the issue that the Senator raised. In the definition of ''medically underserved person'' it says the term ''medically underserved person'' means a person who receives care in a health care facility substantially comparable to any of those designated in the federally-supported Health Centers Assistance Act as shall be determined in regulations promulgated by the Secretary. The Secretary of Health and Human Services has a sufficient amount of control by the promulgation of regulations to certify the types of facilities, and there is accountability.

If you feel that you need to have a Federal agency or a Federal supervisor standing over the shoulder of a health care professional, a doctor who might be earning $200 or $300 an hour performing services but who volunteers his time for free, if you say we cannot trust this person to provide adequate medical care, I think we are selling the medical profession very, very short and we are crediting the Government with an ability to supervise that it does not have.

We do not need a Government agency to oversee the efforts of nurses and doctors who volunteer their time—volunteer their time—to provide needed free medical services to underserved and low-income individuals. Again, we are not limiting the liability of anybody that is served here. We are not saying they cannot bring a claim. We are simply saying that claim, if brought and if successfully brought, will be paid for under the Federal Tort Claims Act and not paid for under the liability insurance of the professional.

Why do we need to do that? We need to do that so we can encourage these people to provide the care. Why is it necessary for most? Because many of these people are retired and they are not able or in a position to continue to pay the exorbitant medical liability insurance, sometimes running $50,000, $60,000, or $80,000, depending on the specialty, in order to cover themselves for the volunteer service they get. The last thing we need is more Federal oversight in a program that does not need oversight.

The PRESIDING OFFICER. Under the previous order the hour of 9:45 having arrived the question is on agreeing to the Specter amendment No. 3682.

Mrs. KASSEBAUM. Mr. President, I ask if we could delay this for 15 minutes. There are a couple more amendments that need to be offered.

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

Mrs. BOXER. Reserving the right to object, Mr. President, I do not wish to object, but I would like to know how much time is left and what the order will be. As I understand it, Senator KENNEDY mentioned I would go next, but if you are just going to finish everything up in 15 minutes, that would leave virtually no time for Senator SIMON and virtually no time for me.

I am confused about whether we will continue after the vote, I guess is the point. I only wish to take 5 minutes on my amendment.

Mr. SPECTER. Mr. President, while we are doing the order here, I think it might be appropriate to spend just a minute on a discussion which I had with the distinguished manager, the Senator from Kansas, talking about hearings before the Labor Committee, hopefully, by the end of May, looking for reauthorization or authorization of the healthy start program.

Mrs. KASSEBAUM. Mr. President, I wish the Senator from Pennsylvania might wait until we worked out the order here.

Mr. SPECTER. I am glad to do that.

Mrs. KASSEBAUM. I suggest at this point perhaps we could go an extra half hour, which I think will then take care of every amendment that is there to everyone's satisfaction.

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

Mrs. KASSEBAUM. I respond, if I may, Mr. President, to the Senator from Indiana. I am a cosponsor, as a matter of fact, of the Senator's Medical Volunteer Act. I think it is a very positive step forward. It encourages medical voluntarism and brings some small measure of relief to the current liability system. There are objections that have been raised to this on the Democratic side, principally, and because of our need to try and get as strong a consensus as possible for the underlying measure I have to object.

At the appropriate time, after all debate is concluded, I would move to table the amendment of the Senator from Indiana.

Mr. KENNEDY. As a matter of order, I think we request to conclude with Senator BOXER and Senator SIMON and then come back to the other side. I think that is what is the order.

The PRESIDING OFFICER. Is there further debate on the Coats amendment?

Mrs. KASSEBAUM. If not, I ask for the yeas and nays and ask that the amendment be set aside.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered on the motion to table the Coats amendment.

The PRESIDING OFFICER. Under the previous order, the Senator from California is recognized.

AMENDMENT NO. 3686

Mrs. BOXER. Thank you very much, Mr. President. I would like to be advised when I have utilized 4 minutes and then I will wrap up my side of the argument.

I send an amendment to the desk and ask for its immediate consideration as a sense of the Senate.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from California [Mrs. BOXER], proposes an amendment numbered 3686.

The Senate finds that:

Patients deserve to know the full range of treatments available to them and,

Patients should know if doctors receive bonuses for withholding treatment from them.

It is the sense of the Senate that Congress should thoughtfully examine these issues to ensure that all patients get the care they deserve.

Mrs. BOXER. Mr. President, this is such a straightforward and simple sense-of-the-Senate. It is rather shocking to me that Members on the other side of the aisle have objected to it. I have to thank the chairwoman of the committee and Senator KENNEDY, who were quite willing to accept such a sense-of-the-Senate resolution. I do not know what Members oppose this. I cannot imagine why they have not identified themselves to me, Mr. President. I just hope that Members will read the sense-of-the-Senate.

Let me tell you a little story about why it is so important.

This is an L.A. Times story, entitled ''HMO 'Gag Clauses' on Doctors Spur Protests.'' I will read just a few paragraphs:

The Santa Monica oncologist thought she was being a strong advocate for her patient.

In May, she referred the patient—a Los Angeles woman in her forties, who was rapidly losing her battle with metastatic colon cancer—to a Johns Hopkins University specialist using an experimental drug that had proven effective with similar cancers. It was, in the doctor's view, perhaps the best chance of extending the woman's life.

But the patient's managed care group had a different view of the oncologist. It saw a doctor who said too much and broke the rules. She received a reproachful letter from the managed care group, stating that the Johns Hopkins specialist was not ''in network'' and that the patient should not have been referred there.

''This occurrence,'' the letter warned, ''had been noted in the computer, and a future occurrence may result in suspension of referral privilege or, in an extreme case, a recommendation for termination.''

Mr. President, this is what is happening across the country in HMO's. Doctors, who refer patients to specialists are being warned that they may be fired. Doctors are receiving bonus payments from the HMO's for not giving care to patients.

Now, all I am asking in this sense-of-the-Senate is that we look into this. Already, we have looked into this in Medicare and, thank goodness, something is being done. Last month, the Department of HHS announced a regulation mandating that managed care plans serving Medicare and Medicaid patients reveal any arrangements in which doctors may face financial pressures to limit services or referrals to specialists.

What about those who are not on Medicare, who are not on Medicaid? Do they not deserve the same protections, at a minimum? Doctors across the country are protesting managed care companies' practices that they contend impede their ability to have candid discussions with patients about treatment options.

In this time of shifting health care needs and our attempt to restructure the health care delivery system, we must not lose sight of the valuable doctor-patient relationship. We should revere it, we should honor it. We should not allow the HMO's, because of the almighty bottom line, to interfere in this relationship and gag our physicians from telling their patients that there are other treatments for cancer, or whatever other condition it might be.

I really do not understand why we cannot get a simple sense of the Senate through this body.

In closing, I am going to read it to you one more time:

The Senate finds that patients deserve to know the full range of treatments available to them, and patients should know if doctors receive bonuses for withholding treatment from them. It is the sense-of-the-Senate that Congress should thoughtfully examine these issues to ensure that all patients get the care they deserve.

Mr. President, we have a very good bill here. We can make it better, I believe, by just pledging to look into this situation and making sure that all of our people throughout this Nation are told all of the options, because if they are not told, they may lose their lives. I do not think we ought to have that on our hands.

Thank you, Mr. President. I reserve whatever time I have remaining.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the Boxer amendment be temporarily set aside.

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

Mr. SIMON addressed the Chair.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

AMENDMENT NO. 3687

(Purpose: To express the sense of the Senate regarding the need to ensure adequate health care coverage for all children and pregnant women)

Mr. SIMON. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Illinois [Mr. SIMON] proposes an amendment numbered 3687.

Mr. SIMON. 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 in the bill insert the following new section:

SEC. . SENSE OF THE SENATE REGARDING ADEQUATE HEALTH CARE COVERAGE FOR ALL CHILDREN AND PREGNANT WOMEN.

(a) FINDINGS.—The Senate finds the following:

(1) The health care coverage of mothers and children in the United States is unacceptable, with more than 9,300,000 children and 500,000 expectant mothers having no health insurance.

(2) Among industrial nations, the United States ranks 1st in wealth but 18th in infant mortality, and 14th among such nations in maternal mortality.

(3) 22 percent of pregnant women do not have prenatal care in the first trimester, and 22 percent of all poor children are uninsured, despite the medicaid program under title XIX of the Social Security Act.

(4) Of the 1,100,000 net increase in uninsured persons from 1992 to 1993, 84 percent or 922,500 were children.

(5) Since 1987, the number of children covered by employment based health insurance has decreased, and many children lack health insurance despite the relative affordability of providing insurance for children.

(6) Health care coverage for children is relatively inexpensive and in 1993 the medicaid program spent an average of $1,012 per child compared to $8,220 per elderly adult.

(7) Uninsured children are generally children of lower income workers, who are less likely than higher income workers to have health insurance for their families because they are less likely to work for a firm that offers insurance, and if such insurance is offered, it is often too costly for lower income workers to purchase.

(8) In 1993, 61 percent of uninsured children were in families with at least one parent working full time for the entire year the child was uninsured, and about 57 percent of uninsured children had a family income at or below 150 percent of the Federal poverty level.

(9) If Congress eliminates the Federal guarantee of medicaid, an estimated 4,900,000 children may lose their guarantee of health care coverage, and those same children may be added to the currently projected 12,600,000 children who will be uninsured by the year 2002.

(10) Studies have shown that uninsured children are less likely than insured children to receive needed health and preventive care, which can affect their health status adversely throughout their lives, with such children less likely to have routine doctor visits, receive care for injuries, and have a regular source of medical care.

(11) The families of uninsured children are more likely to take the children to an emergency room than to a private physician or health maintenance organization.

(12) Children without health insurance are less likely to be appropriately immunized or receive other preventive care for childhood illnesses.

(13) Ensuring the health of children clearly increases their chances to become productive members of society and averts more serious or more expensive health conditions later in life, and ensuring that all pregnant women receive competent prenatal care also saves social costs.

(14) Although the United States has made great improvements in health care coverage through the medicaid program, it is still the only developed nation that does not ensure that all of its children and pregnant women have health care coverage.

(15) The United States should not accept a status quo in which children in many neighborhoods are more likely to have access to drugs and guns than to doctors, or accept a status quo in which health care is ensured for all prisoners but not for all children.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the issue of adequate health care for our mothers and children is important to the future of the United States, and in consideration of the importance of such issue, the Senate should pass health care legislation in the 105th Congress that will ensure health care coverage for all of the United States's pregnant women and children.

Mr. SIMON. Mr. President, all this does, very simply, is say it is the sense of the Senate that in the next congressional session, starting in 1997, the 105th Congress pass health care legislation that protects pregnant women and children. That is all it does.

It is very interesting. Two years ago, we were discussing health care legislation, and virtually everyone in this body, including the majority leader, said, ''We are going to work out some kind of health care for all Americans.'' I have to say, in fairness to Senator PHIL GRAMM, he said right from the start, ''Over my dead body. We are not going to have any national health care program.''

We are the only western industrialized nation that does not protect all of our citizens. Listen to this, Mr. President. I ask my colleagues on the other side to listen to this.

In accepting the Republican nomination for President in 1928, Herbert Hoover said, ''The greatness of any nation, its freedom from poverty and crime, its aspirations and ideals are the direct quotient of the care of its children. . .There should be no child in America that is not born and does not live under sound conditions of health.''

That was in 1928, and we have not achieved Herbert Hoover's dream yet in 1996.

Let me add, providing coverage for children is the least expensive part of health insurance. As we get older, it is more demanding in terms of expense. But still we do not provide it for all children.

All women and children in Italy have health care coverage, but not in the wealthy United States of America.

All women and children in France have health care coverage, but not in the wealthy United States of America.

All women and children have health care coverage in Canada, but not in the wealthy United States of America.

All women and children have health care coverage in Great Britain, but not in the wealthy United States of America.

All women and children have health care coverage in Germany, but not in the wealthy United States of America.

All women and children have health care coverage in Luxembourg, but not in the wealthy United States of America.

All women and children have health care coverage in Belgium, but not in the wealthy United States of America.

All women and children have health care coverage in The Netherlands, but not in the wealthy United States of America.

All women and children have health care coverage in Portugal, but not in the wealthy United States of America.

All women and children have health care coverage in Spain, but not in the wealthy United States of America.

All women and children have health care coverage in Finland, but not in the wealthy United States of America.

All women and children have health care coverage in Austria, but not in the wealthy United States of America.

All women and children have health care coverage in Denmark, but not in the wealthy United States of America.

All women and children have health care coverage in Norway, but not in the wealthy United States of America.

All women and children have health care coverage in Sweden, but not in the wealthy United States of America.

All women and children have health care coverage in Japan, but not in the wealthy United States of America.

Mr. President, what we are just saying here is, let us in the next session of Congress—and I am not going to be here—at least protect pregnant women and children. That is all we ask. It is a sense of the Senate resolution.

I regret that 2 years ago—and I blame myself as much as anyone—that we did not even get a vote on the floor of the U.S. Senate on the fundamental issue of health care. Today, my friends, we are going to get a vote. We do not say how it should be done; we just say it is the sense of the Senate that in the next session of Congress, we are going to at least protect pregnant women and children.

I do not know how we can do anything less than that. That is what my amendment asks for.

Mrs. KASSEBAUM. Mr. President, I recognize it is just a sense-of-the-Senate resolution. But it is about 6 pages, and it is a fairly extensive direction for the next Congress. While there would be certainly a great deal of support for health care coverage for pregnant women and children, we are having a hard enough time in this Congress figuring out what we want to do, let alone applying some issues and directions to the next Congress.

For that reason, Mr. President, I would have to oppose.

Mr. KENNEDY. Mr. President, could we ask for the yeas and nays?

Mr. SIMON. I ask for the yeas and nays.

Mr. KENNEDY. That it would be in order to ask for the yeas and nays on the Boxer amendment.

Mrs. KASSEBAUM. Mr. President, I move to table and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

Mr. SIMON. If the Senator from Kansas will withhold for 30 seconds for me to respond, she mentions a 5-page amendment. These are all whereases. The conclusion is that it is a sense of the Senate. If she wants to agree to this, I will knock out all of the whereases and we will just take the sense of the Senate that we ought to, next session of the Congress, pass health care legislation for pregnant women and children.

Mrs. KASSEBAUM. Mr. President, I very much appreciate that Senator SIMON is always very accommodating. The Senator from Illinois is a superb debater. I would still have to object. If there is no further debate, I will move to table the Simon amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Are there further amendments?

Mr. KENNEDY. Mr. President, as I understand, the Senator is also asking for the yeas and nays on the tabling motion of the Boxer amendment.

Mrs. KASSEBAUM. Yes. Mr. President, if I may just speak for a moment, this is objected to by the Finance Committee because it deals with Medicare. They would like to debate that at another time, even though it is just a sense-of-the-Senate resolution.

Mrs. BOXER. Mr. President, if my friend will yield for a minute, we took out any reference to Medicare and Medicaid at the Senator's suggestion. It has nothing to do with Medicare and Medicaid. The way it reads now is simply that we should look to see whether patients are being denied the information they need. We deleted all reference to Medicaid and Medicare and asked just for the Congress to look at this matter.

So I tried to be very accommodating, if my friend would try to help me. As I say, we do not have any reference in here at all. We simply ask that the Congress should thoughtfully examine the issue of patients, finding out the full range of their treatment, and patients should know if doctors are receiving bonuses from the treatment. It does not mention Medicare and Medicaid.

Mr. BYRD. Mr. President, parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state his parliamentary inquiry.

Mr. BYRD. Is not a motion to table now pending?

The PRESIDING OFFICER. The Senator is correct.

Mr. BYRD. There is no debate on a motion to table.

The PRESIDING OFFICER. The Senator is correct.

Mr. BYRD. Shall we vote?

The PRESIDING OFFICER. We have a previous order to table the votes in sequential order and vote at 10:15.

Mr. BYRD. Very well. I thank the Chair.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The minority manager is recognized.

AMENDMENT NO. 3688

(Purpose: To encourage organ and tissue (including eye) donation through the inclusion of an organ and tissue donation card with individual income refund payments, and for other purposes)

Mr. KENNEDY. Mr. President, there are two amendments which have been agreed to dealing with the organ transplants and information on organ transplants, the Dorgan–Frist amendment, in terms of information on the organ transplants. I would like to send it to the table and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Massachusetts [Mr. KENNEDY], for Mr. DORGAN, for himself and Mr. FRIST, proposes an amendment numbered 3688.

Mr. KENNEDY. 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. 3 . ORGAN AND TISSUE DONATION INFORMATION INCLUDED WITH INCOME TAX REFUND PAYMENTS.

(a) IN GENERAL.—The Secretary of the Treasury shall include with any payment of a refund of individual income tax made during the period beginning on February 1, 1997, and ending on June 30, 1997, a copy of the document described in subsection (b).

(b) TEXT OF DOCUMENT.—The Secretary of the Treasury shall, after consultation with the Secretary of Health and Human Services and organizations promoting organ and tissue (including eye) donation, prepare a document suitable for inclusion with individual income tax refund payments which—

(1) encourages organ and tissue donation;

(2) includes a detachable organ and tissue donor card; and

(3) urges recipients to—

(A) sign the organ and tissue donor card;

(B) discuss organ and tissue donation with family members and tell family members about the recipient's desire to be an organ and tissue donor if the occasion arises; and

(C) encourage family members to request or authorize organ and tissue donation if the occasion arises.

Mr. KENNEDY. Mr. President, I have described what it is. It is information on organ transplant in behalf of Senator DORGAN and Senator FRIST.

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the question is on agreeing to the amendment of the Senator from North Dakota.

The amendment (No. 3688) was agreed to.

AMENDMENT NO. 3689

(Purpose: To prohibit the establishment of certain health plan requirements based on information relating to domestic violence)

Mr. KENNEDY. Mr. President, this amendment is in behalf of Senator WELLSTONE, and it is in regards to information relating to domestic violence. I send the amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Massachusetts [Mr. KENNEDY], for Mr. WELLSTONE, proposes an amendment numbered 3689.

Mr. KENNEDY. 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 9, line 13 insert after evidence of insurability ''(including conditions arising out of act of domestic violence);''.

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the question is on agreeing to the amendment of the Senator from Minnesota.

The amendment (No. 3689) was agreed to.

Mr. WELLSTONE. Is it the Senators' understanding that this language that we have accepted from the House bill ensures that women covered in an employment-based health plan, will not be discriminated against because of a medical condition caused by domestic violence, because of a history of domestic violence, or because of their status as a victim of domestic violence?

Mr. KENNEDY. Yes; that is my understanding.

Ms. KASSEBAUM. Yes; that is my understanding.

Mr. BURNS addressed the Chair.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BURNS. Mr. President, I thank my friend from Kansas. We are redrafting different language where one committee says the first shall be the last and the last shall be first.

I would like to yield the floor to my friend from West Virginia who has, I believe, an amendment to offer.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, the Senator from West Virginia would ask simply for 1 minute to make the following observation.

Earlier this evening there was substantial nonpublic discussion as to nondiscrimination and long-term care. There was then a very helpful, constructive, and useful colloquy on the floor which agreed that in the tax preferential treatment of long-term care, that nondiscrimination would be completely treated. There was some disagreement as to what Treasury was saying constituted nondiscrimination and what the Finance Committee staff said constituted nondiscrimination. There seemed to be a difference.

I simply, as a member of the Finance Committee, wanted to go on record as saying that the nondiscrimination aspect—this is not just racial, but we are talking just about the higher employer as opposed to the lowest employer—that nondiscrimination be done in the usual, customary, and effective manner for the tax preferential long-term care matters that we are now discussing.

AMENDMENT NO. 3690

Mrs. KASSEBAUM. Mr. President, I have here a study request that I cosponsored with Senator HELMS which would ask HHS to study options on point of service. It has been agreed to on both sides.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas (Mrs. KASSEBAUM), for Mr. HELMS, for himself and Mrs. KASSEBAUM, proposes an amendment numbered 3690.

Mrs. KASSEBAUM. 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:

Amend Title III—Miscellaneous Provisions, Section 302 (a) by striking ''two part study'' on line 19, and inserting ''three-part study'' and adding Section 302 (d):

''(d) EVALUATION OF ACCESS AND CHOICE.—Not later than June 1, 1998, the Secretary of Health and Human Services shall prepare and submit to the appropriate Committees of Congress a report concerning—

(1) an evaluation of the extent to which patients have direct access to, and choice of, health care provider, including specialty providers, within a network of providers, as well as the opportunity to utilize providers outside of the network, under the various types of coverage offered under the provisions of this Act;

(2) an evaluation of the cost to the insurer of providing out-of-network access to providers, and the feasibility of providing out-of-network access in all health plans offered under provisions of this Act.

(3) an evaluation of the percent of premium dollar utilized for medical care and administration of the various types of coverage offered, including coverage which permits out-of-network access and choice of provider, under provisions of this Act.

Mr. HELMS. Mr. President, one of the many reasons for my having opposed the Clinton health plan was the well founded fear that the American people would have been denied their right to choose their medical care. The enormous bureaucracy of the Clinton plan made that apprehension a certainty—which is why the American people rejected it.

In the interest of time, I will not offer my amendment to guarantee patients the freedom to choose their health care provider.—This amendment was originally approved by the Senate last October by a vote of 79 to 20 when we considered Medicare reform.—I have no doubt that this provision continues to have strong bipartisan support in the Senate.

However, instead of offering the original amendment I submit this amendment to require the Department of Health and Human Services to conduct a study to make certain that any changes in the health insurance market will not result in the loss of the American people's freedom to choose their health care provider.

Whether Congress considers Medicare reform or health insurance reform, patients must not be deprived of the right to choose their own doctors. Even when Congress attempts to provide access to health insurance, that is only half of the equation. Equally important is that patients must not find themselves unknowingly thrown into health care coverage that limits their freedom to choose their own health care providers.

The purpose of my provisions is to provide to Congress the information Congress may need to evaluate whether patients continue to have direct access to specialist and choice of health care provider, both in-network and out-of-network, as we make changes to the health insurance market place. It will also determine the cost to the insurer of providing this freedom to choose, and if the premium dollar collected is effectively going toward patient care.

This study will not only go a long way to provide our Nation with useful information about health care delivery, but it will also emphasize the importance of preserving the patient's freedom of choice when it comes to their own doctor.

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the amendment is agreed to.

The amendment (No. 3690) was agreed to.

AMENDMENT NO. 3691

(Purpose: To direct the Health Care Financing Administration to determine reimbursement rates for telemedicine services)

Mr. BURNS. Mr. President, I ask unanimous consent that the pending amendment be set aside.

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

Mr. BURNS. I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BURNS], for himself and Mr. HARKIN, proposes an amendment numbered 3691.

Mr. BURNS. 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 71, line 19, add the following:

"SEC. 302.5. REIMBURSEMENT OF TELEMEDICINE.

The Health Care Financing Administration is directed to complete their ongoing study of reimbursement of all telemedicine services and submit a report to Congress with a proposal for reimbursement of fee-for-service medicine by March 1, 1997. The report shall utilize data compiled from the current demonstration projects already under review and gather data from other ongoing telemedicine networks. This report shall include an analysis of the cost of services provided via telemedicine.

Mr. BURNS. Mr. President, this amendment is sponsored also by my friend from Iowa Mr. HARKIN.

The Health Care Financing Administration has been reviewing telemedicine demonstration projects across the country. They have been studying them about 2 years now. They are analyzing the cost effectiveness of providing health services via telecommunications and how to reimburse health care providers.

Telemedicine is a technology that is spreading—thankfully—because rural

areas and inner-city areas are in desperate need of health care. Getting health care services can be a challenge, especially if you are 180 miles away from a specialist. But even if that specialist is willing and able to visit his patients via telemedicine, HCFA will not reimburse him for those services. And as you can imagine, many health care providers aren't too willing to give their time without being compensated.

The study is already underway. But there is no anticipated deadline to finish the study and put the issue of reimbursement behind us. In fact, at a recent telemedicine conference, a HCFA representative stated that there would be no decision until Congress mandated one.

My amendment basically instructs HCFA to decide on reimbursement of telemedicine services by March 1, 1997. That gives them almost an entire year—in addition to the time they have already spent studying the issue—to compile their data, gather data from other ongoing demonstrations, if they choose, and determine the fee-for-service reimbursement for services provided via telemedicine.

There is no cost associated with this, since the study is already ongoing. I am simply asking that they finish the study and let rural areas and urban residents access the health care services that are currently out of their reach.

The Health Care Financing Administration has been in this process now for a couple of years and we think it is about time that they bring this to a close and recommend to the Congress how they are going to deal with it. We have this new technology. We passed a telecom bill that allows a lot of things to happen in distance learning, telemedicine, and these kinds of things, and we think it is now time that we move into the next generation of providing health care to our rural areas via telecommunications.

I appreciate my good friend from Iowa being a part of this.

I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. Is there debate on the amendment?

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I wish to congratulate the Senator from Montana for offering this amendment. I am proud to join with him in this.

When I was chair of the Labor, Health and Human Services Appropriations Subcommittee, Senator SPECTER and I initiated the funding 3 years ago for the demonstration projects for telemedicine. I know Montana was one State, Iowa was another, and there were several other States, I think Georgia, West Virginia, others that were involved in the demonstration projects in telemedicine.

One of the reasons that we had the demonstration projects was so that HCFA could develop a reimbursement means and determine how to reimburse.

We have enough data. They know. We have had 3 years of these projects. The date the Senator has there, they can do that easily. They can actually do that a lot sooner than that. I think the Senator is generous in giving them that much time.

Nonetheless, there is no doubt they have enough data—they have it now—that they can do this.

To echo what the Senator from Montana said, telemedicine will improve access to care in rural areas. It will attract more doctors to rural areas because then they will have the necessary backup they need for correct diagnosis and treatment. It will lower costs in rural areas by cutting down on travel, and it will allow more services to be done like at our rural health clinics where they can reach out over a broader area.

So this is a very good amendment and one that is going to help a lot in a lot of rural areas in the United States.

I hope it will be adopted.

The PRESIDING OFFICER. Is there further debate on the amendment?

The vote now is on agreeing to the Burns amendment.

The amendment (No. 3691) was agreed to.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The majority manager is recognized.

AMENDMENT NO. 3682 WITHDRAWN

Mrs. KASSEBAUM. I would like now to have a colloquy with the Senator from Pennsylvania. Senator SPECTER and myself and Senator KENNEDY have discussed his amendment regarding healthy start and my objection had been it was authorization on this bill which I felt needed to go through the committee with some hearings, review what has always been an appropriations matter rather than an authorization, and I believe this has been agreed to by Senator SPECTER and we will have a hearing if possible by the end of May.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SPECTER. The distinguished Senator from Kansas expresses it accurately. I think that will accomplish the purpose and lead to authorization, or a reauthorization. That is acceptable, and I formally withdraw the amendment.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The minority manager is recognized.

AMENDMENT NO. 3686, AS MODIFIED

Mr. KENNEDY. Mr. President, the Senator from California, Senator BOXER, proposed a sense-of-the-Senate. In her behalf, I have a revised sense-of-the-Senate and I ask unanimous consent that it be in order to send it to the desk and that it be in order for consideration at the appropriate time in the list of amendments.

The PRESIDING OFFICER. Is the Senator modifying the underlying Boxer amendment?

Mr. KENNEDY. The Chair is correct.

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

The amendment as modified is as follows:

At the appropriate place add:

It is the sense of the Senate that patients deserve to know the full range of treatments available to them.

Congress should thoughtfully examine these issues to ensure that all patients get the care they deserve.

Mr. KENNEDY. I will ask for a vitiation of the yeas and nays on that particular amendment.

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

The PRESIDING OFFICER. The hour of 10:15 having arrived, the question is on agreeing to the motion to table amendment No. 3683. That is the amendment offered by the Senator from Iowa, Senator HARKIN. The yeas and nays have been ordered.

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. DOLE. I wanted to get consent that votes occur in the order in which they were debated, with 1 minute of debate after the first vote to be equally divided for explanation; that all votes after the first vote be reduced to 10 minutes in length. I think that is satisfactory to the managers.

The PRESIDING OFFICER. Is there objection? The Chair hears none, and it is so ordered.

VOTE ON AMENDMENT NO. 3683

The PRESIDING OFFICER. The question is on agreeing to the motion to table the Harkin amendment No. 3683. The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. LOTT. I announce that the Senator from Colorado [Mr. CAMPBELL] and the Senator from Florida [Mr. MACK] are necessarily absent.

The result was announced—yeas 62, nays 36, as follows:

[Rollcall Vote No. 76 Leg.]

YEAS—62

Abraham	Ford	McConnell
Ashcroft	Frist	Moynihan
Bennett	Gorton	Murkowski
Bond	Gramm	Nickles
Breaux	Grams	Nunn
Brown	Gregg	Pressler
Bryan	Hatch	Reid
Burns	Hatfield	Robb
Chafee	Helms	Roth
Coats	Hutchison	Santorum
Cochran	Inhofe	Shelby
Cohen	Johnston	Simpson
Coverdell	Kassebaum	Smith
Craig	Kempthorne	Snowe
D'Amato	Kennedy	Specter
Daschle	Kerrey	Stevens
DeWine	Kohl	Thomas
Dodd	Kyl	Thompson
Dole	Lott	Thurmond
Domenici	Lugar	Warner
Faircloth	McCain	

NAYS—36

Akaka	Biden	Boxer
Baucus	Bingaman	Bradley

Bumpers	Harkin	Mikulski
Byrd	Heflin	Moseley-Braun
Conrad	Hollings	Murray
Dorgan	Inouye	Pell
Exon	Jeffords	Pryor
Feingold	Kerry	Rockefeller
Feinstein	Lautenberg	Sarbanes
Glenn	Leahy	Simon
Graham	Levin	Wellstone
Grassley	Lieberman	Wyden

NOT VOTING—2

Campbell	Mack

So the motion to table the amendment (No. 3683) was agreed to.

The PRESIDING OFFICER. Under the previous order there is a minute to be utilized by the sponsor of the bill and the opposition.

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. DOLE. Mr. President, I ask unanimous consent that after all the amendments are disposed of this evening, the vote occur on final passage of S. 1028, as amended, on Tuesday at a time to be determined by the majority leader after consultation of the Democratic leader. Let me indicate why I am doing that. Senator MACK's father passed away. He would like to make the final passage vote, unless there is some objection.

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

Mr. KENNEDY. Is it the intention of the leader that we move to third reading tonight?

Mr. DOLE. Oh, yes. I think there is only one additional vote. I believe this will be the last vote.

The PRESIDING OFFICER. Does the sponsor of the amendment wish to debate the amendment? If not—

Mr. SIMON addressed the Chair.

The PRESIDING OFFICER. The Senator from Illinois, Senator SIMON, is recognized.

AMENDMENT NO. 3687, AS MODIFIED

Mr. SIMON. Mr. President, I ask unanimous consent to vitiate the vote on my amendment and to modify it by dropping 4 words that I have given to the clerk.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The amendment, as modified, follows:

At the appropriate place in the bill insert the following new section:

SEC. . SENSE OF THE SENATE REGARDING ADEQUATE HEALTH CARE COVERAGE FOR ALL CHILDREN AND PREGNANT WOMEN.

(a) FINDINGS.—The Senate finds the following:

(1) The health care coverage of mothers and children in the United States is unacceptable, with more than 9,300,000 children and 500,000 expectant mothers having no health insurance.

(2) Among industrial nations, the United States ranks 1st in wealth but 18th in infant mortality, and 14th among such nations in maternal mortality.

(3) 22 percent of pregnant women do not have prenatal care in the first trimester, and 22 percent of all poor children are uninsured, despite the medicaid program under title XIX of the Social Security Act.

(4) Of the 1,100,000 net increase in uninsured persons from 1992 to 1993, 84 percent or 922,500 were children.

(5) Since 1987, the number of children covered by employment based health insurance has decreased, and many children lack health insurance despite the relative affordability of providing insurance for children.

(6) Health care coverage for children is relatively inexpensive and in 1993 the medicaid program spent an average of $1,012 per child compared to $8,220 per elderly adult.

(7) Uninsured children are generally children of lower income workers, who are less likely than higher income workers to have health insurance for their families because they are less likely to work for a firm that offers insurance, and if such insurance is offered, it is often too costly for lower income workers to purchase.

(8) In 1993, 61 percent of uninsured children were in families with at least one parent working full time for the entire year the child was uninsured, and about 57 percent of uninsured children had a family income at or below 150 percent of the Federal poverty level.

(9) If Congress eliminates the Federal guarantee of medicaid, an estimated 4,900,000 children may lose their guarantee of health care coverage, and those same children may be added to the currently projected 12,600,000 children who will be uninsured by the year 2002.

(10) Studies have shown that uninsured children are less likely than insured children to receive needed health and preventive care, which can affect their health status adversely throughout their lives, with such children less likely to have routine doctor visits, receive care for injuries, and have a regular source of medical care.

(11) The families of uninsured children are more likely to take the children to an emergency room than to a private physician or health maintenance organization.

(12) Children without health insurance are less likely to be appropriately immunized or receive other preventive care for childhood illnesses.

(13) Ensuring the health of children clearly increases their chances to become productive members of society and averts more serious or more expensive health conditions later in life, and ensuring that all pregnant women receive competent prenatal care also saves social costs.

(14) Although the United States has made great improvements in health care coverage through the medicaid program, it is still the only developed nation that does not ensure that all of its children and pregnant women have health care coverage.

(15) The United States should not accept a status quo in which children in many neighborhoods are more likely to have access to drugs and guns than to doctors, or accept a status quo in which health care is ensured for all prisoners but not for all children.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the issue of adequate health care for our mothers and children is important to the future of the United States, and in consideration of the importance of such issue, the Senate should pass health care legislation that will ensure health care coverage for all of the United States' pregnant women and children.

Mr. DOLE. Mr. President, I urge that the amendment be agreed to.

The amendment (No. 3687), as modified was agreed to.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The majority manager is recognized.

Mrs. KASSEBAUM. Parliamentary inquiry. Mr. President, I believe I moved to table the amendment of the Senator from Indiana, is that correct, and that I had asked for the yeas and nays at that time?

The PRESIDING OFFICER. The Senator is correct.

Mrs. KASSEBAUM. So this is a tabling motion.

VOTE ON AMENDMENT NO. 3685

The PRESIDING OFFICER. There is no debate on the amendment. The question is on agreeing to the motion to lay on the table the amendment of the Senator from Indiana, [Mr. COATS]. The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. LOTT. I announce that the Senator from Colorado [Mr. CAMPBELL] and the Senator from Florida [Mr. MACK] are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 47, nays 51, as follows:

[Rollcall Vote No. 77 Leg.]

YEAS—47

Akaka	Ford	Mikulski
Biden	Gorton	Moseley-Braun
Bingaman	Graham	Moynihan
Boxer	Harkin	Murray
Bradley	Hatfield	Pell
Breaux	Heflin	Pryor
Bryan	Hollings	Reid
Bumpers	Inouye	Robb
Byrd	Johnston	Rockefeller
Cohen	Kassebaum	Sarbanes
Conrad	Kennedy	Shelby
D'Amato	Kerrey	Simon
Daschle	Kerry	Snowe
Dodd	Kohl	Wellstone
Feingold	Leahy	Wyden
Feinstein	Levin	

NAYS—51

Abraham	Faircloth	Lugar
Ashcroft	Frist	McCain
Baucus	Glenn	McConnell
Bennett	Gramm	Murkowski
Bond	Grams	Nickles
Brown	Grassley	Nunn
Burns	Gregg	Pressler
Chafee	Hatch	Roth
Coats	Helms	Santorum
Cochran	Hutchison	Simpson
Coverdell	Inhofe	Smith
Craig	Jeffords	Specter
DeWine	Kempthorne	Stevens
Dole	Kyl	Thomas
Domenici	Lautenberg	Thompson
Dorgan	Lieberman	Thurmond
Exon	Lott	Warner

NOT VOTING—2

Campbell	Mack

The motion to lay on the table the amendment (No. 3685) was rejected.

Mr. COATS. Mr. President, I move to reconsider the vote.

Mrs. KASSEBAUM. Mr. President, I move to lay that motion on the table.

The motion to lay on the table was agreed to.

CHANGE OF VOTE

Mr. FORD. Mr. President, on amendment numbered 3681, I am recorded voting ''yea.'' Since it will not change the outcome of the vote, I ask unanimous consent to be changed from ''yea'' to ''nay.''

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

Mr. KENNEDY. I understand that Senator BOXER's amendment is ready for final disposition.

Mr. REID. Mr. President, would my friend yield for a unanimous consent request?

Mr. KENNEDY. I think I will get acceptance for the Boxer amendment.

AMENDMENT NO. 3686

The PRESIDING OFFICER. The question is on agreeing to the Boxer amendment, Amendment 3686, as modified.

The amendment (No. 3686), as modified, was agreed to.

Mrs. BOXER. 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.

CHANGE OF VOTE

Mr. REID. Mr. President, on rollcall vote 75, it was my intention to vote ''nay.'' Therefore, I ask unanimous consent that I be permitted to change my vote. This will in no way affect the outcome.

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

CHANGE OF VOTE

Mr. BRYAN. Mr. President, on rollcall vote 75, I voted ''yea'' and intended to vote ''nay.'' I ask unanimous consent that I be permitted to change my vote. This will in no way change the outcome.

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

Mr. LEAHY. Mr. President, today over 62,000 Vermonters are included in the 39.7 million Americans without health insurance. Unfortunately, this number is increasing every year. Health insurance has simply become less available and affordable, especially for small businesses and individuals. I am proud to cosponsor S. 1028, the Health Insurance Reform Act, that will address some of the issues blocking access to coverage that the uninsured face today.

This bill is a good bill and a step in the right direction. The bill increases the availability of insurance by ensuring that anyone who wants it, and can afford it, will be able to buy it. I am hopeful that provisions to encourage small employers to form voluntary purchasing pools will give some relief from rising health insurance premiums by giving them more leverage to negotiate lower premiums and better conditions of coverage.

To be clear, however, this bill does not address the larger issue of the skyrocketing cost of health care which will continue to be a looming problem that Americans face.

What the bill does do is end insurance practices that restrict the availability of insurance to people with preexisting medical conditions, or avoid enrolling or renewing coverage for older or sicker individuals and groups. The GAO estimates that up to 21 million Americans a year would benefit from federal laws waiving preexisting condition exclusions for persons who had prior coverage.

What these reforms add up to is portability of health insurance—an end to ''job lock.'' Currently, some employees are ''locked'' into their current jobs because changing jobs might subject them to periods without comprehensive coverage while preexisting condition limitations were met. Under this bill, a person with previous group coverage would receive credit from this coverage toward any new limitation period. These portability provisions do not guarantee that an individual currently insured would be covered after a job change—the new employer must offer coverage for this guarantee to exist. The GAO estimates that ending job lock will benefit as many as 4 million Americans who have stayed in their jobs due to concerns about their preexisting conditions.

The individuals who will benefit from this bill are real people who have preexisting conditions that they were born with or people who become sick or have had a severe accident. Without the Kassebaum/Kennedy bill, insurance companies can continue to impose restrictions on the coverage they offer to these people whose health conditions are beyond their control. Even worse, someone seeking insurance who has an adverse health condition can be denied insurance altogether. These are children, teenagers, young people trying to get jobs for the first time, our brothers, sisters, parents, and our grandparents. We cannot, in good conscience, risk the well being of people whose health could be dramatically affected if denied coverage for the care they need.

I am proud to say that Vermont has already addressed many of the health insurance reforms included in S. 1028. In 1991, Vermont was the first state in the nation to prohibit insurance companies from denying coverage or charging excessive rates to high-risk groups. In 1992, the state extended this to the individual market. Today in Vermont, no one can be denied health insurance at a reasonable cost from a carrier doing business in the state.

However, there is a large exception to this rule. Due to a Federal law, the Employee Retirement Income Security Act [ERISA], the State of Vermont's insurance reforms do not apply to businesses that self-insure their health benefits programs.

For example, during the health reform debate in 1994, I was contacted by a Vermont woman who shared with me her husband's experience of losing health coverage due to a preexisting condition. This gentleman had worked for the same business for over 20 years. He had a heart condition, but had always been covered under his employer's health insurance plan. When his employer was bought out by a self-insured company from another state, the new employer deemed the heart condition a preexisting condition and denied insurance coverage.

Because of stories like this, I have sought to address the issue of self-insured employer plans being exempt from State regulation because of ERISA in past Congresses. I am very pleased that a key component of S. 1028 extends these nondiscrimination and portability requirements to self-insured plans. The GAO has estimated that about 44 million Americans are in self-insured health plans that states cannot regulate.

S. 1028 is long overdue. Nearly 2 years ago, Congress was engaged in a great battle over how to get health care costs under control and make health care services available to all Americans. That battle heeded few results and left millions of Americans frustrated and disappointed that health care would continue to be out of their reach. The obstacles that prevented Americans from buying health insurance have not gone away and Congress now owes it to Americans to pass the Kassebaum/Kennedy bill to address some of the issues that these individuals face.

We must pass this bill and make the modest changes that will make it easier for people to get the health care coverage they need. I hope in the future we will be able to come to agreement on further health reforms that will address the skyrocketing cost of health care—simply requiring access to health insurance coverage does not address this looming issue.

Mr. WARNER. Mr. President, at the close of debate during the series of rollcall votes, I was prepared to vote in favor of the amendment offered by the distinguished Senator from California, Senator BOXER, proposing a Senate Resolution that the Congress fully examine administrative practices of Health Maintenance Organizations [HMO's] in which physicians may be precluded from providing full and complete medical counsel, or referral for specialized care.

I am pleased that Senator BOXER's amendment was accepted but wish to take this opportunity to indicate that had there been a rollcall vote, I would have voted in favor of the Boxer Amendment.

No physician should feel that they are being subjected to a ''gag rule'' in the course of their professional practice. Patients are entitled to a full and open discussion of all medical options and physicians should not feel restrained in the process.

LIABILITY FOR BIOMATERIALS

Mr. MCCAIN. Mr. President, I had planned to offer an amendment which would ensure the availability of raw materials and component parts for implantable medical devices. This provision is necessary if Americans are to have continued access to a wide variety of life-saving devices, such as brain shunts, heart valves, artificial blood vessels, and pacemakers. Unfortunately, we were unable to obtain agreement for this amendment from my colleagues on the other side of the aisle.

Currently, the manufacturers and suppliers of materials used in implantable medical devices are subject to substantial legal liability for

selling relatively small amounts of materials to medical device manufacturers. These sales generate relatively small profits and are often used for purposes beyond their direct control. Due to their small profit margins and large legal vulnerability for these sales, some of the manufacturers and suppliers of these materials are now refusing to provide them for use in medical devices.

It is absolutely essential that a continued supply of raw materials and component parts is available for the invention, development, improvement and maintenance of medical devices. Most of these devices are made with materials and parts that are not designed or manufactured specifically for use in implantable devices. Their primary use is in non-medical products. Medical device manufacturers use only small quantities of these raw materials and component parts, and this market constitutes a small portion of the overall market for such raw materials.

While raw materials and component parts suppliers do not design, produce or test the final medical implant, they have been sued in cases alleging inadequate design and testing of, or warnings related to use of, permanently implanted medical devices. The cost of defending these suits often exceeds the profits generated by the sale of materials. This is the reason that some manufacturers and suppliers have begun to cease supplying their products for use in permanently implanted medical devices.

Unless alternative sources of supply can be found, the unavailability of raw materials and component parts will lead to unavailability of life-saving and life enhancing medical devices. The prospects for development of new sources of supply for the full range of threatened raw materials and component parts are remote, as other suppliers around the world are refusing to sell raw materials or component parts for use in manufacturing permanently implantable medical devices in the United States.

The product liability concerns that are causing the unavailability of raw materials and component parts for medical implants is part of a larger product liability crisis in this country. Immediate action is necessary to ensure the availability of raw materials and component parts for medical devices so that Americans have access to the devices they need. Addressing this problem will solve some important aspect of our broken medical product liability system.

This issue came to my attention when I was contacted by one of my constituents, Linda Flake Ransom, about her daughter Tara who requires a silicon brain shunt. Without a shunt, due to Tara's condition called hydrocephalus, excess fluid would build up in her brain, increasing pressure, and causing permanent brain damage, blindness, paralysis and ultimately death. With the shunt, she is a healthy, happy and productive straight-A student with enormous promise and potential.

Tara has already undergone the brain shunt procedure five times in her brief life. However, the next time that she needs to replace her shunt, it is not certain that a new one will be available due to the unavailability of shunt materials. This situation is a sad example that our medical liability system is out of control. It is tragic, but not surprising that manufacturers have decided not to provide materials if they are subject to tens of millions of dollars of potential liability for doing so.

It is essential that individuals such as Tara continue to have access to the medical devices they need to stay alive and healthy. This amendment would have helped to ensure the ongoing availability of materials necessary to make these devices. It would not, in any way, have protected negligent manufacturers or suppliers of medical devices, or even manufacturers or suppliers of biomaterials that make negligent claims about their products. However, it would have protected manufacturers and suppliers whose materials are being used in a manner that is beyond their control.

Mr. President, we must act to ensure the continued availability of biomaterials to ensure that the lives of Tara and thousands of other Americans are not jeopardized. Because this is a life and death situation, I will do everything I can to assure that the Senate addresses this issue in the near future.

HEALTH INSURANCE REFORM AND GENETIC INFORMATION

Mr. HATFIELD. Mr. President, as we are all too aware, the past several months, it has grown exceedingly difficult for Members of Congress to focus their attention on anything other than sad circumstances of our Federal budget. As chairman of the Appropriations Committee, I share in the frustration. Fortunately, I am pleased to see that in the midst of our negotiations, and setbacks, excellent progress has been made in the area of health insurance reform. Senators KASSEBAUM and KENNEDY are to be commended for their efforts this past year. While compromise may not be in fashion, they have utilized this tool with extreme skill, crafting a bill that makes great strides towards improving the infrastructure of health care in the United States.

Accessibility to health care was the focus of debate in the 103d Congress and it has become our focus again. Many of you know that the State of Oregon is already on the cutting edge of improving accessibility for many groups. The Oregon Health Plan, with its focus on providing health care coverage under the Medicaid program, has successfully prioritized those health care services most important to its citizens. Oregon is therefore able to provide coverage to thousands of low-income individuals who would otherwise be uncovered. Oregon is also making progress improving its health insurance system. But issues to accessibility, affordability and portability are national issues as well.

Several of my colleagues have already discussed the merits of the Health Insurance Reform Act. As one who is about to change jobs, I strongly support the goal of increasing health insurance portability. We must keep this focus in mind. Several amendments are being offered, which I would normally tend to vote for. However, in light of our need to ensure that this reform is passed and signed, I will not be supporting such amendments. Again, several of these amendments being considered today are excellent. But if their passage only serves to make health insurance reform impossible to pass, my support would be in vain and our goal to increase portability would be unmet.

Increasing the availability and renewability of health coverage for millions of Americans is a reform Congress has sought for years. Individuals should not be refused the opportunity to renew or change health plans based on their preexisting conditions. Senator KASSEBAUM's bill addresses this problem and it is estimated it will serve over 25 million Americans each year. But I also want to thank Senator KASSEBAUM for clarifying in her bill that individuals with genetic information that predisposes them to a disease will also benefit from the Health Insurance Reform Act's portability conditions. This clarifying language is a first step toward bringing important issues surrounding genetics to their forefront. I would also like to thank Senator HARKIN for his leadership on the Labor Committee in working to see that genetic information is protected in the health insurance reform bill.

New biomedical technologies have resulted in scientific breakthroughs unimaginable just a generation ago. Scientists are working to decode our DNA and will ultimately map and sequence every gene in the human body. Such genetic research is our most advanced tool in the search for treatments and cures to diseases such as breast cancer, Alzheimer's or Huntington's disease. These are exciting medical frontiers, but if the fruit of this labor is to be realized, an unhindered commitment to genetic research must be promoted, and this includes protecting an individual from the threat of genetic discrimination. There have already been cases cited where a physically fit individual, with no previous health problems, is denied insurance on the basis of a single genetic test result.

This is a problem for two reasons. First, information about our genes tells us much about who we are, but is not accurate enough to tell us the state of our health in the future. Our future medical condition is a complex puzzle, of which our genetic makeup is just one piece. Health plans should not be discriminating on the basis of this single piece. Second, cases have been documented of individuals who wanted

to participate in a genetic test, but when they were told that their participation may threaten their insurability, they turned around and walked out of the lab.

This is not in the best interest of research; this is not in the best interest of society; and it is certainly not in the best interest of the individual. Furthermore, while including genetic discrimination in the Health Insurance Reform Act is a good start, but is just the beginning of a process aimed at protecting the privacy and insurability of individuals, regardless of their genetic information or family history.

As I mentioned earlier, it is estimated that this bill will affect about 25 million each year. I have sponsored a separate piece of legislation, the Generic Privacy and Nondiscrimination Act, S. 1416, with Senator MACK, which addresses the needs of millions of Americans who may not fit within the boundaries of the bill we are discussing today. S. 1416 also addresses issues of genetic privacy and employer discrimination. I am hopeful that the Senate's consideration of genetic information in this legislation will open the door wider to a deeper understanding of these important issues.

Mr. KENNEDY. Mr. President, I want to raise two concerns about the long-term care provisions in the leadership amendment to the Kassebaum/Kennedy health insurance reform bill.

First, under the leadership amendment, long-term care insurance receives the same tax treatment as medical insurance. Since long-term care insurance is treated as medical insurance, I want to make sure long-term care insurance provided to employees by an employer is subject to the same nondiscrimination rules as health insurance.

Second, I have a concern that the long-term care provisions in the leadership amendment (which includes the National Association of Insurance Commissioners' model long-term care consumer protections) precludes States from enacting stronger long-term care consumers protections.

Mr. ROTH. Mr. President, with respect to the first point, long-term care insurance is treated the same as medical insurance for tax purposes under the leadership amendment. Since long-term care insurance is treated as medical insurance it is intended that it will be subject to the nondiscrimination rules applicable to medical insurance provided to employees by an employer.

On the Senator's second point, it is not the intent of the leadership amendment to preclude States from enacting stronger long-term care consumer protections. A clarification of this issue can be addressed in the conference report to the bill if necessary.

JEFFORDS-SIMON AND DOMENICI-WELLSTONE AMENDMENTS

Mr. BREAUX. Mr. President, tonight the Senate voted on two amendments to S. 1028. The first offered by Senator JEFFORDS and SIMON, would increase the maximum lifetime benefit caps in health insurance plans to $10 million. The second, offered by Senators DOMENICI and WELLSTONE, would require health plans to provide mental health benefits comparable to their other medical benefits. I believe both of these amendments are good policy—providing meaningful and equitable coverage for those who purchase health insurance. Following the no amendment strategy of the bill's managers—Senators KASSEBAUM and KENNEDY—I regretfully voted to table these amendments. It is the unfortunate outcome the no-amendments strategy to have to table good policy such as these. However, the purpose is intended to maintain an important yet fragile bipartisan coalition to pass necessary insurance reform. I would otherwise support these policies.

Mr. KOHL. Mr. President, earlier today I noted the serious problem this Congress faced in 1994 when it tried to take on too many health care-related issues under one bill. We learned that painful lesson during debate on the President's health care reform proposal.

For that reason, I mentioned that some amendments that would come up today, no matter how meritorious, should be considered on future measures and not impede passage of the Health insurance Reform Act.

Several amendments required votes today that, in another context, I would have strongly supported. The issue of life-time caps, and treatment of mental health coverage were passionately debated and deserve the attention of this Congress.

My votes on these issues were not intended to approve or disapprove of their merits. My overriding concern was that they could complicate this narrowly crafted proposal and jeopardize any chance at health reform this year. The sooner we pass this bill to address insurance problems of pre-existing condition exclusions, portability and renewability, the sooner we can address other pressing problems that affect the quality of health care in this Nation.

In the interest of time, I believe we should pass a clean health reform bill. I also believe that Congress should carefully consider several of the measures that failed today as soon as possible.

Ms. MOSELEY-BRAUN. Mr. President, subpart (a)(1)(B) of Section 101, Subtitle A of Title I of the bill now before us provides that ''an employee health benefit plan or health plan issuer offering a group health plan may establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements under the terms of such plan, except that such requirements shall not be based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability.'' As I understand it, this formulation is intended to ensure that, among other things, that participants and beneficiaries are not excluded from health care coverage because they participate in activities such as motorcycling, skiing, horseback riding, snowmobiling, all-terrain vehicle riding, or other similar kinds of activities. I would like to ask the distinguished manager of the pending bill whether my interpretation of this provision is a correct one.

Mrs. KASSEBAUM. The Senator from Illinois is correct.

Mr. MCCAIN. Mr. President, Americans deserve the security of knowing that they will not lose their health care coverage if they get sick or lose their job or if they can change jobs. Currently, our system does not provide this security, and as a result many of our workers have to choose between changing jobs and retaining adequate health care for themselves or their families. Others live in fear of losing their health insurance if they lose their job. And many who have paid insurance premiums for years cannot get insurance at any price if they get sick. Clearly these Americans deserve to know that when they are sick or injured, they will get the medical attention that they need when they need it, without having to worry about losing their homes, savings and financial security.

Rather than attempting to change the entire health care system at once, this is an incremental approach which targets these specific problems. It will make it easier for those who change or lose their jobs to keep their health insurance, and by limiting exclusions for preexisting conditions, it will assure access to health care for many who are sick. By making health care portable, the legislation will allow millions of Americans to move to better jobs and improve their standard of living. And by ending ''job lock,'' the legislation will improve the fit between workers and their jobs and increase the overall productivity of American workers. Finally, this legislation will make it easier for small employers to obtain adequate coverage for their employees. As a result, health insurance will be available to more Americans.

In addition to providing portability of health insurance and limiting exclusions for preexisting conditions, this legislation contains certain other important provisions. It will increase the tax deduction for health insurance for the self-employed to 80 percent, granting long overdue tax relief to the owners of small businesses and farms. The legislation also provides tax deductibility for long term care and insurance, making it possible for more Americans to avoid financial difficulty as the result of chronic illness.

Although there is broad bipartisan support for this legislation, I am aware of the concerns that it may increase individual health insurance premiums. The legislation addresses this issue in two ways. First, the legislation imposes no limit on the rate which individual insurers may charge those with

preexisting illnesses, allowing premiums to be set at a level which would not raise costs for others. Therefore any increase in premiums which does occur will not be the result of this legislation but of how each State chooses to regulate its individual insurance market. Second, the legislation gives States considerable flexibility in how they address the requirements of the bill. This will allow States to devise strategies which fit their individual situations.

In the past several years, many States have taken significant steps to reform their health care systems, and they are to be commended for these efforts. For example, my home State of Arizona was one of the first to use managed care to improve the efficiency of publicly funded health care, and has passed legislation which encourages the use of Medical Savings Accounts. There are certain reforms, however, which only the Federal Government can make. These reforms fall in that category, and it is our responsibility to make them.

FUNDING MEDICARE FRAUD AND ABUSE CONTROL

Mr. DOMENICI. Mr. President, earlier today we adopted an amendment, now that we have had a chance to review, we find creates a concern.

In effect, in our proper and correct effort to address fraud and abuse in the Medicare Program, we converted spending that previously had been subject to appropriations into entitlement funding.

Because of the consent agreement it is too late to fix this problem.

I had an amendment, however, that would have corrected the problem.

My amendment would have provided a different funding mechanism for the Medicare fraud and abuse control program. Instead of funding this program by creating a very large new entitlement program, my amendment would have provided a different funding mechanism.

The issue is not whether we should fund the Medicare fraud and abuse control program, but how we should fund this program.

I strongly support the Medicare fraud and abuse control program, but I am troubled by the fact that the bill in its current form would create $1.5 billion in new mandatory spending for the administrative expenses for three agencies.

Congress already addressed this issue on the funding mechanism for the Continuing Disability Reviews [CDR's]. As part of the debt limit, we provided for funding for CDR's by providing a mechanism to give these programs additional funding through the appropriations process. My amendment would have essentially taken the same approach as we did with CDR's.

Mr. President, Medicare fraud and abuse control is currently funded through discretionary spending. Discretionary spending is the funding we provide annually for programs through the appropriations process.

My amendment would have replaced the unprecedented new entitlement spending for enforcement in this bill with a mechanism that would have provided an automatic upward adjustment for Medicare fraud and abuse control spending in the appropriations process.

The Medicare Fraud and Abuse Control allowance proposed in this amendment would have provided an automatic upward adjustment in the discretionary spending caps to make sure additional funding for the Inspector General of the Department of Health and Human Services, the FBI, and HCFA is not curtailed by budget limits.

However, under my amendment Congress would still have been required to annually review and fund these programs.

I want to emphasize two important points, Mr. President. First, this amendment would have done exactly what we did for increasing funding for continuing disability reviews in the debt limit bill.

Second, the policy effects for Medicare fraud and abuse control are exactly the same as in the current bill. The increased funding for fraud and abuse control would have still occurred, and the savings would still have resulted.

Mr. President, we will never gain control of Federal spending unless we gain control of entitlement spending. My amendment would have kept us from heading down the slippery slope of creating new entitlements for administrative expenses.

I hope that laying down this concern now, conferees on this bill will attempt to correct his problem before we take final action.

I ask unanimous consent that a copy of the amendment I would have offered be printed in the RECORD.

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

At the appropriate place, insert the following:

SEC. . MEDICARE FRAUD AND ABUSE.

(a) ADJUSTMENT TO DISCRETIONARY SPENDING LIMITS.—Section 251(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding the following new subparagraph:

''(I) Health care fraud and abuse control.—

''(i) Whenever a bill or joint resolution making appropriations for fiscal year 1997, 1998, 1999, 2000, 2001, or 2002 is enacted that specifies an amount for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control' for the Office of the Inspector General of the Department of Health and Human Services, under the heading 'Health Care Fraud and Abuse Control' for the Federal Bureau of Investigations, or under the heading 'Health Care Fraud and Abuse Control' for the Health Care Financing Administration, the adjustments for that fiscal year shall be the additional new budget authority in that Act for such health care fraud and abuse control for that fiscal year and the additional outlays flowing from such amounts, but shall not exceed—

''(I) with respect to fiscal year 1997,

''(aa) $14,000,000 in additional budget authority and $13,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $8,000,000 in additional new budget authority and $6,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $18,000,000 in additional new budget authority and $29,000,000 in additional outlays for the Health Care Financing Administration;

''(II) with respect to fiscal year 1998,

''(aa) $29,000,000 in additional budget authority and $28,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $17,000,000 in additional new budget authority and $15,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $78,000,000 in additional new budget authority and $89,000,000 in additional outlays for the Health Care Financing Administration;

''(III) with respect to fiscal year 1999,

''(aa) $41,000,000 in additional budget authority and $40,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $27,000,000 in additional new budget authority and $24,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $143,000,000 in additional new budget authority and $154,000,000 in additional outlays for the Health Care Financing Administration;

''(IV) with respect to fiscal year 2000,

''(aa) $54,000,000 in additional budget authority and $53,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $37,000,000 in additional new budget authority and $34,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $213,000,000 in additional new budget authority and $224,000,000 in additional outlays for the Health Care Financing Administration;

''(V) with respect to fiscal year 2001,

''(aa) $70,000,000 in additional budget authority and $68,000,000 billion in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $49,000,000 in additional new budget authority and $58,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $263,000,000 in additional new budget authority and $274,000,000 in additional outlays for the Health Care Financing Administration; and,

''(VI) with respect to fiscal year 2002,

''(aa) $88,000,000 in additional budget authority and $86,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $62,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $283,000,000 in additional new budget authority and $294,000,000 in additional outlays for the Health Care Financing Administration.

''(ii) As used in this subparagraph—

''(I) the term 'health care fraud and abuse control' means the administration and operation of the health care fraud and abuse control program including the following activities—

''(aa) prosecuting health care matters (through criminal, civil, and administrative proceedings);

''(bb) investigations;

''(cc) financial and performance audits of health care programs and operations;

''(dd) inspections and other evaluations; and

''(ee) provider and consumer education regarding compliance with the health care fraud and abuse program;

''(II) the term 'additional new budget authority' means new budget authority provided for a fiscal year for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control' for—

''(aa) the Office of the Inspector General of the Department of Health and Human Services in excess of $53,000,000;

''(bb) the Federal Bureau of Investigations in excess of $39,000,000; and,

''(cc) the Health Care Financing Administration in excess of $407,000,000; and

''(III) the term 'additional outlays' means outlays flowing from the amounts specified for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control', including outlays in that fiscal year flowing from amounts specified in Acts enacted for prior fiscal years (but not before 1997), in excess of—

''(aa) $56,000,000 in a fiscal year for health care fraud and abuse control by the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $38,000,000 in a fiscal year for health care fraud and abuse control by the Federal Bureau of Investigation; and

''(cc) $396,000,000 in a fiscal year for health care fraud and abuse control by the Health Care Financing Administration.''

(b) BUDGET ALLOCATION ADJUSTMENT BY BUDGET COMMITTEE—Section 606 of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding the following new subsection:

''(f) HEALTH CARE FRAUD AND ABUSE ADJUSTMENT.—

''(1) IN GENERAL.—

''(A) When the Committee on Appropriations reports an appropriations measure for fiscal year 1997, 1998, 1999, 2000, 2001, or 2002 that specifies an amount for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control'' for the Office of the Inspector General of the Department of Health and Human Services, the Federal Bureau of Investigations, or the Health Care Financing Administration, or when a conference committee submits a conference report thereon, the Chairman of the Committee on the Budget of the Senate or House of Representatives (whichever is appropriate) shall make the adjustments referred to in subparagraph (C) to reflect the additional new budget authority for health care fraud and abuse control provided in that measure or conference report and the additional outlays flowing from such amounts for health care fraud and abuse control.

''(B) the adjustments referred to in this subparagraph consist of adjustments to—

''(i) the discretionary spending limits for that fiscal year as set forth in the most recently adopted concurrent resolution on the budget;

''(ii) the allocations to the Committees on Appropriations of the Senate and the House of Representatives for that fiscal year under sections 302(a) and 602(a); and

''(iii) the appropriate budgetary aggregates for that fiscal year in the most recently adopted concurrent resolution on the budget.

''(C) The adjustments under this paragraph for any fiscal year shall not exceed the levels set forth in section 251(b)(2)(I) of the Balanced Budget and Emergency Deficit Control Act of 1985 for that fiscal year. The adjusted discretionary spending limits, allocations, and aggregates under this paragraph shall be considered the appropriate limits, allocations, and aggregates for purposes of congressional enforcement of this Act and concurrent budget resolutions under this Act.

''(2) REPORTING REVISED SUBALLOCATIONS.—Following the adjustments made under paragraph (1), the Committees on Appropriations of the Senate and the House of Representatives may report appropriately revised suballocations pursuant to sections 302(b) and 602(b) of this Act to carry out this subsection.

''(3) DEFINITIONS.—As used in this section, the terms 'health care fraud and abuse control', 'additional new budget authority', and 'additional outlays' shall have the same meanings as provided in section 251(b)(2)(I)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(c) CONTROL OF MANDATORY SPENDING.—Notwithstanding section 502(b) of this Act, funding for medicare fraud and abuse control provided by this Act shall only be available to the extent provided for in advance by appropriations Acts.

Mr. HARKIN. Mr. President, I am pleased to support and serve as a cosponsor of the Health Insurance Reform Act of 1995. Senators KASSEBAUM and KENNEDY have worked together in a bipartisan manner to craft legislation that every Senator should support because it will help millions of American families. As a member of the Labor and Human Resources Committee, I was proud to join in unanimous support for the bill in committee.

This is not perfect legislation. It does not fix many of the flaws in the current health care system. But it represents an important step toward reforming health care and injecting some fairness and common sense into the system.

While supportive of comprehensive health care reform in the last Congress I also offered a down payment that would have provided for insurance reform, enhanced tax deductibility of health insurance costs for the self-employed, and increased efforts to crack down on fraud, waste, and abuse in health care—all provisions contained in the bill the Senate is considering today.

Millions of Americans would benefit from the insurance reform provisions in S. 1028. Provisions that would gradually raise the percentage of health insurance costs that the self-employed can deduct from 30 percent to 80 percent over the next 10 years would provide greater equity with larger businesses. And, I am pleased that the bill includes provisions to increase funds for the inspector general to combat Medicare fraud and establish tougher sanctions for committing fraud.

Mr. President, Americans should not be denied health care coverage for changing jobs, getting sick or having a preexisting medical condition. And if someone loses their job, they shouldn't have to lose their health insurance, too. This legislation is designed to respond to those concerns.

The Health Insurance Reform Act will provide American families with more security and choices. It will offer some welcome relief for American families worried about losing their health insurance. It will help prevent people from losing their health insurance when they become sick. And it will limit preexisting conditions. These are all fundamental, necessary reforms.

I want to thank both Senators KASSEBAUM and KENNEDY for working with all the members of the committee to strengthen the bill. I am particularly grateful for their help in making sure that the legislation prohibits group and individual health plans from establishing eligibility, continuation, or enrollment requirements based on genetic information. I offered an amendment on this issue during committee consideration of S. 1028 and am pleased it is included in the bill.

I am also grateful for their help in ensuring that States are given appropriate flexibility. The legislation takes into account the progress already made by States like Iowa which just implemented additional and very significant insurance reforms on April 1 of this year. S. 1028 would allow States to preserve laws such as high risk pools that help small groups and individuals purchase insurance.

The provisions in the legislation related to preexisting conditions are important and add some common sense to the current health insurance market. The bill limits the ability of insurers to impose exclusions for preexisting conditions. Under the legislation, no such exclusion can last for more than 12 months. Once someone has been covered for 12 months, no new exclusions can be imposed as long as there is no gap in coverage—even if someone changes jobs, loses their job, or changes insurance companies.

The bill also requires insurers to sell and renew group health policies for all employees who want coverage for their employees. It guarantees renewability of individual policies.

It prohibits insurers from denying insurance to those moving from group coverage to individual coverage. It prohibits group health plans from excluding any employee based on health status.

The preexisting condition provisions will help real people who have already experienced an illness and want to switch insurers or change jobs.

For example, just last week a father from Iowa City called my office about his daughter who has a chronic health condition and will graduate from college this spring. He was worried that when she graduates and is no longer covered under his health insurance policy she will not be able to find insurance coverage for her chronic health condition.

Because the Health Insurance Reform Act would require insurers to credit prior insurance coverage, his daughter can move to another health insurance plan without being denied coverage for her preexisting condition.

The portability provisions in the bill will help with so-called job lock. Workers who want to change jobs for higher wages or advance their careers often have to pass up opportunities because it might mean losing health coverage. The portability provisions contained in

this legislation would benefit at least 25 million Americans annually according to the General Accounting Office. And, these provisions will provide greater security for the millions of Americans currently covered under group health plans.

I've heard from Iowans who have had to pass up new job offers or forego starting their own small business because they or someone in their family has a preexisting condition. Workers with a sick child are forced to pass up career opportunities because their new insurance may not cover a preexisting condition for 6 months or more. These families have played by the rules and have been continuously insured—they deserve to know that if they pay their insurance premiums for years, they cannot be denied coverage or be subjected to a new exclusion for a preexisting condition because they change jobs. The Health Insurance Reform Act would allow people to switch jobs without worrying about denied coverage for preexisting conditions.

Many States, including Iowa, have already enacted standards for insurance carriers. In fact, legislation passed in Iowa is more comprehensive in many respects and includes provisions that help make insurance more affordable for small groups and individuals. But, Federal legislation is necessary because States are prevented from regulating self-funded health plans—the type of plans that cover the majority of Iowans. This legislation will also provide a national floor and a guaranteed level of protection for all Americans.

I support this bill and urge my colleagues to not offer amendments that will weaken it. We should keep this bill free of the objectionable provisions that were included in the House bill—provisions which will surely prompt President Clinton to veto the bill, and that will ultimately deny long-needed assistance to millions of middle-class American families.

ORGAN DONATION INSERT CARD ACT

Mr. DORGAN. Mr. President, first and foremost, I would like to thank the distinguished managers on both sides for agreeing to include this critical provision in the Health Insurance Reform Act.

The Senate's passage of the Organ Donation Insert Card Act is particularly timely. Next week is National Organ and Tissue Donor Awareness Week, and the need for organ and tissue donors is more crucial than ever. Right now, the national waiting list for an organ transplant has topped 45,000 people, and a new name is added to the list every 18 minutes.

The Organ Donation Insert Card amendment represents a simple, cost-effective way for the Federal Government to help save the lives of those who are waiting for an organ transplant. The amendment will provide millions of Americans with organ and tissue donor information with their income tax refund checks in 1997. This one-time insert will give taxpayers the opportunity to learn more about this important subject and to fill out cards to become donors.

Each year, we miss thousands of opportunities for organ transplantation because of a hesitancy among next-of-kin to authorize donation when they do not know their loved ones wishes. Of the 20,000 deaths each year that fulfill the medical criteria for becoming organ donors, only about one-fourth actually become donors.

As a result, eight people die every day while waiting for a transplant. At least some of these deaths could be prevented through the information campaign authorized by the Organ Donation Insert Card Act.

I understand that authorizing donation is a difficult decision for a grieving family to make, and their task is made much harder when they do not know their loved one's wishes. For that reason, I would like to take a moment to acknowledge a few of the families I have heard from who authorized donation.

Gary and Bobbie Schroeder say they did not give a lot of thought to organ transplantation. I suspect that is true for many of us.

But on November 26, 1989, their 21-year-old son Jeff was in a fatal car accident. Gary wrote to me,

> Jeff was a 4th year pre-med college student in Southern California, when he and his roommate, returning from playing in a college basketball tournament, ran into wet and slippery roads and had a single car accident. Jeff sustained a head injury, even though wearing his seat belt, causing brain death. * * *

Jeff was on life support, but tests showed absence of brain activity, and he was declared brain dead 4 days later.

We were then given the opportunity of making a decision that would give some purpose to a tragic situation. * * * Donating Jeff's organs gave us the opportunity to start the healing process. * * *

Jeff was a giver in life, always helping others; we know he would want to continue helping others, even in death.

Jeff's organs helped sustain life to four other individuals, by giving his heart, liver, and kidneys. He helped give hope and extended life to the recipients and their families. Our decision to give has been a step toward healthy grieving, and we would make the same decision again.''

Patrick Pins, a high school Social Studies teacher in Mandan, ND, also knows firsthand the difficult decision that families face when a loved one dies. In 1992, his wife Barbara was attending a family reunion with her family when she developed a severe migraine, nausea, and neck pain. Although she was rushed to the hospital, she had suffered severe brain trauma and died within 24 hours of arriving at the hospital.

While only a machine kept Barbara's body alive, Patrick and the couple's three children struggled with their grief and talked and prayed. Ultimately, they decided to donate Barbara's organs.

Today, like the Schroeders, Patrick says that confronted with the same decision again, ''I'd do the very same thing.''

Throughout her life, Barbara's family and friends say the popular Head Start teacher constantly gave of herself and taught the children in her care and the people around her important lessons. Through the donation of her organs, she has been able to do the same even in death.

As I have worked for the enactment of this bill, I have also been motivated by the many families who have shared with me their stories of agonizing months spent waiting for a suitable organ and of the joy of receiving a chance to live. I think it would be appropriate to share some of those stories to remind us all that there are names and faces behind the statistics.

Donna Grendahl is a Minnesota mom whose son, ROBBY, received a heart transplant in 1986. In her letter to me, Donna wrote:

> My son received the gift of a new heart in transplant surgery 9 years ago. * * * Now 9 years later, he is a 24-year-old college graduate. He teaches American history/civics and coaches hockey and baseball at the high school level. * * *
>
> Thanks to the availability of a donor, he has been able to enjoy the gift of his second chance at life to the fullest.

Bonnie Simonet, a wife and mother and a double-lung transplant recipient, told me: ''I suffered for 10 years with a disease to my lungs. . . .

> Oxygen kept me alive, but my lips and fingernails were blue. I was on oxygen 24 hours a day, and I was only 47-years young, which I consider too young to die. I had a life left to live. . . .
>
> When my doctor suggested a lung transplant, it seemed so drastic, but I wanted to live. I went through a week of evaluation, many tests and had to get approval from my insurance company. When this was set in motion, I was put on the waiting list for a double lung transplant. . . .
>
> On August 4, 1994, after waiting on the list for 9 months, I was called. . .. I was in surgery 6 hours and came out a new person with a 2nd chance at life and a new attitude about what is important.

Janet Johnston's 19-month-old grandson, Colton, is alive today because he received a new liver. According to Janet,

> My grandson, Colton, went through his first surgery at a month and a half old, which didn't take care of his problem. He was put on a list in January for a liver transplant. We waited six long months, always worried if he was going to live long enough before a liver became available. On July 16th we got our gift.
>
> We are pleased to support your proposed ''Organ Donation Insert Card Act. Please continue to work hard. There are people who do benefit and have happy endings.

Finally, Gary Rux, a heart transplant recipient shares his story:

> I recently received a copy of your proposed legislation for an ''Organ Donor Insert Card.'' I want you to know that I support this legislation with all of my new heart. . . .
>
> I have firsthand knowledge of what it is like to spend over 2 years dying, not knowing for sure if I would be around to provide

for my family. In spite of the time I spent waiting for a heart, I ask that you offer no sympathy to me. I am one of the lucky ones. . . . There are many, however, who are not so lucky. It is they who need and deserve our sympathy. Fortunately for them, you are in a position to do more than simply offer sympathy. I thank you on behalf of the many individuals who are waiting, and dying, at this very moment. Bear in mind as you promote this legislation that some of these individuals who are dying are just children. I believe they deserve a chance, and with your and our support, perhaps they can have that chance.

Fortunately, these stories all have happy endings and they are heartwarming to hear, but we must also remember the many families who do not have a happy ending. In my view, the most common tragedy of organ transplantation is not the patient who receives a transplant and dies, but the patient who has to wait too long, dying before a suitable organ can be found.

But today, the Senate has taken a step to prevent some of these needless deaths.

In closing, I want to thank the many organizations and supporters who have endorsed this bill and that worked tirelessly for its enactment. I also want to mention my Senate colleagues who have cosponsored the bill, Senators BRADLEY, COCHRAN, DEWINE, FRIST, HELMS, INOUYE, BOB KERREY, JOHN KERRY, LEAHY, LEVIN, MOSELEY-BRAUN, MURKOWSKI, ROBB, AND SIMPSON.

Finally, I want to again thank the managers, Senators KASSEBAUM and KENNEDY, for accepting this amendment, and I look forward to working with them to retain it in conference.

Mr. KYL. Mr. President, the U.S. Congress has begun the debate on legislation that will affect the way millions of Americans get their health insurance. Both the House and the Senate bills are intended to address a serious concern among millions of working Americans who currently have employer provided health insurance: the threat of losing private health insurance when they lose or change jobs or, try to obtain coverage when they have a preexisting medical condition.

The Kennedy-Kassebaum bill contains some useful provisions and addresses some important problems in the health insurance market. However, I believe these problems are more effectively addressed in the health insurance reform plan passed on March 27 in the House of Representatives—and reportedly contained in the Finance Committee amendment.

I believe the Kennedy-Kassebaum bill could be improved and expanded by incorporating important provisions in the House bill—and in the proposed Finance Committee amendment. These provisions more successfully address the health care problems faced by millions of Americans, such as:

The Problem: An ambitious worker who wants to pursue a career opportunity, but can't change jobs because his son has cancer, and wouldn't be covered by a new employer's insurance.

The Solution: The House bill guarantees that anyone with employer provided insurance can move to another job with employer provided insurance without losing coverage for a preexisting condition.

The Problem: A worker is laid off, and can't get coverage for a preexisting condition in the individual market.

The Solution: The House bill includes group-to-individual portability, so that when you leave a job that provided coverage for a chronic condition, you cannot be denied coverage in the individual market.

The Problem: An uninsured entrepreneur who can't afford insurance as a self-employed person today.

The Solution: The House bill allows the self-employed to deduct 50 percent of their premiums from their taxes. Increasing deductibility makes health insurance more affordable for self-employed individuals. The Finance Committee amendment may increase the deduction to 80 percent.

The Problem: An uninsured person, out of work, who can't afford a costly individual policy because it is loaded down with State mandated benefits.

The Solution: The House bill includes medical savings accounts, so that an individual can buy a high-deductible policy, with a much lower, more affordable premium.

Mr. President, MSA's offer the ultimate in portability and affordability, and I want to further address this critical issue later in my remarks.

The Problem: A small business employee, whose employer can't afford to purchase insurance for his five employees, because one of them has a chronic illness.

The Solution: The House bill allows small businesses to group together to purchase health insurance.

By grouping together, they can share risk and spread administrative costs over a larger group, lowering premiums for everyone.

These ERISA regulated arrangements would be exempted from state mandated benefits and pooling prohibitions that can drive up the cost of care.

The Problem: The federal tax code often discourages citizens from providing for their own health care needs.

The Solution: The House bill provides for tax deductibility for long-term care insurance premiums and expenses and, tax free use of accelerated life-insurance benefits for health expenses.

The Problem: Fear of frivolous lawsuits and outrageous recoveries forces many doctors to practice costly ''defensive medicine.''

The Solution: The House bill reforms medical malpractice claims. Patients who are injured as a result of malpractice deserve to be fully compensated.

But in today's system, an enormous amount of money that should be dedicated to health care spending goes instead to lawyers—sometimes as much as 40 percent to 50 percent.

The Problem: Fraud, waste, abuse and administrative inefficiency cost the health care system billions per year in wasted resources.

The Solution: Tougher penalties for waste, fraud, and abuse along with administrative simplification through electronic billing and uniform forms.

II. Mr. President, during this debate I plan to support the proposed Finance Committee Amendment. The provisions in this amendment will increase portability, tax equity, and affordability.

Mr. President, it is my understanding that the following provisions will be included in the Finance Committee Amendment to the Kennedy-Kassebaum Health Care Reform Act: an increase in the self-employed health care tax deduction to 50 percent or higher; medical savings accounts providing for deposits of $2,000 for individuals and $4,000 for families; deductibility for long-term care premiums and expenses; and, tax-free treatment of accelerated death benefits for the terminally ill.

Mr. President, assuming these provisions are included in the committee's amendment, it would not be my intention to offer any amendments; further, I would not object to a unanimous consent (UC) agreement.

However, in the event that any of the above provisions are not included in the amendment, I will offer and support amendments to replace these provisions.

III. The importance of MSAs. MSAs are one feature of the House bill—and reportedly the Finance Committee Amendment—that will increase the portability, availability, and affordability of health insurance. MSA are a simple, low cost alternative to traditional health care insurance for the millions of Americans who cannot afford today's health insurance options or, who are not happy with available insurance options.

Here is how an MSA can work: The employer purchases a high-deductible health insurance policy and places an amount of money equal to the employees' deductible in a special savings account called a medical savings account. The money in the MSA, tax-free, to cover most medical costs. The individual keeps what is not used after one year, collects interest, and the balance rolls over into the next year, when the employer makes additional contributions to the account.

In addition to covering basic medical services, these funds can be used to cover services not covered by health insurance, such as elective surgery and long-term care. Money accumulated in an MSA can only be withdrawn for medical expenses as established by the Internal Revenue Code. For MSAs to receive the same tax treatment as employer-provided health benefits plans, a high-deductible plan would have to be combined with the MSA. A high-deductible plan would have a deductible of at least $1,500 in the case of an individual, and $3,000 for a family. Individuals—including the self-employed—could make tax-deductible contributions: up to $2,000 if single, $4,000 if married. The inside build-up would be tax-free. The amounts could be withdrawn from the MSA tax- and penalty-free if used for medical purposes. Employer contributions to an MSA would

not be taxable to the employee on whose behalf the contribution is being made.

While Congress has been considering MSAs, many companies have gone ahead on their own and have developed highly successful MSAs or MSA-type programs. A March 1995 study by the Evergreen Freedom Foundation analyzed the experience of 1037 companies nation-wide who had implemented MSAs. For instance, in 1994, the Valley Surgical Group Health Plan of Phoenix implemented an MSA plan for its 14 employees. According to the Evergreen Report, annual employer costs were reduced by $400 per employee in the first year alone. Mr. President, here is why MSAs will work:

1. Parity in tax treatment: MSAs grant high-deductible health plans—paired with an MSA—comparable tax treatment to that of other forms of employment-based group health plans, and allow people to claim the deduction even if they do not otherwise itemize taxes.

2. Positive incentives: MSAs provide Americans the incentives to purchase health care more carefully by letting them keep what they don't spend.

The current unlimited exclusion for employer-based health care encourages unnecessary spending.

3. Major medical protection: MSAs insure that the necessary coverage will be there in the event of an illness or accident.

4. The ultimate in portability: MSAs provide for real portability. Unlike other forms of employer-based health plans, medical savings in the MSA can be taken from job to job.

5. More choices for consumers: The MSAs empower people to make their own health care decisions.

Funds in the MSA may be spent, on qualified medical expenses that may not be covered under high-deductible plan (e.g., prescription drugs, durable medical equipment, etc * * *).

6. MSAs Help meet long term care needs: MSAs will help people who want to protect themselves against future long-term care needs.

MSA funds can be used to purchase long-term care insurance or services.

7. States are moving toward MSAs: Arizona is one of 15 states that have already passed laws granting favorable tax treatment to MSAs.

The failure to establish federal tax rules regarding MSAs will inhibit innovations that many states have decided is good health policy.

Mr. President, in spite of the overwhelming evidence that MSAs are a viable health insurance alternative with wide appeal, there are still a few who say MSAs favor only the healthy and wealthy. This is inaccurate. While MSAs will be attractive for the healthy, they will be equally attractive for the sick. The reason: The MSA gives individuals the ultimate freedom to choose their health care providers, thereby allowing individuals to seek out the best health care services that meet their budget.

The accusation that MSAs will work only for the wealthy is also inaccurate. According to a 1996 analysis by the Joint Committee on Taxation, middle-income Americans will choose MSAs. According to the Joint Committee, one million Americans are expected to sign up for MSAs. An estimated 650,000 people who earn between $40,000 and $75,000 a year would chose MSAs., 120,000 with incomes between $30,000 and $40,000 would choose MSAs.

MSAs could lower overall health care costs. Voluntarily uninsured workers might receive an incentive to obtain health insurance as a result of MSAs. Younger, healthier workers who don't purchase health insurance because they believe they will never get sick, would now have an incentive to be covered against major illnesses as a result of MSAs. This would increase the number of healthy people in the insurance pool and would lower overall health costs.

Are supporters of MSAs out of the mainstream? No. As part of the Kennedy/Kassebaum bill, the Labor Committee passed a ''Sense of the Committee'' resolution that said:

> It is the sense of the Committee that the establishment of medical savings accounts . . . be encouraged as part of any health insurance reform legislation passed by the Senate.

Also in the Kennedy/Kassebaum bill, there is a provision that allows Medicare risk HMOs to offer medical savings accounts.

The Democratic support MSAs. In 1994, all the Democrats on Ways and Means voted to include MSAs in the Clinton plan. In 1994, Representative Gephardt included them in his Democratic Leadership bill. In 1992, Senator JOHN BREAUX introduced a bipartisan MSA bill. Senators TOM DASCHLE, SAM NUNN, Alan Dickson, RICHARD SHELBY, David Boren co-sponsored the legislation. In 1994, Senator PAUL SIMON was a cosponsor of MSA legislation.

Mr. President, MSAs are one of the keys to portability, affordability, and choice of health insurance for millions of Americans. I believe the Senate must pass MSAs.

The PRESIDING OFFICER. The question is on agreeing to the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

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, was read the third time.

The PRESIDING OFFICER. Under the previous order, the clerk will report H.R. 3103.

The legislative clerk read as follows:

> A bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage, and for other purposes.

The PRESIDING OFFICER. By previous order, all after the enacting clause is stricken and the text of S. 1028, as amended, is inserted in lieu thereof and the bill is deemed read a third time.

Under the previous order, the vote on final passage will occur on Tuesday, April 23, at a time to be determined by the majority leader.

MORNING BUSINESS

Mr. ABRAHAM. Mr. President, I ask that there now be a period for the transaction of routine morning business, with Senators permitted to speak for up to 5 minutes each.

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

CONGRESS MUST STOP JUNK GUN VIOLENCE

Mrs. BOXER. Mr. President, in 1968, Senator Robert Kennedy was assassinated in California by an assailant carrying a junk gun. That terrible event convinced Congress that something had to be done about the dramatic increase in gun violence. Specifically, Congress concluded that it had to act to stem the proliferation of these junk guns, or as they are also known, Saturday night specials.

Later that year, Congress passed the Gun Control Act of 1968, which barred the importation of junk guns. The guns affected by the import ban had several things in common: They were cheap. They were poorly constructed, and they lacked important safety devices.

Shortly after the passage of the Gun Control Act, unintended consequences began to emerge. Many new companies were formed to manufacture junk guns domestically. Protected from foreign competition and given a virtual monopoly over the U.S. market, the domestic production of junk guns skyrocketed. In fact, all of the companies that produce today's criminals' favorite junk guns were founded after 1968.

In 1972, Congress tried to end the double standard that allows the domestic manufacture of junk guns. Sixty eight Senators—including BOB DOLE and STROM THURMOND—voted to close the loophole permanently. Unfortunately, despite its more than two to one support in the Senate, that bill was killed in a House committee.

Along with my cosponsors, JOHN CHAFEE and BILL BRADLEY, I have introduced legislation, S. 1654, that is closely modeled after that 1972 bill.

The principle of that bill that passed the Senate so overwhelmingly nearly 25 years ago and the bill I have introduced is simple: if a gun is such a great threat to public safety that its importation is banned, then its domestic manufacture should also be prohibited. Its point of origin is irrelevant.

By every measure, the problem of gun violence has grown worse since passage of the Gun Control Act. This indisputable fact was most recently demonstrated in the release last week of a study by the Children's Defense

Fund. Among CDF's findings was the chilling statistic that a child dies from gunfire every 92 minutes in the United States. And over the last 10 years, the rates of child gun deaths have nearly doubled.

A Center for Disease Control survey found that on an average day, 1 in 20 high school students carries a gun to school. But it is not just a high school problem. A few years ago in San Francisco, a 7 year old second grader was suspended for bringing his mother's junk gun to school, where he threatened to shoot a classmate.

What can we do to fight this problem? One Step is to end this junk gun double standard.

In my State of California, a bill to prohibit the manufacture and sale of junk guns passed the State senate last year, but was blocked in an assembly committee in January.

However, this is a problem that the U.S. Congress created, and it is one that the Congress should fix. Clearly, a nationwide ban would be the most effective way to keep these firearms out of the hands of criminals.

My bill applies prospectively only. It does not affect any guns currently in circulation.

I am proud that my legislation has been endorsed by the California Police Chiefs Association and the chiefs of some of California's largest cities including Willie Williams of Los Angeles, Fred Lau of San Francisco, Art Venegas of Sacramento, and Louis Cobarruviaz of San Jose. In all, 27 California police chiefs and sheriffs have endorsed my legislation. It has also been endorsed by the Coalition to Stop Gun Violence, a leading national antiviolence organization.

I am introducing this measure at the same time that Congress is moving backward on gun issues by reopening the assault weapons ban. I am confident that with the leadership of President Clinton, Senators DIANNE FEINSTEIN, PAUL SIMON and others, we will defeat efforts to roll back our progress on assault weapons, but I believe that just holding our ground is not enough. We must continue to move forward.

What is a junk gun? There are many differences between models, but they have certain traits in common. They are small and light, which make them highly concealable. They are made of inferior materials like zinc, instead of higher quality metal alloys. And they lack important safety features that can help prevent accidental shootings. Junk guns are cheap—some can be bought for as little as $69. The most striking feature in common is that junk guns are used disproportionately in crimes.

One recent study conducted by the U.C. Davis Violence Prevention Center found that junk guns are 3.4 times as likely to be used in crimes as are other firearms. This view was confirmed by Chief Ronald Lowenberg, president of the California Police Chiefs' Association who wrote to me, ''There is no doubt that 'Saturday Night Specials' are disproportionately represented in homicides and other crimes.'' According to the Bureau of Alcohol, Tobacco, and Firearms, of the 10 guns most frequently traced at crime scenes, 8 are junk guns.

Junk guns' price and concealability—the factors that make them so attractive to criminals—are also the factors that make them unsuitable for general use.

What about junk guns for hunting and target shooting? According to firearms experts, they are totally unsuitable because of low accuracy and high failure rates. And what about home and self protection? Again, junk guns are ill suited for the job. These guns are inaccurate, poorly constructed, and lacking important safety features. Keeping a junk gun in the house is an invitation to disaster.

I know of one case in which a man was killed when his gun fell from its holster as he bent over to get a drink of water from a fountain. In another case, a man was critically injured when a junk gun he kept in his car fired when the car hit a bump in the road. These tragedies could have been prevented if these junk guns had better safety features.

I plan to fight hard for this bill, and I am confident that with the strong support of law enforcement and citizens' groups around the country, we will prevail.

TRIBUTE TO EDMUND S. MUSKIE

Mr. SARBANES. Mr. President, I wish to pay tribute to our wonderful colleague and dear friend Ed Muskie who passed away late last month. A distinguished public servant, an accomplished legislator, and a man of great integrity and humanity, Edmund Sixtus Muskie represented the best of the Senate and of the Nation.

Throughout his career in public service Senator Muskie exhibited a rare and remarkable gift; his extraordinary ability to see opportunities where others could not and to translate those opportunities into positive changes for the people of Maine and the Nation.

Ed Muskie began his career of dedicated public service in the Maine Legislature where he initially served as part of a small Democratic minority. From this modest beginning, he assumed the reins of the Maine Democratic party and revitalized it by exercising the vision and leadership necessary to involve people more fully in the political process. His efforts led to his own election as Maine's first Democratic governor in 20 years, and in 1958, he became the first popularly elected Democratic Senator in Maine's history.

But the depth and breadth of Ed Muskie's vision extended far beyond Maine politics. Upon his arrival in the U.S. Senate, he continued to exhibit the same straightforwardness and independent thinking that won him the trust of the citizens of Maine. These traits enabled him to make the Environment and Public Works Committee the forum which produced this Nation's landmark environmental protection legislation, the Clean Air Act and the Water Quality Act. These critical environmental statutes changed the way Americans view our precious natural resources and his work provided the foundation upon which all subsequent environmental protection statutes have been built.

In addition, his efforts were instrumental to the passage of the Congressional Budget Act of 1974, establishing the beginnings of the modern coordinated Congressional budget process. As the first chairman of the Senate Budget Committee, Ed Muskie was committed to the effective disciplined Federal spending; demonstrating that promoting fiscal responsibility and meeting the needs of our people were complementary objectives.

Throughout his lifetime of public service, Ed Muskie was a man his country could turn to in a time of crises. As a U.S. Senator, a vice-presidential and then presidential candidate, and as Secretary of State, he demonstrated an unsurpassed commitment to improving the welfare of all Americans. In his candid, forthright and honest way, he encouraged the free exchange of ideas within the democratic process, working to transcend partisan boundaries and foster what he called a ''politics of trust'' in this Nation.

One of his many legacies to our country is the large number of former Muskie staff members who under his leadership made such extraordinary contributions to our Nation's welfare. Many of these individuals continue to render dedicated public service and they constitute a national asset which is yet another tribute to Ed Muskie's sterling qualities.

Mr. President, I would like to take this opportunity not only to honor the life and service of Edmund Muskie, but to extend my deepest and heartfelt sympathies to his wife, Jane, and to his children, Stephen, Ellen, Melinda, Martha, and Ned, and their families. We thank them for sharing their husband and father with the Nation—America is a far better place for Ed Muskie's contributions.

On Saturday, March 30, 1996, an exceptionally moving service for Ed Muskie was held at the Church of the Little Flower in Bethesda, Maryland, followed by burial at Arlington National Cemetery. At that service, eloquent and heartfelt eulogies were delivered which greatly moved all of us who were present. In testimony to Ed Muskie's life of quality and honor, I ask unanimous consent that these eulogies be printed in the RECORD.

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

REMARKS BY STEVE MUSKIE

Rev. Clergy, President and Mrs. Carter, Ed Muskie colleagues, family and friends. From

my mother and everyone in our family, I want to thank you for coming here today to remember and honor my father. I expect that you will hear others speak about Dad's political life and the work he did over his long career of public service. But I would like to take a few minutes to tell you a little about some of the things that we, his wife, children and grandchildren, remember fondly. Thursday night we had a family dinner to celebrate Dad's 82nd birthday. We drank a toast to him, sang happy birthday and the youngest of Mom and Dad's seven grandchildren blew out the candles on two birthday cakes that we brought to the party. Of course, the celebration was bittersweet because Dad was not physically present. But he was present in spirit, in the thoughts of all of us who learned from him and loved him, you could see and hear the evidence all around the room—in the sixteen people there—some blood relations others bonded by marriage into the Muskie family. I saw it in their mannerisms, vocal inflections, proclivity for puns or quiet contemplation, in a hearty laugh or a mischievous twinkle of an eye. They were the telltale signs of Dad's lasting imprint on our lives. We have all been recalling images of Dad, many of which had been lost for a long time, tucked away in the recesses of our memories.

For me, one of the most vivid is an image of cold summer mornings at our Birch Point cottage on Maine's China Lake, forty years ago. The odor of smoke and the crackling sound of a fire just coming to life greeted Ellen and me when we padded down the stairs and climbed on to Dad's lap as he sat next to the fireplace in a big leather chair. While we warmed ourselves by the fire it was Dad's way to repeat the story that we most enjoyed hearing, a tale of young Biddo Bear who woke one cold morning, just as we had, and went with his father on a fishing trip. The story was replete with the kind of sound effects the public never heard from Dad during speeches. For example, Dad talked about Biddo Bear's father's tug on the starter cord of their small boat's outboard motor—Paroom! Putt-putt-putt! ''They drove down the lake to catch some fishes,'' he said. That was a time when Dad was governor and the demands on his time were less than they were by the time the last of his children were almost grown. My brother Ned recalls that even when Dad was secretary of state, he regularly showed up at school, casually dressed and surrounded by security agents to attend a baseball game in which Ned might be pitching or to help Ned haul luggage and boxes into a new dormitory room. Ned of course swears the security agents didn't do any of the work.

Another powerful image is of Dad seated at the dining table surrounded by several of the youngest grandchildren. They always wanted to be near him at meal time, because he inevitably played games with them, walking his fingers across the table to tickle them or to catch their tiny hands in his big ones until Mom gently chastised him ''now stop that poppa.'' The kids grinned feeling they had gotten away with something. As much as I would like to stand here displaying my photographs of Dad, these images and others like them are much more powerful than those captured by a camera because they improve and evolve with age and the mix of other memories we recall. They will never leave us. However wonderful and comforting those images are, more important are the lessons we learned and the characters we developed as a result of watching and trying to follow Dad's strong examples. My youngest sister, Martha, told me yesterday that her interest in social work really grew from some of those examples. She said:

''Dad believed that all people really are equal. That the color of your skin, the source of your beliefs, where you live or how much money you have doesn't matter.''

When Greg Singleton, from the SW side of Washington, lived with us for several summers, ''It was never any question,'' said Martha, ''that he would be treated exactly like the rest of us.'' Martha's statement made me realize that we have all grown up and lived under the strong influence of both the public and private Ed Muskie. Today we acknowledge our love and gratitude and share with you a celebration of his life.

REMARKS BY LEON BILLINGS

People who loved Ed Muskie, welcome. As was so often the case in the thirty years I worked for Ed Muskie, 15 of which I was paid, I have the honor of speaking for the staff. Those who actually worked for the Senator and those he thought worked for him. The nameless, faceless staff. A couple of years ago, I had lunch with the Senator. By then I was in my early 50s, about the same age he was when he hired me. I decided that I could start calling him Ed. So we sat down and I used his first name and he looked at me and said, so its going to be Ed now is it? So Senator * * * Before I tell a couple stories I remember of some of our lighter moments, I want to say something about your role as this nation's most important environmental leader. Many times you would take a globe of the earth in your hand and point out that the earth's atmosphere was no thicker than that thin patina of shellac that covered that globe. And you would say, ''that's all that protects human life. That thin layer, no thicker than that layer of shellac is all that is between humankind and extinction.'' That analogy in simple terms stated your commitment to achievement of a healthy environment. A concept you invented, a concept you institutionalized and a concept that you internationalized. You changed the way the world acts towards the environment. That legacy will endure as long as people breathe on this earth. From the Clean Air Act of 1970 to Global 2000 as Senator and Secretary of State, you took a problem too few people cared about and converted it into a movement and then into a reality. I recall after the Senate unanimously passed the Clean Air Act in 1970, Senator Eugene McCarthy said to Senator in the elevator, he said ''Ed,'' (he could call him Ed) he said, ''Ed you found an issue better than motherhood, there are even some people opposed to motherhood.'' So everyone here, please take a deep breath, and while holding that breath think just for a moment that each of us, our children, our grandchildren and the children of centuries yet to come, owe a single debt to you, Senator Muskie.

Sometimes working for you wasn't a day at the beach. But we were rewarded by your brilliance, your courageousness and your creative public policy mind. You evinced incredible loyalty. People stayed with you for years, for decades. What a luxury it was to be associated with someone about whom there were no doubt, no doubts about intellect, commitment and integrity. And Senator you gave us a lifetime of stories. Some are even repeatable. Each of us has a favorite and I'm going to tell a couple. Senator Muskie was an avid fisherman and though I was never invited to accompany him, I want to recall two occasions both of which involved President Carter. On the way back from the funeral of Prime Minister Ohira in Japan, the President and Senator Muskie went fishing in Alaska. And when they came back I learned that the President had caught many fish, and the Senator got one. I asked him to explain the difference and he said gruffly, ''its easy to catch them if the secret service ties them down.'' And you know that's all the explanation I got!

On the other occasion, and this will be particularly memorable to some of you who are on the Senate staff. I was on the Senate floor during a budget debate and he called me over. I assumed he wanted my advice on the issue at hand. He said, ''I can't find my fishing pole.'' He said, ''President Carter is coming to Maine to fish and I can't find my fishing pole.'' So I called Gayle Cory, the longest and the loyalist of the Muskie staffers. She was out at his house and I asked her to find the pole and I went back and said, Gayle is at the house and she'll find the pole. And he said, ''Gayle wouldn't know what a fishing pole looks like.'' Needless to say, Gayle found the pole, I didn't have to go out to the house to look for it, and I never learned how many fish he caught on the trip.

I want to close with one story which will be poignant to those who had the opportunity to travel with the Senator, and particularly to Jane, I think. The Senator always took the window seat on the airplane and the staff, and Jane, sat on the aisle to ward off intruders. It was his want to get on a plane and lose himself in a book or magazine and sometimes not talk to anyone for the entire five hour trip. On the occasion that Eliot Cutler remembers on a trip to Los Angeles, the Senator said not a word and at the end of the trip as they arrived to the gate, Eliot got up to proffer him his coat and he looked at Eliot and he said ''what are you doing here?'' He is smiling now, because I suspect he would say to us today, ''what are we doing here?'' Senator we came here to say good-bye. We came here to say thank you for five decades of public service and personal friendship and most of all, we came here to thank you for being the first steward of the planet earth.

REMARKS BY MADELEINE ALBRIGHT

Dear friends, my heart is sad for I have lost a friend. I asked myself why I feel such a void. Its not only the personal memories, memories that I share with many of you, although that is surely a part of it. It is also the fear that what Edmund Muskie represented, what he lived for and stood for, might somehow go with him. He has been our connection to each other, he has been our link to a proud democratic heritage. He gave validity to a vision of our country and service to it that has influenced each of our lives. There is an army of us in Washington, Maine and around the country who worked for him as he rose through the ranks of service to America. Whether we were interested in state government or just plain good government, clean air and water, a budget process that worked, a generous foreign policy that reflected our goodness and strength or just because we believed that politics and principles go together. He attracted us. Even today, when members of the Muskie team see each other any where, we exchange the political equivalent of the high-five. The reason that such a diverse group would have so much in common is that Ed Muskie didn't see his public service as compartmentalized. The federal government was not the enemy of state government. Democrats could work with Republicans. A healthy environment was important not only here, but globally. While as budget chairman, he often asked what was so liberal about wasting money, he worried about jobs and he never denied the resources needed to keep America strong. Can you imagine that he actually believed in the United Nations and Foreign Aid, not only when he was Secretary of State, but even when he was in the Senate. Edmund Muskie made history because he understood history. A lot of it he read, a lot of it be experienced personally and what he didn't know, he asked about. All of us who have been on the receiving end know how persistently he could ask questions. The look on his

face or the ''not so gentle'' reproach when we didn't know the answers became an enormous incentive to learn. As a result, we grew with him, In his book we all, but mostly he himself, were accountable. His roots became ours. The great American leaders and their principles became ours. When he arrived at the State Department in May 1980, having been named by President Carter, he brought with him his capacity for endless questions. He brought Leon, Carole, Gayle and Berl. The foreign policy bureaucracy had a bit of trouble with the approach, not to mention with Leon. In the department and over at the national security council, there were rumblings. ''Why all these questions about environmental consequences, fiscal implications, congressional consultations and public opinion.'' As Secretary of State he did not leave his old identities behind. He was still Mr. Clean, the father of the budget process, the chief sponsor of the War Powers Act, an elected official responsive to the people. Still he insisted on looking at all sides, still he wanted to reason everything out. That is why he got along so famously with his deputy, Warren Christopher, another who values principle and reason. Together, they worked patiently to answer the questions and solve the problems our nation faced. Most important they negotiated the safe return of the hostages from Iran. Reuniting families and leaving for the successor administration a clean slate from which to begin. When he left his official foreign policy post, along with the rest of us in January, 1981, he simply began pursuing public policy by private means. Although he was quite in the opposition he did not use his various platforms or chairmanships, of the Center for National Policy and Georgetown's Institute for the Study of Diplomacy to mention two of my favorites, for the politics of protest but characteristically for the politics of healing. For example to consider mending relations with Cambodia and Vietnam, and in this, as in so many other things he was often ahead of his time.

Before I end with a personal message from President Clinton, I must say one more thing. I would obviously be here in my capacity as a proud member of the Muskie political family no matter what. But I would definitely not be here or anywhere else representing the President of the United States if it were not for Ed Muskie. It might not be the right answer for feminist groups and I do love Eleanor Roosevelt. But the truth is that this man was my role model. While we all had a good laugh when he sometimes slipped into political incorrect vocabulary or shielded his female staff members from some of his salted language, he was the man who earlier than others enabled women to take their place as public servants. Because he had faith in us, we had faith in ourselves. He was the first to name a woman, Karen Hastie-Williams, Chief Counsel of the Budget Committee, as head of the Congressional Budget Office, Alice Rivlin, he gave me the responsibility as his chief legislative director, for coordinating Leon, Al From, Doug Bennett and John McKvoy. The U.N. Security Council is a piece of cake. No wonder I learned about the politics of foreign policy. Finally I want to read a letter:

''DEAR JANE: Hillary and I were so sorry to learn of Ed's death and our hearts go out to you. Our nation was blessed to have Edmund Muskie in public service for so long. As governor, as Senator and Secretary of State. He was a leader of conscience and conviction and I will always be grateful for his wise counsel. His broad knowledge of both international and domestic affairs. His stalwart protection of our precious natural resources and his unshakable integrity as a public figure and private citizen earned him support of millions of Americans and the respect of all of us who were privileged to know him. As a mark of that respect, citizens across our country and around the world are lowering the American flag to half staff today. Hillary and I extend our deepest sympathy to you and your family and we hope you will take comfort in remembering that your husband has left an enduring legacy of public service that continues to inspire us all. We are keeping you in our thoughts and prayers.

''Sincerely

''Bill Clinton, President of the United States.''

Dearest Jane, thank you for sharing this great man with us.

REMARKS BY GEORGE MITCHELL

Jane, Steve and Lexi, Ellen and Ernie, Melinda and Eddie, Martha, Ned and Julia, and other members of the family, Cardinal Hickey, Bishop Gerry and other members of the clergy, President and Mrs. Carter and other distinguished guests and friends of Ed Muskie. Senator Muskie once said that he didn't like being called ''Lincolnesque'' but it fit. With his lanky frame, his long and craggy face, his powerful voice, he was an imposing figure. He was loved and trusted by the people of Maine because they saw in him the qualities they most admire, independence, fairness, the lack of pretense, the willingness to speak the truth even when it hurt. He was plain spoken even blunt at times and they admired him for it. He had his faults and he made mistakes as do all human beings but he conquered his faults and he learned from his mistakes and as a result, he became the greatest public official in Maine's history and one of the most effective legislators in our nation's history. He accomplished much in a long and distinguished career. In that impressive record, nothing surpasses what he did to protect America's natural environment. Harry Truman once said that men make history, not the other way around. In periods where there is no leadership society stands still. Progress occurs when courageous skillful leaders seize the opportunity to change things for the better. Ed Muskie changed things for the better. When he went to the Senate, there were no national environmental laws, there was no environmental movement, there was hardly an awareness of the problem. Industries and municipalities dumped their wastes into the nearest river and America's waters were, for the most part, stinking open sewers. The air was unhealthy, the water polluted, Ed Muskie changed that. It's one thing to write and pass a law, it's another thing to change the way people live, it's yet another and a far more difficult thing to change the way people think. Ed Muskie did that. With knowledge, skill, determination and patience he won approval of the Clean Air Act and the Clean Water Act and America was changed forever for the better. Any American who wants to know what Ed Muskie's legacy is need only go to the nearest river. Before Ed Muskie it was almost surely not fit to drink or to swim or to fish in, because of Ed Muskie it is now almost surely clean. A source of recreation even revenue. Despite the efforts of some to turn back the clock, these landmark laws will survive because the American people know what a difference he has made in their lives. It has been said that what we do for ourselves, leaves this world with us, what we do for others remains behind. That's our legacy, our link with immortality. Ed Muskie's legacy will stand as a living memorial to his vision. It is his immortality. Each of us could say much more about Ed Muskie's public career but we are here today to pay tribute to Ed Muskie the man, so I would like to say a few words about the man who was my hero, my mentor, my friend. Thirty-four years ago this week, I received a telephone call that changed my life. It was from Don Nicoll, Senator Muskie's Administrative Assistant and close friend who is here today. He invited me to come to Capitol Hill to meet the Senator who was looking for someone from Maine to fill a vacancy on his staff. To help him evaluate me, Don asked that I prepare a memorandum on the legal aspects of an issue that was then being considered by the Senate. I prepared the memo and went up for the interview. I thought the memo was pretty good, but unknowingly I had made a huge mistake. I reached a conclusion that was the opposite of the Senator's. I had never met him but he didn't bother with any small talk. Within minutes of our introduction, he unleashed a ferocious cross-examination. He came out from behind his desk, he towered over me, he shook his finger at me and he took my memo apart, line by line. I was stunned, so intimidated that I couldn't control the shaking of my legs even though I was sitting down. I tried as best as I could to explain my point of view and we had what you might call a lively discussion. As I left he said the next time you come in here, you'll be better prepared. That's how I learned I'd been hired and I sure was better prepared the next time. Ed Muskie was even more imposing intellectually than he was physically. He was the smartest person that I ever met with an incisive analytical mind that enabled him to see every aspect of a problem and instantly to identify possible solutions. He challenged everyone around him to rise to his level of excellence. No one quite reached his level, but those who took up the challenge were improved by the effort. Those who knew him learned from that relationship, those of us who worked for him, most of all. Just about everything I know about politics and government I learned from him. Just about everything I have accomplished in public life, can be traced to his help. No one ever had a better mentor or a better friend. No discussion of Ed Muskie would be complete without mention of his legendary temper. After he became Secretary of State, a news magazine in an article described his temper as entirely tactical, something that he turned on and off at will to help him get his way. I saw him a few days later, he showed me the article, in fact he read it to me, and then he said laughingly, ''all these years you thought my temper was for real.'' Well, I said, you sure fooled me, and a lot of other people. I think the reality is that it was both. When he yelled at you it was terrifyingly real, but you could never be sure that it wasn't also a tactic to move you his way, to get you to do what he wanted done and that's the way he wanted it and liked it. Almost as unnerving as one of his eruptions was the swiftness with which it passed and was forgotten. He was a passionate man and expressed himself with emotion. His point having been made, he moved on, he didn't believe in looking back or nursing grudges and maybe that's how he got past the disappointments he suffered. It surely also helped that he was a secure man, confident in, and comfortable with his values. Those values were simple, yet universal in their reach and enduring in their strength. They were faith, family and country. He was constant in his faith. He was comforted by it and he was motivated by its message. The prayer printed on the back of the program today written by Senator Muskie more than a quarter century ago with its emphasis on compassion and tolerance was the essence of his faith. He was totally devoted to his family, especially to Jane. They would have celebrated their 48th anniversary in May and for all those years, she supported him, she comforted him, she helped him. He was a

passionate believer in democracy and especially in American democracy. I had the privilege of traveling all over Maine and all this country with him. Back when I was on Senator Muskie's staff we didn't have the resources available today so we used to share a motel room in small towns all across Maine as I drove him from one appearance to another. And I can recall the many times he spoke of his Father who he greatly admired and who he was very influenced by. His Father was a Polish immigrant who, like many others who fled from tyranny, flourished in the free air of this blessed land. No person I have ever heard and few in our history could match Ed Muskie's eloquence on the meaning of America. Once in public office, his profound respect for American democracy led him to act always with dignity and restraint, lest he dishonor those he represented. As a result, he was the ideal in public service, a man who accomplished much without ever compromising his principles or his dignity. Character is what you are when you are alone in the dark as well as with others in the daylight. Ed Muskie's character was strong. Strong enough to light up other people's lives. He taught us that integrity is more important than winning. That real knowledge counts more than slogans or sound bites. That we should live our values rather than parading them for public approval. Many years ago, Maine's greatest poet, Henry Wadsworth Longfellow, wrote of another great man these words: ''Were a star quenched on high for ages would its light still traveling downward from the sky shine on our mortal sight. So when a great man dies for years beyond our kin, the light he leaves behind him lies upon the paths of men.'' A great man has died and for years his life will shine upon our paths. Goodbye Ed, may God bless you and welcome you.

Remarks by President Jimmy Carter

Ed Muskie had the appearance, the mannerisms, the actions of a true statesman. I first knew about him was when I became Governor and faced the almost overwhelming lobbying pressure from the power companies with their smokestacks spewing forth back smoke and the thirteen pump mills in our state that were destroying our rivers. I saw the difficulty then of an incredible political battle. But there was a hero in Washington which has been mentioned several times who faced much greater lobbying pressure from nationwide pollutants of our streams and air. Ed Muskie changed all of that. One of my heroes in Georgia was Dr. Benjamin Mays a graduate of Bates College which was very close to Ed Muskie. And in an unpublicized way, Ed Muskie was also a champion of basic civil rights at a time when it wasn't popular to be so. And he and Dr. Benjamin Mays worked hand-in-hand to inspire people like me and other governors and public servants around the country who looked on him with great admiration. I hope everyone here will read the prayer on the back of the program that George just mentioned that was given by Ed Muskie at a Presidential prayer breakfast in 1969, and see how pertinent it is to our nation's capital today, how Ed Muskie is needed. We saw then a budget problem in Washington and he decided to do something about it. He helped orchestrate and get passed a new budget law. He became the first Chairman of the Budget Committee and despite the equally formidable challenges that we now face, that he faced then, he was able to bring order out of chaos and to work harmoniously not only with the Senators, but members of the House of Representatives, jealous of their own prerogatives and with the Presidents who served with him. Democrats and Republicans, President Nixon, President Ford, and President me. I think that Ed was so successful in bringing this coalition together and healing the disparities between Capitol Hill and the White House, because when he spoke you knew at least three things: First, he deeply believed what he said, second, he knew what he was talking about, and third, it was the absolute truth. So I admired him from a distance until the Spring of 1972 when Ed was campaigning for President and he came down to Atlanta for a fund-raiser. I very eagerly invited him to spend the night with me at the Governor's mansion because of my admiration and because I had in the back of my mind, you won't believe this, the thought that he was going to get the nomination and he might be looking for a southern governor to be his running mate. So I wanted to make a good impression on him and I wanted him to think that I was a little more sophisticated than I was. So that night in the so-called Presidential suite in the front of the Governor's mansion, late at night he was very tired, he had been campaigning all day, and I said ''Senator would you like to have a drink?'' He said ''yes Governor I believe I would.'' I said ''well what would you like,'' he said ''I'd like Scotch and milk.'' I was taken aback. I knew about Bourbon and Branch Water and a few other drinks of that kind but I tried to put on the appearance of being knowledgeable and I left him in the room and went down to the kitchen to prepare a drink. I got about halfway down the hall and a terrible question came to me and I went back into the room and I think ruined all my chances of being on the ticket. I said ''is that sweet milk or buttermilk?'' He very gently said ''sweet milk.'' Later when I was elected President, I turned to Ed Muskie as one of my closest and most valued advisers. He was still a hero to me and I turned to him often. In 1980, as some of you would remember, my administration was in trouble. Fifty-three hostages were still being held by militants in Iran. In April we tried to rescue them and my Secretary of State in protest resigned with a great deal of public fanfare. I was facing a revolution in my own party from Senator Kennedy and others who were more liberal than I and it seemed very doubtful that I would even be renominated as an incumbent President. I turned to Ed Muskie who had a secure seat in the U.S. Senate and I ask him if he would serve as Secretary of State, and after checking with George and others, he said ''yes.'' In a way I thought that I was doing him a big favor but when we had the little ceremony in the White House, I introduced him as the new Secretary of State being willing to serve and his comment was, ''Mr. President, I'm not going to say thanks, I'm going to wait a few months and then make a judgment about whether I thank you or not.'' But he brought to the State Department, as Madeleine just pointed out, his formidable knowledge as a long-time Chairman of the Budget Committee, of every domestic and foreign policy program that our nation had and that statesmanship from Maine that let the members of our Congress, the people of our nation and leaders throughout the world know, that here was a man who spoke with absolute integrity. When the Prime Minister of Japan passed away, Ohira, who was one of my closest friends as Leon has pointed out, I wasn't going to mention this, we went to the funeral with a very devout expression on our face but arranged to stop in Alaska for a day of fishing which Ed suggested as a way for me to forget my troubles. I don't guess he was worried about his own troubles. We went to a little lake about an hour and one-half helicopter flight from Anchorage and were fishing for Grayling and I have to confirm part of Leon's story, I did catch 15 or 20 Grayling, the Secret Service were quite a distance from me I might add, and Ed only caught one fish. So after we got through fishing, Ed came up to me and said ''Mr. President, I'd like to make a comment about the trip'' and I waited for his approval and he said ''you really need to practice your cast'' and I said ''thank you very much, Mr. Secretary.'' Later he sent me a wonderful fishing rod that I still have Leon. In the last few days of our administration it was Ed Muskie's integrity, his sound judgment, his wisdom and his determination and his patience that had made it possible for us to bring every hostage home, safe into freedom. Typically, Ed Muskie did not seek any credit for that achievement, he let others take the credit. I looked up last night the citation I read when I gave Ed Muskie the Presidential Medal of Freedom. ''As Senator and Secretary of State, candidate and citizen, Edmund Muskie has captured for himself a place in the public eye and in the public's heart. Devoted to his nation and our ideals, he has performed heroically and with great fortitude in a time of great challenge.'' His response was you forgot that I was also Governor. This week I made a statement about my friend Ed Muskie and I closed the statement by saying of all the people I've ever known, no one was better qualified to be President of the United States but Jane, I'd like to say now that I don't believe many Presidents in history have ever contributed as much to the quality of life of people in our nation and around the world as your husband, Edmund Muskie. I am grateful to him. Thank you very much.

Remarks by Edmund S. Muskie, Jr.

I could not be more proud than to be here to read to you a prayer that my father wrote. He delivered this prayer at the Presidential Prayer Breakfast here in Washington, DC in January of 1969.

''Our father, we are gathered here this morning, perplexed and deeply troubled. We are grateful for the many blessings You have bestowed upon us.—the great resources of land and people—the freedom to apply them to uses of our own choosing—the successes which have marked our efforts. We are perplexed that, notwithstanding these blessings, we have not succeeded in making possible a life of promise for all our people. In that growing dissatisfaction threatens our unity and our progress towards peace and justice. We are deeply troubled that we may not be able to agree upon the common purposes and the basis for mutual trust which are essential if we are to overcome these difficulties. And so, our Father, we turn to you for help. Teach us to listen to one another, with the kind of attention which is receptive to points of view, however different, with a healthy skepticism as to our own infallibility. Teach us to understand one another with the kind of sensitivity which springs from deeply-seated sympathy and compassion. Teach us to trust one another, beyond mere tolerance, with a willingness to take the chance on the perfectibility of our fellow men. Teach us to help one another, beyond charity, in the kind of mutual involvement which is essential if a free society is to work. We ask it in Jesus' name, Amen.''

CRISIS IN LIBERIA

Mr. PELL. Mr. President, the resumption of violence in Liberia is of great concern to me. A factional standoff over an ousted government minister has led to widespread looting, arson, and murder, plunging the country into a state of chaos. This spasm of violence is the first major interruption of the Abuja Accords, which have held peace together in Liberia since last August.

The deterioration of Liberia is disheartening. Since 1989, the civil war has caused the deaths of more than 150,000 people and has displaced more than 800,000. Thousands of children have been conscripted to the armed forces. The resumption of violence threatens the lives of even more Liberians. The potential of a massive humanitarian disaster is high, as supplies of food and water dwindle, sanitary conditions deteriorate, and outbreaks of cholera erupt.

Mr. President, The United States has a special responsibility toward Liberia. Founded in the early 19th century by freed slaves, the United States and Liberia have had almost 150 years of uninterrupted friendship. In World War II, the airfields and ports of Liberia were a key part of the link to supply the battlefields in North Africa and Europe. During the cold war, the people of Liberia were at many times the only reliable ally of the United States in Africa. Liberia served as a ''listening post'' and headquarters to the United States intelligence services. At the United Nations, Liberia consistently voted for the United States position even when this position was unpopular with other developing nations.

In addition, I would like to add that I have a special interest in this war-devastated country as so many emigrants from Liberia have settled in Rhode Island. Just this morning, a delegation of approximately 400 Liberian-Americans who live in my State participated in an impressive demonstration of their eagerness for peace to be restored to this tragically war-torn country.

These Rhode Islanders, led by long-time community leader Lady Bush, marched several miles into downtown Providence where they demonstrated in front of the Federal Courthouse Building and met with members of my staff and the staff of my colleague, Senator CHAFEE.

The demonstrators presented a petition, entitled ''Plea for an Immediate End To the Human Carnage in Liberia.'' It urges active U.S. Government efforts to end the fighting and places the blame for the latest outbreak of terror and fighting squarely on the assorted warlords whose forces control various portions of the capital and the country.

I ask unanimous consent that a copy of that petition be printed in the RECORD at the conclusion of my remarks.

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

(See exhibit 1.)

Mr. PELL. Mr. President, it is understandable that the international community is hesitant about investing anything more in Liberia. It is up to the faction leaders who constituted the last Council of State and who control the rival forces to stop the looting and killing and to rebuild a sense of national unity. The rival warlords must demonstrate that they are ready for peace. The people of Liberia should not have to endure any more violence. If the United States pulls out of Liberia, it will certainly put the last nail in the coffin for this poor, African nation. Moreover, if the situation in Liberia continues to unravel, the regional implications will be of monumental proportions.

I believe the United States must have an immediate response to this crisis. As a result, I am cosponsor of the resolution introduced this afternoon by my distinguished colleague from Wisconsin, Senator FEINGOLD. Among others, this resolution urges the administration to support West African peacekeepers, to influence other nations to support the peacekeeping force, and to lead efforts in the United Nations to sanction those parties which violate the U.N. arms embargo on Liberia.

I would like to add that it is imperative that the international community, at its highest levels, make public their views on the atrocities in Liberia. The international community, moreover, must actively engage with ECOMOG and ECOWAS, to find a lasting solution. And most importantly, I call upon the competing warlords to stop the pillaging of Liberia. There has already been too much bloodshed, too much hope lost.

EXHIBIT 1

LIBERIAN COMMUNITY ASSOCIATION OF RHODE ISLAND, INC.,
Providence, RI, April 18, 1996.

Petition of the Liberian Community Association of Rhode Island to the Government of the United States

Subject: Plea for an Immediate End To the Human Carnage in Liberia

Whereas the Republic of Liberia was founded and funded by humanitarian societies in the United States, with the appropriation and assistance of the American Government as a safe haven for emancipated people of color;

And whereas throughout its one hundred forty nine years of independence, the people and Government of these United States of America have manifested friendly and benign interest in Liberia's right to exist as a sovereign state, lending aid in times of national exigencies and emergencies;

And whereas Liberia has always shown its gratitude and appreciation to the Government and people of the United States by being staunch ally and trusted African friend during times and circumstances critical to the national interest of the United States;

And whereas the on-going genocidal civil conflict in Liberia resulted from the rash, diabolical, dictatorial, and military rules which set the stage for subsequent atrocities and infrastructure destruction, causing the displacement at home and abroad of over one half the population, many of whom are stranded in the United States;

And whereas the civil war since 1989 has resulted into the slaughter of a quarter million people, most of whom are civilians; women, children and the elderly;

And whereas the war-lords do not have the fortitude to honor the many peace accords that they themselves signed, resulting into the carnage that began on April 5, 1996 and continues to date, described by the international press and the United States Government as the worst in three years;

And whereas the EMOMOG has proven that it cannot enforce the cease-fire, monitor the disarmament process and protect innocent civilians;

And whereas the rebels and government troops, some as young as six are still heavily armed;

And whereas the recent carnage that began April 5, 1996 is so war torn that the United States is evacuating its citizens from Liberia;

And whereas the recent massacre of women and children is so contiguous that Americans, Americans of Liberian descent, and Liberians residing in Rhode Island convened on April 14, 1996 and after deliberation resolved that the organization petitions the United States Government to intervene to help bring the carnage to an immediate end.

We therefore, appeal to the United States to:

1. intervene directly to bring the carnage to an end;
2. use it economic, diplomatic and military leverages to encourage the warring factions to call for, and honor a true cease-fire and disarmament;
3. convene a meeting of the war-lords in the United States to work out modalities for the enforcement of the cease-fire as in the case of Bosnia;
4. to help plan, monitor, and enforce the disarmament process;
5. impose an embargo on the shipment of arms to any of the warring factions;
6. freeze all assets of the war-lords, their family members, and representatives; and
7. deny all war-lords, their family members and representatives visas to travel to the United States except for a conference to resolve the conflict.

We call on all peace loving countries of the world, the United Nations and other international organizations to join the United States, a country of goodwill that has practically resolved all conflicts in modern times, to do the same for Liberia. We are pleading. Please help us.

NUCLEAR SECURITY

Mr. BIDEN. Mr. President, I rise today to call attention to the single greatest security threat to Americans in the post-cold war ERA—the possibility that weapons of mass destruction could be acquired by rogue states, criminal organizations, or terrorists, and used against American targets.

In the coming weeks, I hope that this body will have the opportunity to act on the Chemical Weapons Convention and reduce one portion of this threat.

Today, however, as President Clinton prepares to join President Yeltsin and the G–7 leaders in Moscow for a nuclear safety and security summit over the next 2 days, I would like to focus my remarks on the nuclear threat.

President Clinton has placed nuclear nonproliferation at the top of the U.S. national security agenda—he is clearly committed and willing to lead on this issue. Vice President GORE's regular meetings with Russian Prime Minister Chernomyrdin also have advanced nuclear security. Indeed, in the last 3 years we have seen important agreements and cooperative projects between U.S. officials and their counterparts in Russia and other Republics of the former Soviet Union.

Despite these positive steps, however, the threat before us remains immense, and the path to nuclear security remains long and difficult. We need to understand the potential magnitude of

the threat, and muster the resolve and resources to address it effectively.

THE NATURE OF THE THREAT

Mr. President, Soviet nuclear missiles no longer point at American cities. With the START process, we have also seen and hopefully will continue to see significant reductions in strategic nuclear weapons in the former Soviet Union. But these arms control successes should not give us a false sense of security.

Over 100,000 weapons or weapons equivalent material remain strewn—literally strewn—about Russia, Ukraine, Kazakhstan, and Belarus. The centralized system that prevented the possible theft or diversion of this immense quantity of fissile material during the cold war no longer exists.

I should also note that each year as more nuclear warheads are dismantled, additional tons of weapons-grade material move from relatively more secure military facilities to less secure nuclear storage facilities. The 3,000 warheads that are dismantled each year yield 15 tons of plutonium and 45 tons of highly-enriched uranium.

Of this veritable cornucopia of dangerous fissile material spread across the territory of the former Soviet Union, only a small fraction would be required to wreak unspeakable damage.

It takes only 25 kilograms of highly enriched uranium or 8 kilograms of plutonium to create a weapon capable of massive destruction. We are talking about an amount of uranium the size of a softball—or a baseball in the case of plutonium. That small amount of material could be easily concealed and transported in a sturdy briefcase or a backpack.

As my colleagues know, the greatest barrier to overcome in manufacturing a nuclear weapon is acquiring the appropriate grade and quantity of fissile material. After that, it just takes a little time, money, and technical know-how.

A determined terrorist or rogue state does not even need to build a perfectly designed atomic bomb with the highest grade fissile material to create unimaginable terror. A weapon built of crude, low-grade nuclear material such as a nuclear radiological device would be sufficient to generate widespread panic.

This is not just doomsday rhetoric. Does anyone actually deny that there exists a great demand today for nuclear material? Those who are not yet convinced need only consider the chilling incidents that have occurred over the last few years. As my colleagues are well aware, gram and kilogram quantities of weapons-grade uranium—almost surely leaked from the former Soviet Union—have been seized in Moscow, Munich, and Prague. In addition, dismantled parts of Soviet nuclear missiles have made their way to Iraq.

We know that the demand exists. We also know that the supply exists. Elementary economics tells us that without intervention, a supply curve and a demand curve will intersect—and you will have a transaction. It is incumbent upon us to intervene and prevent even one of these potentially deadly transactions from occurring.

These are the key challenges we face in doing so:

How do we develop a comprehensive accounting system for all nuclear material in the former Soviet Union?

How do we gather and physically protect nuclear material in a limited number of secure sites?

How do we safely dispose of excess nuclear material?

How do we prevent the theft and smuggling of nuclear material?

And, how do we prevent former Soviet nuclear experts from selling their knowhow to rogue states or terrorists?

The answers to these questions are not exclusively of concern to the United States. They are vitally important to Western Europe, Japan, and even to Russia.

THE SITUATION IN THE FORMER SOVIET UNION

Perhaps it would be useful if I briefly walked through what we know about the situation in Russia today to demonstrate the difficulties we face in meeting these challenges.

First, the collapse of the Soviet command and control security system has been replaced by chaos and the absence of many controls at sites where nuclear materials are stored. In the context of Russia's current tumultuous social and economic conditions, we are talking about an environment conducive to theft and extortion.

Second, the Soviet Union had no comprehensive accounting system for nuclear weapons and fissile material—certainly no computerized inventory. In other words, we—including the Russians—do not even know exactly where all of the Soviet Nuclear material is stored or how much of it exists. We think most nuclear material is located in 80 to 100 sites. But there may be another 40 sites. We think the Soviet Union produced some 1,200 metric tons of highly enriched uranium and some 200 metric tons of plutonium. Needless to say, it would be difficult to determine if a few kilograms of this material were misplaced here and there.

Third, the lack of physical protection of nuclear material in the former Soviet Union is shocking. Nuclear material is stored in containers without seals to prevent tampering. Many of the labs, research centers, and power plants with nuclear material do not have perimeter fences, electronic sensors, or monitoring cameras to deter and detect intruders. Instead, U.S. officials have seen nuclear rods stored in metal lockers secured with padlocks. According to the Russian Government, 80 percent of its nuclear facilities—80 percent—do not have radiation detectors to prevent those on the inside from walking out the door with nuclear material.

Fourth, there are nuclear technicians and guards at these facilities who have not been paid in months. I have heard that the senior staff of one nuclear facility abandon their posts a few hours a day to tend to their potato gardens, so that they will have food to eat. It seems to me that these conditions are so ripe for corruption that the threat of an inside job is much greater than the threat of an outside thief entering a nuclear facility—as easy as that may be.

Fifth, current border controls throughout the former Soviet Union are notoriously weak. If smuggled nuclear material passes through Europe, we have some chance that intelligence officials and law enforcement can interdict it. However, trafficking routes through the Caucasus or Central Asia are another story—the chances of successful interdiction are slim to none.

Finally, we have the problem of the thousands of nuclear scientists and technicians in the former Soviet Union with knowledge about nuclear weapons who are looking for ways to make a living in the new world order. Their expertise would certainly be welcome in some aspiring nuclear states that immediately come to mind.

THE U.S RESPONSE

After a slow start 4 years ago, many of these problems are now being addressed by our Departments of Defense and Energy. The Energy Department, for example, has equipped a number of nuclear facilities in the former Soviet Union with fences, monitors, and sensors. The United States Enrichment Corporation has arranged for the purchase of 500 metric tons of highly enriched uranium to be converted into commercial reactor fuel. Newly created international research institutes have employed hundreds of Russian nuclear scientists. Such cooperative efforts need to be evaluated and duplicated on a much larger scale.

I commend my distinguished colleagues Senator NUNN and Senator LUGAR for bringing attention to global proliferation threats through Senator NUNN's recent hearings of the Permanent Subcommittee on Investigations and Senator LUGAR's hearings last august on the issue of Loose Nukes. I might add that Senator LUGAR's hearings are the only hearings that have been held on this critical issue in the Foreign Relations Committee in the 104th Congress.

Mr. President, I think that it is worth asking: are we directing America's limited resources proportionately to meet a clear and present threat which I and many of my colleagues regard as our greatest national security challenge?

In 1991, my colleagues Senators NUNN and LUGAR had the foresight to devise the cooperative threat reduction program to assist the states of the former Soviet Union in dismantling nuclear warheads and protecting nuclear materials. Over the last 5 years funding for the Nunn-Lugar program has totaled $1.5 billion—an average of $300 million

per year, or about one-tenth of 1 percent of our annual defense budget. In addition, this year's funding level was cut 25 percent from last year's level.

In contrast, consider how much time, money, and energy we have spent on the proposed missile defense system to meet the improbable long-range ballistic missile threat, which we are told is at least 15 years away. We have spent some $35 billion over the years on missile defenses. I find it hard to believe that this disparity in spending corresponds to the threats we face.

As I have repeatedly stated on this floor, a long-range ballistic missile will not be the most likely means of delivery of a weapon of mass destruction to the United States. No. A much more likely scenario is that a terrorist group will smuggle material and parts for a nuclear, chemical, or biological device onto our shores—perhaps by any of the many routes used by narcotics traffickers—and then reconstruct a weapon of mass destruction, put it in a van, and detonate it in near an important American landmark.

That is the more likely threat, and that is where we should be focusing the bulk of our energies, not on reviving star wars.

THE NUCLEAR SUMMIT

Mr. President, I hope that my colleagues recognize that we are engaged in a race against time. Either we will help secure this material and provide our citizens with the safety to which they are entitled, or rogue elements will procure this material and use it to blackmail civilization.

The danger of uncontrolled nuclear material is a first level national security threat to the United States of America and a first level national security threat to our friends and allies. We cannot simply ignore the problem and leave if for Russia to solve on her own. Likewise, Russia cannot simply downplay the potential threat and delay implementing concrete measures. Indeed, Russia itself is a target—just last November Chechen separatists placed radioactive material in a Moscow park.

To be successful, the nuclear safety and security summit must build a global consensus on the nature of the threat before us and generate wider cooperation for swift action.

The critical first step must be to improve the physical protection of nuclear material at the source—secure the material at a limited number of sites and institute a comprehensive accounting system. That, in my opinion, is the most important agenda item for the leaders of the G–7 and Russia at the nuclear summit.

World leaders at the summit will also discuss ways to improve cooperation in countering nuclear material smuggling. Given the limited success we have had in interdicting narcotics traffickers, I am not optimistic about the prospects of interdiction alone to prevent the proliferation of nuclear material. Nonetheless, much more can and should be done to improve border controls and intelligence cooperation.

Mr. President, it is my hope that the nuclear safety and security summit in Moscow this week will help propel the world's leaders to take immediate preventative and rational steps toward nuclear security. The alternative is to delay action until after our first nuclear terrorist incident—whether in a Moscow park, a Tokyo subway, or a New York office building.

Mr. President, no other nation can match the expertise and resources of the United States. We must be the leader in promoting cooperative efforts to reduce the nuclear threat. Investments we make in this area today will reap a future return in the form of enhanced security for all Americans.

TRIBUTE TO FORMER ALABAMA AGRICULTURE COMMISSIONER A.W. TODD

Mr. HEFLIN. Mr. President, my longtime friend A.W. Todd, who served 3 terms as Alabama's commissioner of agriculture, passed away at his home on March 29, 1996. He was regarded as one of our State's most popular government leaders and one of the most colorful and effective politicians to ever hold office in Alabama.

A long-time Democrat, A.W. Todd represented Franklin, Colbert, and Marion Counties in the State Senate from 1950–1954. Colbert is my home county. His terms as commissioner of the Department of Agriculture and Industries ran from 1955–1959, 1963–1967, and 1991–1995. He was also a gubernatorial candidate in 1958 and 1966. He had boundless energy and was a tireless campaigner. In fact, the last time I saw him, A.W. told me that he was planning to run again for agriculture commissioner in 1998.

He is regarded by many as the best agriculture commissioner Alabama ever had. The small, family farmer was always foremost in his mind, and the agriculture community in the state benefitted directly from his devotion and hard work. Among his many accomplishments as commissioner was the coliseum program, which resulted in 6 coliseums being built statewide. He also oversaw the expansion of the farmers' market program to Birmingham, Montgomery, Slocomb, and Mobile. The quality of eggs sold in the State was dramatically improved through the Todd Egg Law, which placed new inspection requirements on eggs and established a grading system.

While serving in his last term, A.W. Todd had the distinction of being the oldest elected State official in Alabama and was among the oldest in the entire country. He took pride in introducing himself as the country's oldest ''Young Democrat.'' He was an old-school Democrat who grew up in Belgreen, Alabama. When he was only 13, he was permanently injured in a hunting accident that resulted in his left arm being severed.

This did not slow him down at all. He used a job on Auburn University's experiment farm to work his way through college. After graduating, he returned to Franklin County, where he operated a feed mill and poultry company and served in State government. One of his children, Elizabeth Campbell, followed him into public service, becoming a Federal magistrate in Birmingham.

A.W. Todd was an outstanding public servant who will be greatly missed. I was proud to have known and worked with him over the years. I extend my sincerest condolences to his wife, Robbie, and their entire family in the wake of this tremendous loss.

TRIBUTE TO CHARLES E. GRAINGER

Mr. HEFLIN. Mr. President, one of the major reasons that Huntsville, AL, has been nationally recognized as one of the country's top high-technology growth areas is the strength and vitality of its community leadership. One of these visionary leaders is Charles E. Grainger, vice president of administration at Teledyne Brown Engineering and 1992 chairman of the Huntsville-Madison County Chamber of Commerce. Recently, he received the chamber's Distinguished Service Award.

As chairman of the chamber 4 years ago, Charlie Grainger expanded its economic development emphasis to create a coordinated Partnership for Economic Development. Madison County led all Alabama's counties in new plant and equipment investments that year.

As vice president of administration at Teledyne Brown, a major defense contractor, Charlie is responsible for coordinating governmental relations activities with agencies and Congress. He has overall management responsibility for the departments of human resources, facilities, public relations, administrative services, security, technical communications, and computing resources and technology. He has held his current position since 1978, having served as director of administration from 1967 to 1978. He joined Brown Engineering as assistant to the director of administration in 1963.

Charlie was elected to the Alabama House of Representatives in 1968 and 1970, and was an award-winning legislator. He sponsored a water pollution control act and a school bus safety act, both of which became national models. Both pieces of legislation were named after their sponsor by joint resolution, which is somewhat rare. As a member of the Ways and Means Committee, he secured funding to begin the University of Alabama in Huntsville nursing education program, to establish physical health facilities at Alabama A&M University, and to complete the Huntsville-Madison County Mental Health Center. He served as an elected member of the Alabama Democratic Executive Committee from 1966 through 1990, serving as a delegate to the 1980 Democratic National Convention. He was a presidential campaign coordinator for

Senator John GLENN in 1984 and Vice President AL GORE in 1988.

A native of Lawrence County, Alabama, Charlie grew up in Sheffield, attended Florence State College, and earned a master of science degree in management from Southeastern Institute of Technology. His work as a member of the Base Realignment and Closing Commission Community Task Force was invaluable during the base closure rounds of 1991, 1993, and 1995. He has received the Governor's Air Pollution Control Award; Madison County Good Government Award; Alabama Water Conservationist of the Year Award; and Huntsville-Madison County Mental Health Distinguished Service Award.

He was originally a journalist. He spent several years as a reporter for the Birmingham News. He served as editor and publisher of the Valley Voice, a weekly newspaper published in Tuscumbia.

One of the secrets to Charlie Grainger's phenomenal success is that he truly understands that in order to thrive and grow, the various groups and resources within a community must be united in supporting the bottom-line economic imperatives. In Huntsville's case these are the defense and space industries. He is an instrumental unifying force who sees the big picture and Huntsville's role in that picture. He is a leader who brings people from divergent points of view to common understandings so they can work together for the common good.

I congratulate and commend Charlie for all his accomplishments and for his superb leadership role in the development, growth, and vitality of the Hunstville area. He is a unique role model and a living testament to the tremendous results which can be realized through strong partnerships between government and industry.

TRIBUTE TO JAMES STILLMAN FREE

Mr. HEFLIN. Mr. President, on April 3, James Stillman Free, a native of Gordo, Alabama and for 33 years the Washington correspondent for The Birmingham News, passed away at the age of 87. Jim enjoyed a rich and colorful career as a journalist and historian. Back in November 1993, I had the opportunity to attend his 85th birthday celebration and it was a wonderful experience for his many friends and associates as we gathered with him to celebrate and reflect.

Jim Free attended the public schools of Tuscaloosa, AL; earned his bachelor's degree at the University of Alabama; and obtained his master's degree from Columbia University. He was part owner and editor of a weekly Tuscaloosa newspaper shortly before joining the News in 1935.

Jim's 33 years as The Birmingham News' Washington correspondent was the longest tenure for any Washington correspondent for Alabama newspapers. He spent a total of 35 years with that paper, his name and writings becoming synonymous with Alabama political coverage and analysis in the nation's capital. He also served as the Washington correspondent for the Chicago Sun, Raleigh News and Observer, and Winston-Salem Journal during the 1940's and '50's.

His coverage extended from the Great Depression and New Deal through World War II preparations and his own combat duty as a Navy Captain in the Pacific; the McCarthy ''Red Scare'' era; the Civil Rights movement; the assassinations of John and Robert Kennedy and Martin Luther King; and all national defense, medical, educational, and environmental issues that affected Alabama. He was an on-the-scenes, eye witness to much of the social change and history of this century.

His many ''scoops'' included President Truman's 1946 order for the Army to take over strike-threatened railroads, and he led the national press with his stories on the Justice Department's civil rights decisions. Jim filed overseas reports on the 1957 Berlin crisis and NATO operations in the North Sea, Western Europe, and the United Kingdom in 1966. He served as the historian for the Gridiron Club and was the author of ''The First One Hundred Years: a casual chronicle of the Gridiron Club.''

His World War II service allowed him to bring special insight into his coverage of national defense issues. In an October 1961 article on his time in Berlin, he said, ''* * * our test of strength with Russia in the months and years ahead * * * will be 90 percent non-military. It will be political, economic, scientific, and educational. It will be a showdown of our way of life against theirs.'' Indeed, history proved him right.

While covering the Justice Department, Jim relayed messages from Alabama moderates to then-Attorney General Robert Kennedy during the Freedom Rider bus burning crisis. He was also one of the first reporters to question in print the validity of charges brought against public officials and private citizens by Senator Joseph McCarthy.

Jim held a number of leadership positions in his field and received a number of honors. In 1967, he was elected president of the Washington chapter of the Society of Professional Journalists. In 1989, he was inducted into the society's hall of fame. The Raymond Clapper Award committee gave him a special citation for exceptional reporting on national affairs and he received the Outstanding Alumnus Award from the University of Alabama alumni association.

It is a grand understatement to say that Jim Free was a highly regarded and respected figure. He was a well-rounded professional and a genuine person of integrity. Jim never tried to purposely harm anyone's reputation through his reporting. His professional ethics dictated that he would let the facts speak for themselves. He never tried to make a career of finding dirt on government officials. He was not a practitioner of yellow journalism and was not a purveyor of scandal.

Jim was a gentleman who possessed all the traits that one would expect to find in a gentleman—civility, an educated mind, sensitivity, courteousness, and a healthy respect for the views of others.

I was proud to have known Jim Free, who will long be remembered in the dual worlds of journalism and politics for his lifetime of service to the cause of informing citizens about the world around them. I extend my condolences to his family in the wake of their tremendous loss.

BUSINESSWOMAN EULA SIMS DURBIN

Mr. HEFLIN. Mr. President, Eula Sims Durbin, who was a pioneer of the modern poultry industry in Alabama and throughout the southeast, passed away late last month at the age of 98. She earned a place in the annals of Alabama business history during the dark years of the Great Depression when she and her husband Marshall used her $500 in savings to finance a new business venture, a fish concession. Eventually, the Durbins switched to dressed chickens because of the great difficulty in keeping fresh fish, and opened their own processing plant in Birmingham. Today, the Birmingham-based Marshall Durbin Companies is the nation's 10th largest poultry producer.

On April 2, the Birmingham Post-Herald carried an excellent story detailing the history and growth of Marshall Durbin Companies and of the crucial role Mrs. Durbin played in its enormous success. I ask unanimous consent that the text of the article be printed in the RECORD after my remarks.

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

(See Exhibit 1.)

Mr. HEFLIN. Mr. President, Mrs. Eula S. Durbin will long be remembered for her astute business instincts, for her willingness to take risks, and for her perseverance in the face of great uncertainty and adversity. I extend my condolences to her family in the wake of their loss.

EXHIBIT 1

[From the Birmingham Post-Herald, April 2, 1996]

MRS. DURBIN'S RISKS ARE REMEMBERED

(By Patrick Rupinski)

When they write about the seeds of Alabama's successful businesses, the gamble of Eula Sims Durbin will be recorded.

Mrs. Durbin risked all of her personal savings in a move that helped build the poultry industry in both Alabama and the Southeast.

Mrs. Durbin, who co-founded Marshall Durbin Cos. with her husband—the late Marshall Durbin Sr., died Thursday. She was 98.

''She worked to build this company and kept an active interest in it even in her 90s,''

said Pat Shea, a spokeswoman for Birmingham-based Marshall Durbin Companies, the nation's 10th largest poultry producer.

Mrs. Durbin's place in Alabama's business history occurred as the Great Depression gripped Birmingham in the 1930s.

Her husband wanted to start a business even though businesses were failing in record numbers.

Money was tight, but Mrs. Durbin believed in her husband enough to give him her $500 in savings to finance the venture, a fish concession at a Birmingham market.

The business struggled, particularly in the hot Alabama summers when a lack of refrigeration made keeping fish fresh difficult. But Mrs. Durbin never shied from taking a risk and supported her husband's decision to begin selling dressed chickens.

The move proved popular and soon chicken sales replaced fish. In time, the Durbins opened their own chicken processing plant in downtown Birmingham.

It started small with Mrs. Durbin doing the bookkeeping and other chores, said Ms. Shea, who had interviewed Mrs. Durbin for a history of the company.

By the 1950s, the poultry industry was changing. No longer did farmers with a few hens sell directly to poultry processors. The industry was becoming highly integrated.

By the 1960s, Marshall Durbin Companies had become part of the changes. It added more processing plants plus feed mills, hatcheries, growing facilities and distribution centers.

Today, the family-owned company has annual sales of about $200 million with facilities in three states—Alabama, Mississippi and Tennessee.

The chickens—processed at a rate of more than 2 million a week—end up as everything from frozen breaded nuggets at local supermarkets to cut pieces at KFC restaurants in California and frozen leg quarters shipped to Russia.

Ms. Shea said Mrs. Durbin however, always seemed to take the most pride in how her husband taught their son the business.

Durbin died in 1971. The couple's son, Marshall Durbin Jr., runs the company today.

Mrs. Durbin's interest in the company never waned. Even in her 90s when she was legally blind, she would have someone read her the monthly employee newsletter, Ms. Shea said.

Mrs. Durbin was born in Brookhaven, Miss., and moved to Sulligent after finishing her education, becoming a secretary to the president of a lumber company. She met her future husband while in Sulligent.

Their courtship blossomed after Mrs. Durbin moved to Birmingham to take another secretarial job.

Mrs. Durbin's funeral will be at 2 p.m. today at Ridout's Valley Chapel, followed by a private family burial. Survivors besides her son include two granddaughters, two great-grandsons and six sisters.

In lieu of flowers, the family suggests memorials to the Eula Sims Durbin Scholarship Fund at Birmingham-Southern College, Box 549003, Birmingham, Ala. 35254.

TRIBUTE TO BUCKY MILLER

Mr. HEFLIN. Mr. President, one of the most interesting people and charming characters I have met in my lifetime is Aura J. ''Bucky'' Miller, who celebrates the 55th anniversary of first coming to work at the Marriott Grand Hotel Resort and Golf Club in Point Clear, AL, on April 18, 1996. He just celebrated his 79th birthday on April 12 and, thankfully, has no plans to retire.

As an associate at the Grand Hotel over the course of these many years, Bucky Miller has become the very embodiment of hospitality. For many years, he has served as the hotel's resident expert on mint juleps, all-around hospitality ambassador, and official historian. He is well-known throughout Alabama and the South. Once he meets a guest, he never forgets the name or face. He has taken care of a seemingly endless number of politicians, sports figures, actors, and business people who have been guests at the hotel over the decades.

As an extraordinary hospitality ambassador, he has received a great deal of recognition and attention for his natural skills in making people feel welcome and comfortable. In 1989, the town of Fairhope, which is near Point Clear, declared the first week of June ''Bucky Miller Week.'' That same year, he was chosen along with 17 other Marriott associates nationwide to receive the J.W. Marriott Award of Excellence in recognition of exceptional hospitality skills.

As a people-person, Bucky has a caring attitude that really endears him to his guests. He has a talent for making people feel like they are special.

Over the years, Bucky has worked as a housekeeping aide, wine steward, bartender, and kitchen steward. He left the hotel for a time to serve in World War II and to teach mathematics, but soon returned for good saying, ''This hotel is in my blood.'' His outgoing personality soon earned him the title ''Mr. Hospitality,'' and resulted in a continuous flow of favorable guest comments and feature articles in newspapers and magazines.

His legendary mint juleps, which he makes from his own recipe with fresh mint he grows in a garden outside the lounge, are internationally known. Seagram's published his recipe in its recipe book and named Bucky one of the country's 100 best bartenders. Bucky's other specialties include his country lemonade, the Grand Hotel brunch punch, and his hot mint toddy.

An avid sports fan, he is well-known for his philosophical conversations about football with such notable figures as Alabama Coach ''Bear'' Bryant and sportscaster Howard Cosell.

I am proud to be among those many privileged patrons of the Grand Hotel to have enjoyed the unique charm and natural hospitality of Bucky Miller over the years. He has always practiced what he preaches, which is, ''Let simplicity, sincerity, and service be your motto.'' As I look toward retirement, I want to thank and commend him for all his hard work and achievements. I am looking forward to enjoying more of his simplicity, sincerity, and service when I return to Alabama next year.

TRIBUTE TO DAVE HARRIS

Mr. HEFLIN. Mr. President, earlier this year, Dave Harris retired from his position as head of the public affairs office for Redstone Arsenal and the Army Missile Command in Huntsville, AL. He was a dedicated and outstanding public servant for 33 years.

An editorial which appeared in The Huntsville Times at that time discusses his career and the characteristics which make him a truly unique individual and pleasure with which to work. I ask unanimous consent that a copy of the editorial, ''One Who Made a Difference,'' be printed in the RECORD following my remarks.

The PRESIDING OFFICER. without objection, it is so ordered

(See Exhibit 1.)

Mr. HEFLIN. I commend and congratulate Dave Harris for all his accomplishments and hard work on behalf of the Army over the years, and hope he is enjoying his well-earned retirement.

EXHIBIT 1

[The Huntsville Times, Friday, Dec. 8, 1995]

ONE WHO MADE A DIFFERENCE

There are a handful of people who make a difference in any community. They're usually visible personalities like government or community leaders, businessmen or clergy. Dave Harris has made an impact behind the scenes for 33 years.

Harris, 65, will retire Jan. 3 as the head of the public-affairs office for Redstone Arsenal and the Army Missile Command. During that time, he's been a trusted source of information for the media on subjects ranging from high-tech missiles to traffic accidents. He's also been a trusted source for Army employees, squelching unfounded rumors that could affect morale or raising legitimate concerns to management's attention.

Less well known has been his role as adviser to Redstone commanders, project managers and community leaders on matters of importance to each.

Harris is uncommon partly because he has been at the same job for so long. He knows who to call for answers. He has a historical perspective on weapons development and the community and knows how to put both in the proper context for generals, soldiers, civil servants and citizens.

Very few media spokespersons today have any actual media experience. Harris worked for a newspaper. He is a skilled writer and knows how a story will play. He not only understands reporters and tolerates their eccentricities, he likes working with them. Those qualities make news stories more accurate and cast the Army in a more positive light.

He has believed in what his Army was doing at Redstone Arsenal. Generals to whom Harris reported describe him as ''the heart and soul'' and ''conscience and ombudsman'' of the command.

Dave Harris possesses intelligence, honesty, integrity, common sense, a sense of duty and responsibility, and a long-standing reputation for all the above. He will be difficult to replace.

U.S. FOREIGN OIL CONSUMPTION? HERE'S TODAY'S WEEKLY BOX SCORE

Mr. HELMS. Mr. President, the American Petroleum Institute reports that, for the week ending April 12, the U.S. imported 7,635,000 barrels of oil each day—1,155,000 barrels more than the 6,480,000 barrels imported during the same period a year ago.

Americans now rely on foreign oil for more than 50 percent of their needs, and there are no signs that this upward trend will abate. Before the Persian Gulf war, the United States obtained about 45 percent of its oil supply from foreign countries. During the Arab oil embargo in the 1970's, foreign oil accounted for only 35 percent of America's oil supply.

Anybody else interested in restoring domestic production of oil—by U.S. producers using American workers? Politicians better ponder the economic calamity that will occur in America if and when foreign producers shut off our supply, or double the already enormous cost of imported oil flowing into the U.S.—now 7,635,000 barrels a day.

Mr. President, Joseph J. Romm and Charles B. Curtis wrote in the April 1996 Atlantic Monthly an extensive analysis of the impending crisis due to U.S. dependence on foreign oil. The article, ''Mideast Oil Forever?'' is very thorough and detailed—and I commend it to Senators and staff. At the very least, I hope Senators will read several paragraphs from this article under the subheading ''The Coming Oil Crisis.'' Mr. President, I ask unanimous consent that the text be printed in the RECORD.

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

[From the Atlantic Monthly, Apr. 1996]

MIDEAST OIL FOREVER?

THE COMING OIL CRISIS

Given that the most recent war America fought was in the Persian Gulf, let's start by examining the likelihood that an oil crisis will occur in the coming decade. Forecasting is always risky, especially where oil is concerned, but consider what a variety of experienced energy hands from every point on the political spectrum have said in the past year alone. Donald Hodel, who was a Secretary of Energy under Ronald Reagan, has said that we are ''sleepwalking into a disaster,'' and predicts a major oil crisis within a few years. Irwin Stelzer, of the American Enterprise Institute, says that the next oil shock ''will make those of the 1970s seem trivial by comparison.'' Daniel Yergin says, ''People seem to have forgotten that oil prices, like those of all commodities, are cyclical and will go up again.'' James Schlesinger, who was the Secretary of Energy under Jimmy Carter, has said, ''By the end of this decade we are likely to see substantial price increases.'' In March of last year Robert Dole, the Senate majority leader, said in a speech at the Nixon Center for Peace and Freedom, ''The second inescapable reality of the post-twentieth-century world is that the security of the world's oil and gas supplies will remain a vital national interest of the United States and of the other industrial powers. The Persian Gulf . . . is still a region of many uncertainties. . . . In this 'new energy order' many of the most important geopolitical decisions—ones on which a nation's sovereignty an depend—will deal with the location and routes for oil and gas pipelines. In response, our strategy, our diplomacy, and our forward military presence need readjusting.'' The chairman of the Federal Reserve, Alan Greenspan, not known for being an alarmist, in testimony before Congress last July raised concerns that a rising trade deficit in oil ''tends to create questions about the security of our oil resources.''

Concerns about a coming oil crisis have surfaced in the financial markets as well. Last October, in an article titled ''Your Last Big Play in Oil,'' Fortune magazine listed several billionaires and ''big mutual fund managers'' who were betting heavily that oil prices would rise significantly. The magazine went on to suggest an investment portfolio of ''companies that are best positioned to profit from the coming boom.''

Fundamental trends in oil demand and supply underlie this emerging consensus. First, the world will probably need another 20 million barrels of oil a day by the year 2010, according to the Energy Information Administration (EIA). The International Energy Agency projects an even greater growth in demand, following the inexorable tide of population growth, urbanization, and industrialization.

Second, the world's population is expected to increase by 50 percent by 2020, with more than half those additional people born in Asia and Latin America. And as farm workers move to the city, much more energy and oil will be needed. The fundamentals of urbanization—commuting, transporting raw materials, constructing infrastructure, powering commercial buildings—all consume large amounts of oil and electricity. At the same time, fewer farms will have to feed more people, and so the use of mechanization, transportation, and fertilizer will increase, entailing the consumption of still more energy and oil. An analysis by one of the Department of Energy's national laboratories found that a doubling of the proportion of China's and India's populations that lives in cities could increase per capita energy consumption by 45 percent—even if industrialization and income per capita remained unchanged.

Finally, industrialization has an even greater impact on energy use. As countries develop industries, they use more energy per unit of gross national product and per worker. Crucial industries for development are also the most energy-intensive: primary metals; stone, clay, and glass; pulp and paper; petroleum refining; and chemicals. In the United States these industries account for more than 80 percent of manufacturing energy consumption (and more than 80 percent of industrial waste).

As Fortune has noted, if the per capital energy consumption of China and India rises to that of South Korea, and the Chinese and Indian populations increase at currently projected rates, ''these two countries alone will need a total of 119 million barrels of oil a day. That's almost double the world's entire demand today.''

Barring a major and long-lasting worldwide economic depression, global energy demand will be rising inexorably for the foreseeable future. The Persian Gulf, with two-thirds of the world's oil reserves, is expected to supply the vast majority of that increased demand—as much as 80 percent, according to the EIA. Within ten to fifteen years the Persian Gulf's share of the world export market may surpass its highest level to date, 67 percent, which was attained in 1974. The EIA predicts that in the face of increased demand, oil prices will rise slowly to $24 a barrel (1994 dollars) in 2010. If, instead, they remain low, the Gulf's share of the world export market may rise as high as 75 percent in 2010.

Although non-OPEC nations did increase production by almost 15 percent from 1980 to 1990, they increased proven reserves of oil by only 10 percent. The net result is that the remaining years of production for non-OPEC reserves has actually fallen from eighteen years to seventeen years. On the other hand, while OPEC increased production by 20 percent in the 1980s, it increased its proven reserves by 75 percent. As a result, OPEC's reserves-to-production ratio doubled to ninety years.

The growing dependence on imported oil in general and Persian Gulf oil in particular has several potentially serious implications for the nation's economic and national security. First, the United States is expected to be importing nearly 60 percent of its oil by ten years from now, with roughly a third of that oil coming from the Persian Gulf. Our trade deficit in oil is expected to double, to $100 billion a year, by that time—a large and continual drag on our economic health. To the extent that the Gulf's recapture of the dominant share of the global oil market will make price increases more likely, the U.S. economy is at risk. Although oil imports as a percent of gross domestic product have decreased significantly in the past decade, our economic vulnerability to rapid increases in the price of oil persists. Since 1970 sharp increases in the price of oil have always been followed by economic recessions in the United States.

Second, the Persian Gulf nations' oil revenues are likely to almost triple, from $90 billion a year today to $250 billion a year in 2010—a huge geopolitical power shift of great concern, especially since some analysts predict increasing internal and regional pressure on Saudi Arabia to alter its pro-Western stance. This represents a $1.5 trillion increase in wealth for Persian Gulf producers over the next decade and a half. That money could buy a tremendous amount of weaponry, influence, and mischief in a chronically unstable region. And the breakup of the Soviet Union, coupled with Russia's difficulty in earning hard currency, means that for the next decade and beyond, pressure will build to make Russia's most advanced military hardware and technical expertise available to well-heeled buyers.

The final piece in the geopolitical puzzle is that during the oil crisis of the 1970s the countries competing with us for oil were our NATO allies, but during the next oil crisis a new, important complication will arise; the competition for oil will increasingly come from the rapidly growing countries of Asia. Indeed, in the early 1970s East Asia consumed well under half as much oil as the United States, but by the time of the next crisis East Asian nations will probably be consuming more oil than we do.

THE BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, on Friday February 23, 1996, the Federal debt broke the 5 trillion dollar sound barrier for the first time in history. The records show that on that day, at the close of business, the debt stood at $5,017,056,630,040.53.

Twenty years earlier, in 1976, the Federal debt stood at $629 billion, after the first 200 years of America's history, including two world wars. The total Federal debt in 1976, I repeat, stood at $629 billion.

Then the big spenders went to work and the interest on the Federal debt really began to take off—and, presto, during the past 2 decades the Federal debt has soared into the stratosphere, increasing by more than $4 trillion in 2 decades—from 1976 to 1996.

So, Mr. President, as of the close of business yesterday, Wednesday, April 17, 1996, the Federal debt stood—down to the penny—at $5,146,356,518,536.99. On a per capita basis, every man, woman

and child in America owes $19,445.43 as his or her share of that debt.

This enormous debt is a festering, escalating burden on all citizens and especially it is jeopardizing the liberty of our children and grandchildren. As Jefferson once warned, ''to preserve [our] independence, we must not let our leaders load us with perpetual debt. We must make our election between economy and liberty, or profusion and servitude.'' Isn't it about time that Congress heeded the wise words of the author of the Declaration of Independence?

THE 12TH ANNUAL TUFTONIA'S WEEK CELEBRATION AT TUFTS UNIVERSITY

Mr. KENNEDY. Mr. President, next week Tufts University in Medford, MA, will hold its 12th Annual Tuftonia's Week Celebration. Tufts alumni from around the world will gather to honor their outstanding university. This celebration has special meaning for me because my daughter, Kara, is a graduate of Tufts, and I am proud to count myself as a member of the Tufts family.

Tufts was founded in 1852, and it now has over 8,000 students from all 50 States and more than 100 foreign countries. The university offers degrees in a wide range of disciplines, including Liberal Arts, Engineering, Occupational Therapy, Nutrition Science and Policy, Medicine, Dentistry, Veterinary Medicine, and Law and Diplomacy.

This year, the theme of Tuftonia's Week is community service. The occasion will honor the large number of Tufts graduates across the country who are volunteering in their communities and helping to improve the lives of others in their neighborhoods through the TuftServe program. Last year, Tufts alumni contributed more than 19,000 volunteer hours, and an even higher level of participation is anticipated this year. Tufts deserves great credit for its leadership among universities in emphasizing the value of service learning and providing opportunities for students to combine community service with their academic curriculum.

I am honored to take this opportunity to congratulate Tufts' President, John DiBiaggio, and the others in the Tufts community for their impressive accomplishments.

THE TEAM ACT

Mr. BURNS. Mr. President, I recently became a co-sponsor of S. 295, the Teamwork for Employers and Management Act, a bill that is scheduled for markup today in the Labor Committee and which the Small Business Committee, on which I sit, will consider tomorrow. This bill is very important to small businesses. It is important to all business but, with 98 percent of Montana's businesses considered small, those are the folks I'm hearing from.

Many of the businesses that have contacted me were in shock. They had no idea that the committees they had formed with their employees were in violation of the law. As far as they were concerned, they were just good business practice. The committees kept the employees involved in operations and improved customer satisfaction.

But according to the National Labor Relations Act, employee involvement is illegal. The intent of the law, established in the 1930's, was to prevent employers from dominating a labor organization. And labor organization is defined as a group of employees that discusses terms or conditions of employment with the employer. That may be well and good as far as collective bargaining is concerned—at the time, the NLRA wanted to stop employers from establishing these company unions to keep independent unions out—but the law is being interpreted to mean that discussions of safety, productivity, and quality are considered conditions of employment. That's causing more than a little heart burn.

Let me give you an example. There is a Montana company I have heard from, and I will not name them since, understandably, many small businesses are afraid of having their practices brought to the attention of the NLRB. But this company, with diversified interests, has formed a committee on safety—safety not only of employees who work with a variety of equipment but of the thousands of visitors who use their facilities every day. This committee gives the employees ownership of their surroundings and results in a safer workplace for everyone.

This same company also has a committee on customer satisfaction. The employees survey the facilities periodically and decide on changes in decorations, improvements in the surroundings, how to make the area more customer friendly—basically how to draw business in and keep it. Once again, this is not only a good business practice, it is a way to keep the employees energized about their work conditions. How can this possibly be against the law? That is not only the question they are asking, it is one we should all ask.

Yet, if the National Labor Relations Board learned about these employee involvement teams, according to the law, they could penalize the employer. And in a number of cases, they already have. That does not even make sense.

Now, I know that the Government is famous for not making sense—and that is what our regulatory reform efforts are about—but here is one specific place we can make a difference. By passing this bill, the Teamwork for Employees and Management Act, without any taxpayers dollars, without any new volumes of paperwork, we can let business get back to business without fear of the heavy hand of Government coming down on them.

By simply amending the National Labor Relations Act, we can allow teamwork to continue, and allow businesses to form teams to safeguard working conditions, improvement productivity and efficiency, and boost the quality of their products. This does not just benefit the employer and the employee, it helps our economy.

Mr. President, this provision of the law may have served its purposes 60 years ago, but it is not necessary today. Small businesses need all the help they can get to survive in today's competitive market and being flexible is vital to that success. Small business owners need the input, the advice, the cooperation, and the labor of their employees. To prohibit that involvement is to squash innovation and prosperity, the very ideals that make up the American Dream.

I strongly support this legislation, Mr. President. I hope we can bring this to the floor quickly and relieve the stress on our small businesses around the Nation who have learned of their allegedly ''illegal'' business practices. Let us get the government off their backs once again, and let business do what they do best—create jobs and produce high quality goods and services for the world to enjoy.

THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT REAUTHORIZATION

Mr. BURNS. Mr. President, an important bill was recently reported out of the Senate Labor Committee and I hope it will make its way to the Senate floor quickly. This is a bill that was designed with not only children in mind—and that is foremost—but with the needs of teachers, administrators, and parents of children with disabilities. That can be a delicate balance, but I think it was achieved.

S. 1578, the Individuals With Disabilities Education Act reauthorization, ensures that children with disabilities have access to a free appropriate public education. At first, that may sound like something we would assume is a guaranteed right of any American citizen. And it is. But many children with disabilities have special needs—needs that neither the parents nor the schools can meet without sacrifice. And it seems that when this bill was first enacted in 1975, the burdens on some were increased. And 21 years later, we have the opportunity to make some positive changes.

Let me just highlight a few of the changes that are proposed that prompted me to sign my name on this bill. To begin with, S. 1578 reduces the bureaucratic maze that schools have been required to fight their way through. Right now, State and local education agencies must submit a plan or application every 3 years. Now, they will only have to prepare that plan once, unless they institute substantial changes. And the data they are required to collect is cut in half.

Some may say, ''But how will that affect my child's education?'' As I've visited with school administrators and teachers around Montana, it has

amazed me to hear how many resources are tied up with paperwork generating, reporting requirements, and tracking. If it wasn't required by law, I wouldn't be surprised if schools refused to enroll children with disabilities. The amount of time it takes a school employee to keep up with the regulations, the amount of financial resources that are used to document school activities and student performance—it's almost a miracle that the school has the time to educate the children.

When we reduce the paperwork, the reporting requirements, the documentation, we free up time and money to devote to the education of our children and we allow those children with disabilities to achieve as much as they can possibly achieve. It allows the teacher to get back to the classroom, the administrator to get back to making sure the school is safe and the curriculum is top-notch, and the parents to rest easy knowing that their child is receiving the same educational opportunities every other child is receiving.

But one of the most common remarks I've heard from Montana schools is that they need more flexibility. And this bill gives them that. In particular, the question of discipline is often raised. Current law prohibits schools from suspending a disabled child for more than 30 days even if the child brought in a dangerous weapon or threatened a teacher or student. S. 1578 gives the school some flexibility in deciding how to handle that violation. If a child with a disability violates such a policy, that child may be suspended for up to 10 school days. In that time, the IEP team may designate an alternative placement for up to 35 days. And, if the behavior was not related to the disability, the child can be disciplined as any other nondisabled child would be.

Mr. President, I want to make sure that all children have access to a free, appropriate public education. Whether a child has a disability, mental or physical, whether a child is poor or disadvantaged, whether the parents of schoolaged children have the resources to afford special care or not—we need to take the responsibility of educating our future generations very seriously.

And there is a balance we need to maintain. Order and discipline in our schools is essential to creating an environment conducive to learning, for disabled and nondisabled children alike. There should be a balance between the parents involvement and the schools efforts in educating a child with disabilities. And there is a balance to be kept between making sure schools are accountable for the Federal dollars they receive and overburdening them with red tape. This bill, S. 1578, strikes that balance.

I join my colleagues in supporting this important legislation and I commend Senator FRIST for his hard work in making sure that both parents and schools were consulted in proposing these changes. With the bipartisan support it enjoyed in the Labor Committee, I look forward to seeing this bill brought to the Senate floor soon. Our Nation's future—our children—depend on it.

SECRETARY RON BROWN AND BARRY CONRAD

● Mr. MACK. Mr. President, I offer my heartfelt condolences and prayers to the family of Commerce Secretary Ron Brown and to all of the other families who have lost a loved one in this terrible tragedy.

It is never easy to lose someone close to you. Yet I believe those that Commerce Secretary Brown left behind—his wife Alma, his daughter Tracey, and his son Michael—can be comforted and given strength by the knowledge that Ron Brown died doing what he loved: Representing the President as Commerce Secretary and serving America by promoting American economic interests abroad.

Secretary Brown will be remembered for his commitment to our democracy, his charisma, and the enthusiasm with which he embraced new ideas and challenges. I will keep Alma, Tracey, Michael, and all others who are mourning this great loss, in my thoughts and prayers during their time of grief.

I would also like to offer my condolences at this time to the family of Barry L. Conrad who was accompanying Secretary Brown on his trip to the Balkans. Mr. Conrad was the founder of the Barrington Group, a dynamic hotel company in Miami, and had previously headed Burger King's U.S. franchise operation.

In addition to being a successful businessman, Mr. Conrad was a very prominent and well-respected member of the south Florida community. This is a great loss not only for the family and friends of Mr. Conrad but for the entire State of Florida.

I am praying for the Conrad family, and all others who are mourning as a result of this tragedy.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Thomas, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the PRESIDING OFFICER laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the Committee on the Judiciary.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 11:54 a.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 842. An act to provide off-budget treatment for the Highway Trust Fund, the Airport and Airway Trust Fund, the Inland Waterways Trust Fund, and the Harbor Maintenance Trust Fund.

ENROLLED BILLS SIGNED

At 2:07 p.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the speaker has signed the following enrolled bills:

H.R. 255. An act to designate the Federal Justice Building in Miami, Florida, as the ''James Lawrence King Federal Justice Building.''

H.R. 869. An act to designate the Federal building and U.S. Courthouse located at 125 Market Street in Youngstown, Ohio, as the ''Thomas D. Lambros Federal Building and U.S. Courthouse.''

H.R. 1804. An act to designate the United States Post Office-Courthouse located at South 6th and Rogers Avenue, Fort Smith, Arkansas, as the ''Judge Isaac C. Parker Federal Building.''

H.R. 2415. An act to designate the United States Customs Administrative Building at the Ysleta/Zaragosa Port of Entry located at 797 South Ysleta in El Paso, Texas, as the ''Timothy C. McCaghren Customs Administrative Building.''

H.R. 2556. An act to redesignate the Federal building located at 345 Middlefield Road in Menlo Park, California, and known as the Earth Sciences and Library Building, as the ''Vincent E. McKelvey Federal Building.''

The enrolled bills were signed subsequently by the President pro tempore (Mr. THURMOND).

At 4:09 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 735) to prevent and punish acts of terrorism, and for other purposes.

MEASURED REFERRED

Pursuant to the order of August 4, 1977, with instructions that if one Committee reports, the other Committee have thirty days to report or be discharged, the following bill was read the first and second times by unanimous consent and referred as indicated:

H.R. 842. An act to provide off-budget treatment for the Highway Trust Fund, the Airport and Airway Trust Fund, the Inland Waterways Trust Fund, and the Harbor Maintenance Trust Fund; to the Committee on the Budget and the Committee on Governmental Affairs.

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–2262. A communication from the Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, the cumulative report on rescissions and deferrals dated April 1,

1996; referred jointly, pursuant to the order of January 30, 1975, as modified by the order of April 11, 1986, to the Committee on Appropriations, to the Committee on the Budget, to the Committee on Agriculture, Nutrition, and Forestry, to the Committee on Armed Services, to the Committee on Environment and Public Works, to the Committee on Finance, and to the Committee on Foreign Relations.

EC–2263. A communication from the President of the United States, transmitting, pursuant to law, a report of proposed rescissions of budgetary resources; referred jointly, pursuant to the order of January 30, 1975, as modified by the order of April 11, 1986, to the Committee on Appropriations, to the Committee on the Budget, and to the Committee on Armed Services.

EC–2264. A communication from the Chairman of the Federal Maritime Commission, transmitting, pursuant to law, the report of activities for fiscal year 1995; to the Committee on Commerce, Science, and Transportation.

EC–2265. A communication from the Administrator of the National Aeronautics and Space Administration, transmitting, pursuant to law, a report relative to requests for extraordinary contractual relief; to the Committee on Commerce, Science, and Transportation.

EC–2266. A communication from the Administrator of the Federal Aviation Administration, transmitting, pursuant to law, a report relative to foreign aviation authorities; to the Committee on Commerce, Science, and Transportation.

EC–2267. A communication from the Administrator of the Federal Aviation Administration, transmitting, pursuant to law, a report relative to the Traffic Alert and Collision Avoidance System; to the Committee on Commerce, Science, and Transportation.

EC–2268. A communication from the Administrator of the Federal Aviation Administration, transmitting, pursuant to law, the report of the Aviation System Capital Investment Plan; to the Committee on Commerce, Science, and Transportation.

EC–2269. A communication from the Chairman of the Federal Trade Commission, transmitting, pursuant to law, the report of accomplishments during fiscal year 1994; to the Committee on Commerce, Science, and Transportation.

EC–2270. A communication from the Secretary of Transportation, transmitting, pursuant to law, a report relative to export vessels; to the Committee on Commerce, Science, and Transportation.

EC–2271. A communication from the Secretary of Transportation, transmitting, a draft of proposed legislation entitled ''The Department of Transportation Regulatory Reform Act of 1996''; to the Committee on Commerce, Science, and Transportation.

EC–2272. A communication from the Secretary of Transportation, transmitting, pursuant to law, a report on waste disposal sites; to the Committee on Commerce, Science, and Transportation.

EC–2273. A communication from the Secretary of Transportation, transmitting, pursuant to law, the report entitled ''The Automotive Fuel Economy Program''; to the Committee on Commerce, Science, and Transportation.

EC–2274. A communication from the Secretary of Transportation, transmitting, pursuant to law, a report relative to the Airport Improvement Program; to the Committee on Commerce, Science, and Transportation.

EC–2275. A communication from the Secretary of Transportation, transmitting, pursuant to law, a report on tanker simulator training; to the Committee on Commerce, Science, and Transportation.

EC–2276. A communication from the Secretary of Transportation, transmitting, pursuant to law, a report on tanker navigation safety standards; to the Committee on Commerce, Science, and Transportation.

EC–2277. A communication from the Secretary of Transportation, transmitting, pursuant to law, a report on the evaluation of oil tanker routing; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. CHAFEE, from the Committee on Environment and Public Works, with an amendment in the nature of a substitute:

S. 811. A bill to authorize research into the desalinization and reclamation of water and authorize a program for States, cities, or qualifying agencies desiring to own and operate a water desalinization or reclamation facility to develop such facilities, and for other purposes (Rept. No. 104–254).

EXECUTIVE REPORTS OF COMMITTEES

The following executive report of committee was submitted:

By Mr. Stevens, from the Committee on Governmental Affairs:

Robert E. Morin, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

(The above nomination was reported with the recommendation that he be confirmed, subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.)

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. SARBANES:

S. 1682. A bill to authorize the Secretary of Transportation to issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for the vessel *Liberty*, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. WYDEN:

S. 1683. A bill to amend part E of title IV of the Social Security Act to require States to regard adult relatives who meet State child protection standards as the preferred placement option for children, and to provide for demonstration projects to test the feasibility of establishing kinship care as an alternative to foster care for a child who has adult relatives willing to provide safe and appropriate care for the child; to the Committee on Finance.

By Mr. REID:

S. 1684. A bill to require that applications for passports for minors have parental signatures; to the Committee on Foreign Relations.

By Mr. KERRY:

S. 1685. A bill to provide income and economic security to the American family, and for other purposes; to the Committee on Finance.

By Mr. FORD (for himself, Mr. COATS, Mr. LUGAR, Mrs. HUTCHISON, and Mr. MCCONNELL):

S. 1686. A bill to provide for early deferred annuities under chapter 83 of Title 5, United States Code, for certain former Department of Defense employees who are separated from service by reason of certain defense base closures, and for other purposes; to the Committee on Governmental Affairs.

By Mr. KERRY:

S. 1687. A bill to provide for annual payments from the surplus funds of the Federal Reserve System to cover the interest on obligations issued by the Financing Corporation; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. DOLE (for himself, Mr. SIMON, Mr. ABRAHAM, Ms. MOSELEY-BRAUN, Mr. MURKOWSKI, Ms. MIKULSKI, Mr. HELMS, Mr. ROTH, Mr. SANTORUM, and Mr. LUGAR):

S.J. Res. 51. A joint resolution saluting and congratulating Polish people around the world as, on May 3, 1996, they commemorate the 205th anniversary of the adoption of Poland's first constitution; 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 Mr. FEINGOLD (for himself, Mrs. KASSEBAUM, Mr. SIMON, Mr. LEAHY, Mr. JEFFORDS, and Mr. PELL):

S. Res. 248. A resolution relating to the violence in Liberia; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WYDEN:

S. 1683. A bill to amend part E of title IV of the Social Security Act to require States to regard adult relatives who meet State child protection standards as the preferred placement option for children, and to provide for demonstration projects to test the feasibility of establishing kinship care as an alternative to foster care for a child who has adult relatives willing to provide safe and appropriate care for the child; to the Committee on Finance.

THE KINSHIP CARE ACT OF 1996

● Mr. WYDEN. Mr. President, I introduce the Kinship Care Act of 1996. Today Representative Connie Morella is introducing companion legislation in the House.

Grandparents caring for grandchildren represent one of the most underappreciated natural resources in our Nation. They hold tremendous potential for curing one of our society's most pressing maladies: The care of children who have no parents, or whose parents simply aren't up to the task of providing children a stable, secure and nurturing living environment.

There is such a great reservoir of love and experience available to us, and more especially to the tens of thousands of American children who desperately need basic care giving. We provide public assistance to strangers for this kind of care, but the folks available to provide foster care homes are in short supply.

At the same time, inflexibility in current regulations often force us to

ignore a precious alternative that is right at our doorstep. Our public policy planners have missed the forest for the trees. Grandparents can fill the gap. They are ready, willing and able to provide the kind of care these youngsters so desperately need.

The legislation I plan to introduce in the Senate today will give States the flexibility to provide the support these grandparents need, so that our seniors can help fill the care gap.

The House included my legislation, similar to today's bill, as part of the welfare reform measure last year. My new legislation will continue the process of shifting the focus of our child welfare system from turning children over to strangers, to granting them the loving arms of grandparents and other relatives.

States have been moving in this direction for over a decade. Over the past 10 years the number of children involved in extended family arrangements has increased by 40 percent. Currently, more than 3 million children are being raised by their grandparents. In other words, 5 percent of all families in this country are headed by grandparents.

It's time that the Federal Government get with the program and start developing policies that make it easier, instead of more difficult, for families to come together to raise their children.

My bill has several parts. The first would require States to give preference to relative providers when a child is removed from their parents' home. Too often I have heard stories of grandparents or other relatives, not finding out that their grandchildren have been removed from their children's home. By the time they know what is happening, the grandchildren are locked into the foster care system.

Often I have heard stories where brothers and sisters are split up and grandparents spend years in court trying to reunite their own families. As we rethink our child protection system, we need to rededicate ourselves to looking to families, including extended families, for solutions. When a child is separated from their parents, it is usually a painful and traumatic experience. Living with people that a child knows and trusts gives children a better chance in the world and gives families a better chance to rebuild themselves.

The second part of my bill allows States to obtain waivers to set up kinship care guardianship systems where grandparents and other relative providers can receive some financial assistance without having to turn over custody of the child to the State, and without having to go through the paperwork and bureaucratic hurdles of the foster care system.

Our child protection system is where our welfare system was about 10 years ago. We know it isn't working well, but States and the Federal Government are still fumbling for solutions. What we need to do now, as we did for our welfare system, is start opening the door for States to try new ideas to both protect children and keep families together.

As we reevaluate the effectiveness of our country's child protection systems, it's time that we identify new ideas and new ways to find loving environments for our Nation's most vulnerable children. Grandparents can provide the lynchpin for such a new system.●

By Mr. REID:

S. 1684. A bill to require that applications for passports for minors have parental signatures; to the Committee on Foreign Relations.

THE MIKEY KALE PASSPORT NOTIFICATION ACT OF 1996

Mr. REID. Mr. President, I rise to introduce legislation I intended to offer as an amendment to the immigration bill. Unfortunately, it does not appear I will have the opportunity to offer this as an amendment to that bill. I therefore decided to offer this as a free-standing bill as I believe it is an issue that needs to be addressed whether or not we decide to go back to this bill.

Much of the debate on the immigration legislation involves complex issues and arcane areas of the law. My legislation is pretty easy to understand. It is a common sense legislative solution to a simple, but troubling, issue. The issue my bill attempts to resolve is that of international parental abductions. Significantly, my bill does not attempt to right a wrong. Rather, it attempts to prevent future wrongs from occurring. And there is little dispute that absent legislation, future wrongs will occur.

The wrong that occurs is best illustrated by a living nightmare forced upon an American family from Henderson, NV. No parent should ever have to go through what Fred and Barbara Spierer went through in 1993. That year, on Valentine's Day, Barbara Spierer's ex-husband took her son to his native country, war-torn Croatia. She would soon learn that upon their arrival, her ex-husband initiated official custody proceedings in a Croatian court.

Through tremendous emotional and financial costs, Fred and Barbara Spierer were able to secure the return of young Mikey. Incredibly, this could all have been prevented if our laws didn't permit such easy procurement of passports for minors. Few would disagree that parental consent should be given before a passport is issued to a minor child. Both parents ought to be notified before the State Department issues a document permitting their child to be taken out of this country.

Presently, such joint notification is not required. Under current law, one parent can apply for a U.S. passport for his or her child, receive it, and then depart from the country with that child. Again, this can all be accomplished without the notification of the other parent. Current law is an invitation to engage in the grossest of misbehavior by a scurrilous parent. And engage in it they do. Sadly, the case of Fred and Barbara Spierer is not an isolated incident.

International parental abductions are a growing problem. In 1994, there were over 600 cases of children being abducted from the U.S.A. Thousands of parents are attempting to bring home their children who were taken from this country by a mother or father. While these cases are tracked by the State Department, children's advocates believe many more go unreported. Often, the children are snatched during a divorce. The abducting parents usually have strong ties to a foreign country. But sometimes an American-born mother or father will take off for an unfamiliar nation to flee U.S. law. Regrettably, such surreptitious travel is made quite easy because of current law. Why? Because one parent can procure the child's passport without the other one knowing.

Left-behind parents are faced with wading through a maze of foreign laws and customs in their efforts to secure their child's return. Imagine how difficult it is to find a missing child in the United States and then multiply it by 1,000. That's about how difficult it is to locate and return a child abducted overseas. And finding a missing child is only the start.

A parent must then take their case to the foreign country's legal system. Most nations do not recognize custody orders from U.S. courts. Even when criminal charges have been filed against the abducting parent in the United States, many nations will not honor a U.S. request for extradition. Some countries simply discriminate against women. The decision to fight for a child's return consumes enormous amounts of time and money. Many parents are simply without the financial wherewithal to engage in a protracted international legal battle.

For a variety of reasons, the Government is able to do very little to assist these parents. The current budgetary constraints realistically preclude doing more to secure the return of abducted children. But they do not preclude efforts to implement additional barriers to prevent these tragic abductions from occurring.

My bill takes cost effective steps toward preventing future abductions. It implements a system of checks prior to the issuance of a minor child's passport. Both parents would be required to sign the passport application of a child under the age of 16. Or, if the parents were already divorced, the application would have to be signed by the parent of the child having primary custody. If such a law had been in place by 1993, Barbara Spierer's ex-husband would not have been able to abduct their child to Croatia. The passport would not have been issued because her written permission had not been given. I believe it is drafted in such a manner so as to give the State Department the

discretion to implement a reasonable and flexible rule.

This bill is not just about parental rights and preventing these tragic international abductions. It is also about protecting the rights of our children. No one disagrees that the rights, liberties and freedoms provided in our Nation make it the best country in the world. No child should be forced to lose these rights. No child should be forced to undergo what Mikey Kale lived through. No American child, regardless of his age, should be abducted to the middle of a war torn part of the world. American parents should not be forced to endure the living nightmare that the Spierers' were forced to go through. If my bill prevents only one family from having to endure this nightmare it will be judged a success. I believe that more can be done but this is the most cost effective step we can take today.

I encourage my colleagues to cosponsor this legislation and support it should we return to consideration of the immigration 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. 1684

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

SECTION 1. PASSPORTS ISSUED FOR CHILDREN UNDER 16.

(a) IN GENERAL.—Section 1 of title IX of the Act of June 15, 1917 (22 U.S.C. 213) is amended—

(1) by striking ''Before'' and inserting ''(a) IN GENERAL.—Before'', and

(2) by adding at the end the following new subsection:

''(b) PASSPORTS ISSUED FOR CHILDREN UNDER 16.—

''(1) SIGNATURES REQUIRED.—In the case of a child under the age of 16, the written application required as a prerequisite to the issuance of a passport for such child shall be signed by—

''(A) both parents of the child if the child lives with both parents;

''(B) the parent of the child having primary custody of the child if the child does not live with both parents; or

''(C) the surviving parent (or legal guardian) of the child, if 1 or both parents are deceased.

''(2) WAIVER.—The Secretary of State may waive the requirements of paragraph (1)(A) if the Secretary determines that circumstances do not permit obtaining the signatures of both parents.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to applications for passports filed on or after the date of the enactment of this Act.

By Mr. KERRY:

S. 1685. A bill to provide income and economic security to the American family, and for other purposes; to the Committee on Finance.

THE AMERICAN FAMILY INCOME AND ECONOMIC SECURITY ACT

Mr. KERRY. Mr. President, today I am introducing the American Family Income and Economic Security Act.

Not long ago the Treasury announced that the leading economic indicators were up 1.3 percent for February, the gross domestic product rose half a percent, the stock market is at record levels, inflation is subdued, interest rates are stable, unemployment is the lowest in the industrial world, job growth is the highest with over 8 million jobs since 1993; and—to topoff all of these positive indicators—the Democratic economic plan—that passed without one Republican vote—has cut the deficit by more than half—down from $290 billion to $140 billion.

We worked hard with the President against Republican stonewalling, gridlock, and continued opposition to make this happen so that even the Republican Chairman of the Federal Reserve, Alan Greenspan, told me 2 weeks ago, at a Banking Committee hearing, that this is the longest period of the most robust and sustained economic growth since the end of the Second World War, and he expects the economy to continue to grow ''at a steady clip.''

But this economic growth is best reflected in corporate boardrooms—businesses are finding it easier to borrow money, interest rates are low, executive salaries are up and continue to mushroom, regulations are being eased in every sector from financial services to basic manufacturing. But, in living rooms across Massachusetts there is extraordinary anxiety about jobs, health care, education, wages, and retirement.

Mr. President, I have talked to family after family in Massachusetts who told me that people at the top are doing great, but their friends on the shop floor are not. Statistics show that corporate executives are earning 170 times that of their lowest paid worker. Just last year CEO's had an average salary increase of 15 percent while their workers are downsized into the street. These workers—whose real wages have fallen half-a-percent every year since 1973—worry about the future, about elderly parents getting sick, about their kids' education, about their own health care if they lose their job, about the debt they are carrying, and about their retirement.

I understand how difficult it is when productivity rose 7 percent but real wages fell 3 percent in the first 6 years of the 1990's. A family that used to take out a loan for a major expense like a car, now put gas on their credit cards. They took out loans to send kids to college, now they take out loans to send kids to the pediatrician. The American family is sinking further and further into debt and this Republican Congress is making it worse.

In 1995 commercial banks earned an all-time record high profit of $48.8 billion while consumer debt has soared 39 percent in the last 5 years and now exceeds $1 trillion. Personal bankruptcies rose by 6 percent in 1 year, and consumers owe $360 billion on their credit cards. And families in Massachusetts, fourth in the Nation in loan delinquencies, have defaulted on $80 million in consumer loans.

Mr. President, in these economic times, the average American family has four credit cards—each with balances of $4,800. It's no wonder we are anxious. Thousands and thousands of families are one paycheck away from economic disaster. But, it took Pat Buchanan to wake up the Republican Party to do something the Democrats have been doing since the Roosevelt administration—fighting for working families and people struggling to make ends meet. Yet the Republicans have done nothing to alleviate this anxiety. They will not even raise the minimum wage—in fact they have downsized the American dream for millions of hard working families, but voted time and again to increase corporate welfare, and give huge tax breaks to the wealthiest Americans.

Therefore, today, to fight back, I am announcing that I will introduce the American Family Income and Economic Security Act.

It helps families by increasing the minimum wage, helps them educate their kids and re-educate themselves, helps secure portable, affordable, health care with no preexisting conditions clause, and makes investments for retirement easier. I believe that this legislation can go a long way to restoring faith in the American dream.

The American Family Income and Economic Security Act gives incentives to businesses that become better corporate citizens and that foster a family-friendly environment that provides high-wage jobs for the 21st century.

It includes 10 new approaches to family economic problems, and 10 initiatives that I have sponsored before. But, what makes this proposal unique is that it takes simple, necessary, common sense steps in the right direction. Each element of this plan can stand alone. It uses the Tax Code to help workers keep up, and rewards businesses that reward workers.

I believe that these proposals are what real families need to make ends meet and to feel that they have a chance in the new economy.

Let us start with wages. Under this proposal we reward work—those who are on the job and off the dole—by increasing the minimum wage from $4.25 and hour to $5.15 an hour. Maybe my Republican opponents don't know what an increase means in real terms: It means an additional $1,800—the equivalent of 7 months of groceries.

Second, when it comes to educating kids—while the Republicans are cutting Pell grants and student loans for average working families—I want to use the Tax Code creatively. This proposal gives every family a $10,000 maximum deduction for tuition costs; and it allows their sons or daughters, who take out a student loan, to deduct the interest on that loan so they are not saddled with debt as soon as they graduate.

But more than helping families pay for tuition costs, I want to help parents get the lifetime education and training they will need to compete. That is why my proposal encourages companies to provide education and training with a $5,200 per employee tax deduction for training.

These proposals are real-life solutions to real-life family problems. How can we say that everyone should go to college—everyone should be trained and retrained—and then make it as difficult as we can to do it. How can we not provide incentives to help educate our workforce when we know that in 1972 people with advanced degrees earned 72 percent more than high school graduates—when we know that by 1992 those with graduate degrees made 2.5 times more than high school graduates—and when we know that today high school dropouts earn scarcely half as much as high school graduates and the education gap is widening?

But education costs and retraining are not the only hurdles families are facing. Health care costs and the fear of catastrophic illness of a loved one add to America's insecurities. Every American has the right to feel secure that if they get sick, or their child or parents get sick, they will not face financial ruin. So, my plan endorses the Kennedy-Kassebaum bill that makes health insurance portable and limits preexisting condition clauses. But it goes one step further.

We know too well the horrors of a family who has tragically lost a loved one at a young age. The entire family, in a time of grief, can be faced with mounting medical bills. This proposal provides some security for younger families who are forced to sell family property because of a terminal illness. It zeroes-out capital gains taxes for them to give them a chance to recover.

I am tired of going around Massachusetts and hearing stories of a family that took 10 years to crawl out from under the burden of debt caused by the loss of a loved one to breast cancer—which strikes 1 in every 9 Massachusetts women—or AIDS—which is the leading killer of Massachusetts residents aged 25 to 44. I am tired of going back to Washington to see Republicans continue their attempts to cut Medicare and Medicaid and cruelly leave so many of these young families in their political wake.

Young families are the strength of this Nation. If they work hard they have every right to expect success, security, and a piece of the dream—and it is up to us to help them achieve it. I came to the Senate when my daughters were young and I know how hard it is to have a career and be a good parent. Many families cannot afford the cost of daycare, and do not want to be separated from their children. That is why I am proposing that businesses get a tax credit of up to 50 percent of their investment up to $150,000 for establishing on-site daycare centers for employees. Since the average American family spends $9,000 a year on daycare, it makes sense to help businesses keep families together—kids can be a few floors away rather than a few miles away, and we can take away parental anxiety while we raise their productivity. The Glass Ceiling Commission and others said that on-site daycare raises the productivity of American workers by 10 percent. So what are we waiting for?

These are proposals to put more money in people's pockets, and there is one more proposal that is especially important to Massachusetts and working families everywhere: I am proposing to create a Federal tax deduction for local sewer and water fees to help those hardest hit by soaring water rates that are above 1 percent of a taxpayers adjusted gross income.

In and around Boston, water rates continue to escalate—from $185 per year in 1985 to $525 per year in 1992 and $618 for 1996. By the year 2000, the rate is projected to rise to $800. The Tax Code allows deductions for State and local taxes, and this will similarly avoid the double tax on water and sewer rates for homeowners.

And most importantly I reiterate my strong desire to double the income levels for those who participate in IRA's. I want individuals with incomes of $50,000 and couples who make $80,000 to be allowed to deduct IRA contributions. And I want them to be allowed early distribution to finance education, first time home buying, medical bills associated with catastrophic illness and long-term unemployment. This is a common sense approach to increasing the national savings rate without breaking the Treasury. This is an innovative approach that gives families the flexibility to grow and build and cope with economic reality.

These are the creative programs we should incorporate into the Tax Code instead of giving tax breaks to MacDonalds to finance their foreign advertising budget. That is why I sponsored a bipartisan bill to cut $60 billion in corporate welfare and that is why I am proposing to stop companies from deducting the salaries of employees who earn over $1 million a year.

No wonder the average American does not trust Government to help them.

To begin helping business move us in the right direction I am proposing today a seven part business-to-family plan that provides direct assistance to high-growth, high-wage, job-producing businesses; and punishes businesses that put the bottom-line first and families last.

On the positive side, I am proposing to completely eliminate capital gains taxes for investors who hold stock for more than 10 years in qualified small, high-growth, job-creating, critical-technology companies that do at least 75 percent of their business in the United States; and I am proposing to reduce the tax burden by 50 percent for investors who hold stock for at least 5 years.

Massachusetts leads the Nation in these cutting-edge technology-driven businesses, and is a model for the Nation on making investments count for American working families. Let us make the Massachusetts high-tech experience, America's experience.

These businesses are doing it right and expanding into the global market, and we should be encouraging that expansion. That is why this plan encourages small businesses to export and that is why it levels the playing field in Federal export financing between the Export-Import Bank's 90-percent guaranteed coverage and the Small Business Administration's 75 to 80 percent coverage. The Coalition of New England Companies for Trade strongly supports this export enhancement idea because they know it will work. But, most importantly, it encourages companies to keep jobs in this country and—like Aaron Feuerstein—it encourages them to recognize that their employees are an asset not a liability.

My friends, as I meet people across this State, I find that many are concerned about their retirement. Employee pension plans should be sacred. That is why this proposal makes sure that private pension plans are not the toybox of corporate America. I am proposing that we prohibit companies from using pension plans when considering financing mergers and acquisitions; and we prohibit companies from deducting merger and acquisition expenses if the merger results in a 15 percent reduction in the work force.

And we should not be rewarding corporate behavior with misguided tax loopholes that gives favorable tax treatment to companies that move offshore. If nothing else, a good corporate citizen keeps jobs in America, stays in America, and builds the American economy. I am proposing that we close those loopholes immediately.

To take corporate citizenship one step further, I think we should punish Federal contractors that hire illegal immigrants. The Federal Government should lead by example and not allow its contractors to hire undocumented foreign workers at the expense of an American job. That is common sense and its the kind of corporate citizenship that we have every right to demand.

I am also proposing that Congress give its unequivocal support to the idea of companies granting stock options to people they layoff and downsize out of a job. Why should not CEO's with guaranteed golden parachutes give loyal workers at least a tin parachute to make downsizing easier?

I am also proposing that we retroactively and permanently extend the Research and Development tax credit that is so critical to a pro-growth, future oriented economy that understands that responsible, thoughtful investment in research and development can and will create the kind of high-

wage jobs we need. This provision is, perhaps, the most critical of all. It establishes our commitment to investing in the future. It is not a gamble or a waste of taxpayers' dollars. It is a sure bet; and we should be willing to make it.

We should be willing to accept the costs of any and all of these proposals—first because they can be offset by the $60 billion in savings we get from stopping corporate welfare under the bi-partisan bill that Senator MCCAIN and I sponsored; and second, because we have to step up to the plate for what's right for working families and what's right for America.

So, what does my American Family Income and Economic Security Act do? It helps workers, it supports businesses, and it rewards corporate citizenship. It addresses the anxieties of American working families, and it begins to move us in the right direction. It fights against the wrong-headedness of Republican policies that have downsized the American dream and shifted wealth to the top 10 percent of Americans.

It is time to begin the shift back at least enough to protect hard working families from the extreme political agenda of the Republicans in Congress. So, this proposal is a hedge against the incredible odds that working families face every day in meeting the bills for health care, education, and a decent retirement. It is a hedge against stagnant wages, and it is a challenge to businesses to be good corporate citizens, and to build a family friendly workplace so that, together, we can build a better stronger American economy.

By Mr. FORD (for himself, Mr. COATS, Mr. LUGAR, Mrs. HUTCHISON, and Mr. MCCONNELL):

S. 1686. A bill to provide for early deferred annuities under chapter 83 of Title 5, United States Code, for certain former Department of Defense employees who are separated from service by reason of certain defense base closures, and for other purposes; to the Committee on Governmental Affairs.

DEFENSE PRIVATIZATION AND WORKER PROTECTION LEGISLATION

Mr. FORD. Mr. President, this country has undergone tremendous changes over the last few years as a result of military downsizing and base closures. Making the transition has proved very difficult to communities all across the country and today, in an effort to ease that transition, I am introducing legislation with original cosponsors Senators COATS, LUGAR, HUTCHINSON, and MCCONNELL directed at specific problems we've seen with privatization of these bases.

I know many of my colleagues are aware of the job loss that results from downsizing. That is because many jobs have become obsolete or redundant. But, there's also a whole other category of affected employees, whose skills and expertise are still needed by the military in the same roles, but in new privatized facilities. Under the 1995 Base Closure and Realignment Commission (BRAC), these employees are still eligible to work for the Federal Government and receive a Federal pension.

However, this would defeat one of our major goals in privatization—to save the taxpayer money. The idea under privatization is to continue utilizing these workers' much-needed skills, but in the private sector, at a reduced cost to the taxpayer. Yet, by sending these workers out into the private sector, we are asking a huge portion of them to give up their retirement benefits.

These workers are in a catch-22. If they move into the privatized facilities, where they would be performing the same mission and jobs as they had as Federal employees, they lose hard-earned pensions. If they remain in the Federal Government, they could face lower paying positions, while the community loses those workers altogether.

With little incentive to move into the private sector, these employees could create a vacuum that private contractors are unable to fill. Under that scenario everyone loses: Highly skilled workers will be underemployed and underpaid. Private contractors won't be able to meet the challenge of taking over government facilities. And the taxpayer will foot the $390 million cost-avoidance bill the Navy estimates the government faces if they have to keep these workers on the payroll and deal with the failure of privatization.

This problem was brought to my attention when the Louisville Naval Ordnance Station began the process of privatization, where unlike other base closings, moving the work would be a far greater cost than privatizing. But, it is a problem faced by workers in the same situation all across the country.

That is why I am introducing legislation to provide a deferred annuity for those Department of Defense employees who are targeted for privatization, but stand to lose their benefits under the Civil Service Retirement System (CSRS). With this legislation, we can make good on the promise our Government made with these employees when they entered Government Service, and assure private contractors that a skilled work force will be available to them when they assume control of former Defense Department facilities.

Most Federal employees hired before 1984 participate in the CSRS, while workers hired after 1984 belong to the Federal Employees Retirement System (FERS). Unlike CSRS, FERS is a portable plan, allowing a Federal employee to move between Federal and non-federal employment, without significantly penalizing the accrual of Federal benefits. Unfortunately, CSRS participants do not enjoy this same flexibility, because CSRS is a single component defined benefit plan.

Because CSRS-covered employees are forced to separate from Federal employment before they're eligible for an immediate annuity, they see their federal retirement benefits lose considerable value. And, employees who withdraw their retirement contribution not only forfeit all benefits, but also cost the government money up front.

I think we can all agree that privatization is a key component of reorganizing our defense priorities in this post-cold-war era of military downsizing. But, I believe my legislation is critical to ensuring that privatization works.

It can accomplish these goals by providing a deferred annuity with indexing pension benefits for CSRS Department of Defense employees. Their positions will be immediately transferred to contractors assuming the workload designated for privatization. In this way we can provide a very restricted, but common sense way of keeping our military infrastructure running smoothly as we embark on military privatization's maiden voyage.

And perhaps equally important, my legislation sends a clear message to this work force that their loyalty and dedication did not go unnoticed. These workers provided our men and women in uniform with the finest maintenance, supply and logistics system in the world. The best way we can repay this commitment to excellence is to uphold the Federal Government's end of the contract made when these workers first entered Government Service. That's in the workers' best interest and in the best interest of the Nation.

I would also like at this time to thank Mrs. Carolyn Merk of the Congressional Research Service for her outstanding professional work in helping craft this legislation that we're introducing today.

Mr. President, I ask unanimous consent that additional material be printed in the RECORD.

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

S. 1686

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

SECTION 1. EARLY DEFERRED ANNUITIES OF CERTAIN FORMER EMPLOYEES OF THE DEPARTMENT OF DEFENSE.

(a) DEFINITIONS.—For purposes of this section—

(1) the term ''Civil Service Retirement System'' means the retirement system under subchapter III of chapter 83 of title 5, United States Code;

(2) the term ''defense contractor'' means any entity that—

(A) contracts with the Department of Defense to perform a function previously performed by Department of Defense employees;

(B) performs that function at the same installation at which such function was previously performed by Department of Defense employees or in the vicinity of that installation; and

(C) is the employer of one or more transferred employees;

(3) the term ''early deferred retirement age'' means the first age at which a transferred employee would have been eligible for immediate retirement under subsection (a)

or (b) of section 8336 of title 5, United States Code, if such transferred employee had remained an employee within the meaning of section 8331(1) of such title continuously until attaining such age;

(4) the term ''severance pay'' means severance pay payable under section 5595 of title 5, United States Code;

(5) the term ''separation pay'' means separation pay payable under section 5597 of title 5, United States Code; and

(6) the term ''transferred employee'' means a former employee of the Department of Defense (other than a temporary employee) who—

(A) while employed by the Department of Defense at a military installation to be closed or realigned pursuant to recommendations of the Defense Base Closure and Realignment Commission that were approved by the President in 1995 under section 2903(e) of the Defense Base Closure and Realignment Act of 1990 (title XXIX of Public Law 101–510; 10 U.S.C. 2687 note) and while covered under the Civil Service Retirement System, was separated from Federal service in a reduction-in-force resulting from conversion from performance of a function by Department of Defense employees at that military installation to performance of that function by a defense contractor at that installation or in the vicinity of that installation;

(B) is employed by the defense contractor within 60 days following such separation to perform substantially the same function performed before the separation;

(C) remains employed by the defense contractor or a successor defense contractor, or subcontractor of a defense contractor until attaining early deferred retirement age or is involuntarily separated from employment by the defense contractor before attaining such age for reasons other than misconduct;

(D) at the time separated from Federal service, was not eligible for an immediate annuity under the Civil Service Retirement System;

(E) does not withdraw retirement contributions under section 8342 of title 5, United States Code; and

(F)(i) has not received separation pay or severance pay due to a separation described in subparagraph (A); or

(ii) has repaid the full amount of such pay with interest (as determined by the Office of Personnel Management) to the Department of Defense before attaining early deferred retirement age.

(b) RETIREMENT BENEFITS OF TRANSFERRED EMPLOYEES.—Notwithstanding the age requirement under section 8338(a) of title 5, United States Code, payment of a deferred annuity for which a transferred employee is eligible under that section shall commence on the first day of the first month that begins after the date on which the transferred employee attains early deferred retirement age.

(c) COMPUTATION OF AVERAGE PAY.—(1)(A) This paragraph applies to the computation of the annuity of a transferred employee who retires under this section who immediately before separation from Federal service as described under subsection (a)(6)(A) was employed in a position classified under the General Schedule.

(B) Subject to subparagraph (C), in the computation of an annuity referred to under subparagraph (A) for a transferred employee, the average pay of the transferred employee under section 8331(4) of title 5, United States Code, shall be adjusted at the same time and by the same percentage that rates of basic pay are increased under section 5303 of title 5, United States Code, during the period beginning on the date on which the transferred employee separates from Federal service as described under subsection (a)(6)(A) and ending on the date on which the transferred employee attains early deferred retirement age.

(C) Average pay as adjusted by this paragraph may not exceed the limitation on maximum pay, final pay, or average pay (as applicable) under section 8340(g)(1) (A) or (B) of title 5, United States Code.

(2)(A) This paragraph applies to the compensation of an annuity of a transferred employee who retires in accordance with this section who immediately before separation from Federal service as described under subsection (a)(6)(A) was a prevailing rate employee as defined under section 5342(2) of title 5, United States Code.

(B) In the computation of an annuity referred to under subparagraph (A) for a transferred employee, average pay under section 8331(4) of title 5, United States Code, shall be adjusted at the same time and by the same percentage that pay rates for positions that are in the same area as, and are comparable to, the last position the transferred employee held as a prevailing rate employee, are increased under section 5343(a) of such title during the period beginning on the date on which the transferred employee separates from Federal service as described under subsection (a)(6)(A) and ending on the date on which the transferred employee attains early deferred retirement age.

(d) SERVICE FOR A DEFENSE CONTRACTOR RELATING TO CREDITABLE SERVICE AND HEALTH INSURANCE.—(1) Service performed by a transferred employee for a defense contractor after separation from Federal service as described under subsection (a)(6)(A) shall not be treated as creditable service for purposes of computing the amount of an early deferred annuity in accordance with this section.

(2) Nothing in this section shall be construed to require employee or agency contributions under chapter 89 of title 5, United States Code, for any period of service performed by a transferred employee for a defense contractor after separation from Federal service as described under subsection (a)(6)(A).

(e) RECEIPT OF BENEFITS WHILE EMPLOYED BY A DEFENSE CONTRACTOR.—A transferred employee may commence receipt of an early deferred annuity in accordance with this section while continuing to work for a defense contractor.

(f) LUMP-SUM CREDIT PAYMENT.—If a transferred employee dies before attaining early deferred retirement age, such employee shall be treated as a former employee who dies not retired for purposes of payment of the lump-sum credit under section 8342(d) of title 5, United States Code.

(g) IMPLEMENTING REGULATIONS.—The Office of Personnel Management shall promulgate regulations to carry out the provisions of this section.

(h) EFFECTIVE DATE.—This section shall take effect on August 1, 1996, and shall apply to transferred employees separated from Federal service on or after that date.

BRAC PRIVATIZATION: THE CSRS ISSUE

ISSUE

The 1995 Base Realignment and Closure (BRAC) Commission recommended the privatization of certain military facilities. The President has directed the Air Force to privatize two Air Force logistic centers. For privatization to succeed, the maintenance of an experienced workforce is critical. Retirement benefits have become recognized as a major impediment to the privatization of the Louisville and Indianapolis Navy facilities and other Department of Defense (DOD) facilities.

Without legislation to protect their retirement benefits many employees will—and are—transferring to other Federal positions to maintain and protect their retirement benefits under the Civil Service Retirement System (CSRS).

If many key employees transfer within the Government rather than work for a private sector contractor, privatization savings to the Government may not be fully realized. The Department of the Navy estimates that privatization of Louisville and Indianapolis would provide up to $390 million in ''cost avoidance'' to the Government. Unlike other Base closings, the cost to the Federal government to close and move the work at Louisville and Indianapolis is far greater than the cost of privatization. The retention of the Federal employees at these facilities is essential to the private contractor.

BACKGROUND

The 1995 BRAC Commission directed privatization of two Navy facilities with a large federal workforce, the Naval Surface Warfare Center, Louisville, Kentucky and the Naval Surface Warfare Center, Indianapolis, Indiana. In addition, President Clinton directed the Air Force to try and privatize two Air Force logistic centers, one in Texas and one in California which were ordered to be closed by the 1995 BRAC.

These Federal employees are different from other employees adversely affected by downsizing. The key difference is that these employees are not being separated because their services are no longer needed or because the work they accomplished is redundant or unnecessary. Under the BRAC ''Close and Move'' scenario, these employees would have been eligible to continue their Federal employment (and qualify for an annuity) at another federal installation. These employees are expected to continue accomplishing the same mission as before, but they will be working as private sector employees.

Most Federal employees hired before 1984 currently participate in the CSRS. Those workers hired after 1984 participate in the Federal Employees Retirement System (FERS). FERS is different than CSRS because it is a portable plan that allows a Federal employee to move between Federal and non-federal employment. In doing so, the accrual of Federal benefits is not significantly penalized.

However, employees under CSRS have no portability because it is a single component defined benefit plan. Therefore, when CSRS-COVERED workers are forced to separate from Federal employment before they are eligible for an immediate annuity, their retirement benefits lose considerable value. Employees who lose their Federal position and withdraw their retirement contribution early will forfeit all benefits from the Federal government and thereby are not eligible for a pension.

Employees with the most experience tend to be covered under CSRS. These are the employees the contractor taking over the work at a government facility considers to be very valuable. For example, 46% of the employees at the Louisville Naval Surface Warfare Center are covered by CSRS and are not eligible for retirement. Many of these employees, and those in Indiana, Texas and California who are highly skilled, are seeking to transfer to other Federal positions. Some are even accepting lower paid positions within DOD so they may maintain their CSRS retirement benefits. As a result, there is little incentive for CSRS employees to accept positions with the private contractor. Therefore, the privatization of Federal facilities could fail at a significant cost to the Government and the U.S. taxpayers.

LEGISLATIVE REMEDY:

To rectify the CSRS issue, the attached draft legislation proposes to index a deferred

annuity for certain DOD CSRS Employees. The legislation would address the issue of CSRS employees receiving a retirement benefit by:

Indexing the average pay on which the annuity is computed, and

Allowing a Federal deferred annuity to be paid to specific CSRS employees at the individuals optional retirement age.

The legislation will apply only to Transferred Employees of the Department of Defense. A Transferred Employee is one whose job is privatized pursuant to a 1995 decision of the BRAC Commission and pursuant to a President directive privatizing a base to be closed by the 1995 BRAC. This indexedial deferred annuity will be available only to individuals participating in CSRS, and not to those participating in FERS. The proposed legislation will apply to only those CSRS employees who are ineligible to retire and who accept work with the private contractor. They will be ineligible for severance pay.

Reasons for legislation:

At this time there are no administrative remedies.

Treats employees equitably and thus stabilizes the work force for privatization.

By Mr. KERRY:

S. 1687. A bill to provide for annual payments from the surplus funds of the Federal Reserve System to cover the interest on obligations issued by the Financing Corporation; to the Committee on Banking, Housing, and Urban Affairs.

THE FEDERAL RESERVE SURPLUS ACT OF 1996

● Mr. KERRY. Mr. President, I am introducing the Federal Reserve Surplus Act of 1996 to provide a solution to an impending crisis in our financial services industry, and to avoid once again having to use taxpayers' money to bail out another round of S&L failures. I am happy to join my colleague in the House, Congressman BARNEY FRANK as well as other members of the Massachusetts delegation, Congressmen JOE KENNEDY, MARTY MEEHAN, and RICHARD NEAL, who introduced the companion bill in the House of Representatives.

This bill will ease the obligation remaining from the savings and loan crisis of the 1980's with a creative approach that does not burden the banking institutions or taxpayers, but uses an existing $3.7 billion fund at the Federal Reserve. The GAO tells us that because the Federal Reserve's interest income so far exceeds its expenses, we believe it is highly unlikely the System will ever incur sufficient annual losses such that it would be required to use any funds in the surplus account.

Savings and loans are required to pay almost $800 million per year in interest on financing corporation bonds which were sold to cover depositor claims on S&L's that failed in the 1980's. This legislation would use $3 billion from the Federal Reserve's surplus fund as a contribution toward the payment of the FICO interest obligation. This would leave about $1 billion in the fund.

It is generally believed, within the financial community, as Congressman FRANK has said, that ''continuing to require the savings and loans to pay the entire FICO interest obligation would worsen the disparity between what banks must pay to such a degree as to risk default by the SAIF, which would ultimately result in a further drain on the Treasury.''

Mr. President, this just makes sense. The Federal Reserve is controlling a fund with no specific purpose—paid in by banks—and the Congress should turn to this fund first before asking bankers in this country to bear the burden of recapitalizing the savings association insurance fund.

Mr. President, I ask unanimous consent to have the bill printed in the RECORD.

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

S. 1687

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 ''Federal Reserve Surplus Act of 1996''.

SEC. 2. TRANSFER OF FEDERAL RESERVE SURPLUS FUNDS TO MEET FICO CARRYING COSTS.

(a) IN GENERAL.—Section 7(a) of the Federal Reserve Act (12 U.S.C. 289) is amended by adding at the end the following new paragraph:

''(4) FICO PAYMENTS.—

''(A) IN GENERAL.—During the period beginning on the date of enactment of the Federal Reserve Surplus Act of 1996 and ending on the date on which the Financing Corporation ceases to have any obligations outstanding under section 21(e) of the Federal Home Loan Bank Act, the Board shall annually transfer (in addition to the transfers of funds required under paragraph (3)) to the Financing Corporation, from amounts in the surplus funds of the Federal reserve banks, an amount equal to $3,000,000,000 divided by the number of calendar years any portion of which falls within such period for use in accordance with section 21(f)(1) of the Federal Home Loan Bank Act.

''(B) ALLOCATION.—The Board shall annually determine, on the basis of such factors as the Board considers appropriate, the manner in which the amount of the obligation of the Board under subparagraph (A) shall be allocated among the surplus funds of the Federal reserve banks.''.

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 21(f) of the Federal Home Loan Bank Act (12 U.S.C. 1441(f)) is amended to read as follows:

''(1) FEDERAL RESERVE SURPLUS.—

''(A) IN GENERAL.—Amounts transferred to the Financing Corporation by the Board of Governors of the Federal Reserve System from the surplus funds of the Federal reserve banks in accordance with section 7(a)(4) of the Federal Reserve Act.

''(B) TREATMENT IN CASE OF BANK INSURANCE FUND MEMBER ASSESSMENTS.—To the extent Bank Insurance Fund members (as defined in section 7(l)(4) of the Federal Deposit Insurance Act) are subject to any assessments under this subsection, the total amount of such assessments which, but for this subparagraph, would be imposed on all such members for any year shall be reduced by the transferred amount referred to in subparagraph (A) with respect to such year.''.●

By Mr. DOLE (for himself, Mr. SIMON, Mr. ABRAHAM, Ms. MOSELEY-BRAUN, Mr. MURKOWSKI, Ms. MIKULSKI, Mr. HELMS, Mr. ROTH, Mr. SANTORUM, and Mr. LUGAR):

S.J. Res. 51. A joint resolution saluting and congratulating Polish people around the world as, on May 3, 1996, they commemorate the 205th anniversary of the adoption of Poland's first constitution; to the Committee on the Judiciary.

POLAND CONSTITUTION 205TH ANNIVERSARY COMMEMORATION JOINT RESOLUTION

Mr. DOLE. Mr. President, today I am introducing a joint resolution which salutes and congratulates Polish people around the world on the occasion of the 205th anniversary of the Polish Constitution. I am pleased to be joined by Senators SIMON, ABRAHAM, MOSELEY-BRAUN, MURKOWSKI, MIKULSKI, HELMS, ROTH, SANTORUM, and LUGAR. This resolution is being introduced today in the House by Congressman JACK QUINN of New York and a number of bipartisan cosponsors.

Poland is one of America's oldest and closest friends. Many of its sons and daughters have crossed the ocean to our shores over the past 200 years. Indeed, from the very birth of our great nation we have benefited from the talent and dedication of the Polish people. When we fought for our independence, Thaddeus Kosciuszko—a native son of Poland—fought alongside General Washington. Today, memorials to Kosciuszko's courage, military skill, and genuine friendship, can be found in our Capital and in many cities across the United States.

Following the War of Independence, Kosciuszko carried back to Poland the American concept of constitutional democracy. Poland's 1791 Constitution was the first constitution in Central and Eastern Europe to secure individual and religious freedom for all persons. It also formed a government much like ours, composed of distinct legislative, executive, and judicial powers. I would like to quote from the Polish Constitution which declares, ''All power in civil society should be derived from the will of the people.''

Tragically, this Constitution was only in effect for less than 2 years. However, its principles endured for 2 centuries. And over the last 5 years—since the disintegration of the Warsaw Pact—Poland has finally realized the promise of freedom and democracy held in the 1791 Constitution.

So, on May 3, 1996, when the citizens of Poland celebrate the 205th anniversary of the adoption of Poland's first Constitution, we want them to know that the United States Congress shares in their celebration. No doubt, all across our 50 States, Polish-Americans will be celebrating and taking pride in their rich heritage. This joint resolution salutes and congratulates all Polish people, wherever they may now reside, on this great and historic occasion.

Mr. President, I ask unanimous consent that the text of the joint resolution be printed in the RECORD.

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

S.J. RES. 51

Whereas, on May 3, 1996, Polish people around the world, including Americans of Polish decent, will celebrate the 205th anniversary of the adoption of the first Polish constitution;

Whereas American Revolutionary War hero Thaddeus Kosciuszko introduced the concept of constitutional democracy to his native country of Poland;

Whereas the Polish constitution of 1791 was the first liberal constitution in Europe and represented Central-Eastern Europe's first attempt to end the feudal system of government;

Whereas this Polish constitution was designed to protect Poland's sovereignty and national unity and to create a progressive constitutional monarchy;

Whereas this Polish constitution was the first constitution in Central-Eastern Europe to secure individual and religious freedom for all persons in Poland;

Whereas this Polish constitution formed a government composed of distinct legislative, executive, and judicial powers;

Whereas this Polish constitution declared that ''all power in civil society should be derived from the will of the people'';

Whereas this Polish constitution revitalized the parliamentary system by placing preeminent lawmaking power in the House of Deputies, by subjecting the Sejm to majority rule, and by granting the Sejm the power to remove ministers, appoint commissars, and choose magistrates;

Whereas this Polish constitution provided for significant economic, social, and political reforms by removing inequalities between the nobility and the bourgeoisie, by recognizing town residents as ''freemen'' who had judicial autonomy and expanded rights, and by extending the protection of the law to the peasantry who previously had no recourse against the arbitrary actions of feudal lords;

Whereas, although this Polish constitution was in effect for less than 2 years, its principles endured and it became the symbol around which a powerful new national consciousness was born, helping Poland to survive long periods of misfortune over the following 2 centuries; and

Whereas, in only the last 5 years, Poland has realized the promise held in the Polish constitution of 1791, has emerged as an independent nation after its people led the movement that resulted in historic changes in Central-Eastern Europe, and is moving toward full integration with the Euro-Atlantic community of nations: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That—

(1) the people of the United States salute and congratulate Polish people around the world, including Americans of Polish descent, as on May 3, 1996, they commemorate the 205th anniversary of the adoption of the first Polish constitution;

(2) the people of the United States recognize Poland's rebirth as a free and independent nation in the spirit of the legacy of the Polish constitution of 1791; and

(3) the Congress authorizes and urges the President of the United States to call upon the Governors of the States, the leaders of local governments, and the people of the United States to observe this anniversary with appropriate ceremonies and activities.

ADDITIONAL COSPONSORS

S. 881

At the request of Mr. PRYOR, the name of the Senator from North Carolina [Mr. HELMS] was added as a cosponsor of S. 881, a bill to amend the Internal Revenue Code of 1986 to clarify provisions relating to church pension benefit plans, to modify certain provisions relating to participants in such plans, to reduce the complexity of and to bring workable consistency to the applicable rules, to promote retirement savings and benefits, and for other purposes.

S. 953

At the request of Mr. CHAFEE, the names of the Senator from Nebraska [Mr. KERREY], the Senator from Maine [Ms. SNOWE], the Senator from Iowa [Mr. HARKIN], and the Senator from South Carolina [Mr. HOLLINGS] were added as cosponsors of S. 953, a bill to require the Secretary of the Treasury to mint coins in commemoration of black revolutionary war patriots.

S. 968

At the request of Mr. MCCONNELL, the name of the Senator from Wyoming [Mr. SIMPSON] was added as a cosponsor of S. 968, a bill to require the Secretary of the Interior to prohibit the import, export, sale, purchase, and possession of bear viscera or products that contain or claim to contain bear viscera, and for other purposes.

S. 984

At the request of Mr. GRASSLEY, the name of the Senator from Alaska [Mr. MURKOWSKI] was added as a cosponsor of S. 984, a bill to protect the fundamental right of a parent to direct the upbringing of a child, and for other purposes.

S. 1028

At the request of Mr. WYDEN, his name was added as a cosponsor of S. 1028, a bill to provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

At the request of Mrs. KASSEBAUM, the names of the Senator from Colorado [Mr. CAMPBELL], and the Senator from New Mexico [Mr. DOMENICI] were added as cosponsors of S. 1028, supra.

S. 1183

At the request of Mr. HATFIELD, the name of the Senator from Hawaii [Mr. INOUYE] was added as a cosponsor of S. 1183, a bill to amend the Act of March 3, 1931 (known as the Davis-Bacon Act), to revise the standards for coverage under the Act, and for other purposes.

S. 1355

At the request of Mr. DORGAN, the names of the Senator from West Virginia [Mr. ROCKEFELLER], the Senator from Nevada [Mr. BRYAN], the Senator from Arkansas [Mr. PRYOR], the Senator from California [Mrs. BOXER], and the Senator from Hawaii [Mr. INOUYE] were added as cosponsors of S. 1355, a bill to amend the Internal Revenue Code of 1986 to end deferral for United States shareholders on income of controlled foreign corporations attributable to property imported into the United States.

S. 1400

At the request of Mrs. KASSEBAUM, the name of the Senator from Indiana [Mr. COATS] was added as a cosponsor of S. 1400, a bill to require the Secretary of Labor to issue guidance as to the application of the Employee Retirement Income Security Act of 1974 to insurance company general accounts.

S. 1473

At the request of Ms. SNOWE, the name of the Senator from North Dakota [Mr. CONRAD] was added as a cosponsor of S. 1473, a bill to authorize the Administrator of General Services to permit the posting in space under the control of the Administrator of notices concerning missing children, and for other purposes.

S. 1505

At the request of Mr. LOTT, the name of the Senator from Oklahoma [Mr. INHOFE] was added as a cosponsor of S. 1505, a bill to reduce risk to public safety and the environment associated with pipeline transportation of natural gas and hazardous liquids, and for other purposes.

S. 1537

At the request of Mr. ROBB, the name of the Senator from Missouri [Mr. ASHCROFT] was added as a cosponsor of S. 1537, a bill to require the Administrator of the Environmental Protection Agency to issue a regulation that consolidates all environmental laws and health and safety laws applicable to the construction, maintenance, and operation of above-ground storage tanks, and for other purposes.

S. 1563

At the request of Mr. SIMPSON, the name of the Senator from Louisiana [Mr. BREAUX] was added as a cosponsor of S. 1563, a bill to amend title 38, United States Code, to revise and improve eligibility for medical care and services under that title, and for other purposes.

S. 1568

At the request of Mr. HATCH, the name of the Senator from Colorado [Mr. CAMPBELL] was added as a cosponsor of S. 1568, a bill to amend the Internal Revenue Code of 1986 to provide for the extension of certain expiring provisions.

S. 1578

At the request of Mr. FRIST, the name of the Senator from Rhode Island [Mr. CHAFEE] was added as a cosponsor of S. 1578, a bill to amend the Individuals with Disabilities Education Act to authorize appropriations for fiscal years 1997 through 2002, and for other purposes.

S. 1610

At the request of Mr. BOND, the name of the Senator from Arizona [Mr. KYL] was added as a cosponsor of S. 1610, a bill to amend the Internal Revenue Code of 1986 to clarify the standards used for determining whether individuals are not employees.

S. 1623

At the request of Mr. WARNER, the names of the Senator from Virginia [Mr. ROBB] and the Senator from California [Mrs. BOXER] were added as cosponsors of S. 1623, a bill to establish a National Tourism Board and a National Tourism Organization, and for other purposes.

SENATE RESOLUTION 226

At the request of Mr. DOMENICI, the names of the Senator from Virginia [Mr. WARNER] and the Senator from Minnesota [Mr. WELLSTONE] were added as cosponsors of Senate Resolution 226, a resolution to proclaim the week of October 13 through October 19, 1996, as ''National Character Counts Week.''

SENATE RESOLUTION 248—RELATIVE TO LIBERIA

Mr. FEINGOLD (for himself, Mrs. KASSEBAUM, Mr. SIMON, Mr. LEAHY, Mr. JEFFORDS, and Mr. PELL) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 248

Whereas, the war in Liberia begun in 1989 has devastated that country, with more than 150,000 people killed, up to 1 million forced to flee as refugees to neighboring countries, and thousands of children conscripted into the rebel armies;

Whereas, the Abuja Accords signed in August 1995 represented the most realistic path for lasting peace;

Whereas, the Senate passed a resolution on September 20, 1995, expressing the sense of the Congress that the United States should strongly support the peace process in Liberia, including support for the west African peacekeeping force;

Whereas the U.S. committed $10 million in support for the west African peacekeeping force, but has delivered only $5.5 million, most of which arrived only in February 1996;

Whereas, the peacekeeping force has fewer than 6,000 soldiers, but needs over 15,000 to carry out its mission;

Whereas, violence characterized by massive looting, shelling, and ethnic hostilities broke out in Monrovia on April 6, 1996, forcing tens of thousands of people into hiding, without food and water, halting most humanitarian assistance programs in Liberia, and signifying a failure of the west African peacekeeping force to maintain order and stability in Monrovia;

Whereas, 214 U.S. armed forces and 1400 support personnel have been deployed to Liberia to facilitate the successful evacuation of approximately 1800 people, including over 300 Americans, from Liberia;

Whereas, while the U.S. is the only functioning diplomatic mission in Monrovia, some nations, such as Japan, have continuing economic concerns in Liberia and other nations, such as France, have national interests in western Africa; and

Whereas, negotiations for a ceasefire and the peaceful release of hostages are being led by Ghanian Kojo Tsikata, and Cote D'Ivoire, Burkina Faso and others are trying to use their influence to moderate combatants.

Therefore, be it resolved, that the Senate

(1) commends the U.S. Armed Forces and the U.S. Embassy personnel for the successful evacuation of over 1795 people from Liberia;

(2) declares that a breakdown of the Abuja process would have disastrous humanitarian ramifications and seriously threaten other U.S. interests in west Africa;

(3) calls upon all factions to reach a ceasefire and re-commit themselves to the Abuja process; and

(4) urges the Administration to:

a. scrutinize the Federal budget to identify funds that could be either re-programmed or transferred and used to support additional non-Nigerian West African peacekeepers;

b. consider the provision of excess defense articles for communications and logistical support and training for crowd-control techniques for non-Nigerian troops to participate effectively in a west African peacekeeping force;

c. use its influence with other nations with interests in Liberia to solicit further support for west African peacekeeping forces, including their participation at the April 26 meeting of a newly-formed Contact Group in Liberia; and

d. lead efforts in the United Nations to activate a Commission in the United Nations to develop an implementation plan and sanctions against those parties violating the U.N. arms embargo on Liberia.

Mr. FEINGOLD. Mr. President, I am submitting a resolution today on behalf of myself, and Senators KASSEBAUM, SIMON, LEAHY, JEFFORDS, and PELL, which includes proposals for United States action in support of the Liberian peace process. I will be speaking at length on this later this week.

AMENDMENTS SUBMITTED

THE IMMIGRATION AND NATIONALITY ACT AMENDMENT ACT OF 1996

FAIRCLOTH AMENDMENT NO. 3674

(Ordered to lie on the table.)

Mr. FAIRCLOTH submitted an amendment intended to be proposed by him to the bill (S. 1664) to amend the Immigration and Nationality Act to increase control over immigration to the United States by increasing border patrol and investigative personnel and detention facilities, improving the system used by employers to verify citizenship or work-authorized alien status, increasing penalties for alien smuggling and document fraud, and reforming asylum, exclusion, and deportation law and procedures; to reduce the use of welfare by aliens; and for other purposes; as follows:

At the appropriate place in the bill, insert the following new section:

SEC. . REVIEW OF CONTRACTS WITH STANDARDIZED CITIZENSHIP TEST CENTERS.

(a) IN GENERAL.—The Attorney General of the United States shall investigate and submit a report to the Congress regarding the practices of test centers authorized to administer the standardized citizenship test pursuant to section 312.3(a) of title 8, Code of Federal Regulations. The report shall include any findings of fraudulent practices by the centers.

(b) PRELIMINARY AND FINAL REPORTS.—Not later than 90 days after the date of the enactment of this Act, the Attorney General shall submit to the Congress a preliminary report of the findings of the investigation conducted pursuant to subsection (a) and shall submit to the Congress a final report within 275 days after the submission of the preliminary report.

THE HEALTH INSURANCE REFORM ACT OF 1996

KASSEBAUM (AND KENNEDY) AMENDMENT NO. 3675

Mrs. KASSEBAUM (for herself and Mr. KENNEDY) proposed an amendment to the bill (S. 1028) to provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes; as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Reform Act of 1996''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Definitions.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

Sec. 101. Guaranteed availability of health coverage.
Sec. 102. Guaranteed renewability of health coverage.
Sec. 103. Portability of health coverage and limitation on preexisting condition exclusions.
Sec. 104. Special enrollment periods.
Sec. 105. Disclosure of information.

Subtitle B—Individual Market Rules

Sec. 110. Individual health plan portability.
Sec. 111. Guaranteed renewability of individual health coverage.
Sec. 112. State flexibility in individual market reforms.
Sec. 113. Definition.

Subtitle C—COBRA Clarifications

Sec. 121. COBRA clarifications.

Subtitle D—Private Health Plan Purchasing Cooperatives

Sec. 131. Private health plan purchasing cooperatives.

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

Sec. 201. Applicability.
Sec. 202. Enforcement of standards.

TITLE III—MISCELLANEOUS PROVISIONS

Sec. 301. HMOs allowed to offer plans with deductibles to individuals with medical savings accounts.
Sec. 302. Health coverage availability study.
Sec. 303. Sense of the Committee concerning medicare.
Sec. 304. Effective date.
Sec. 305. Severability.

SEC. 2. DEFINITIONS.

As used in this Act:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(2) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(3) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except

that such term shall include only employers of two or more employees.

(4) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''employee health benefit plan'' means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))), or any health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)), that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a group health plan offered by a health plan issuer as defined in paragraph (8); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be construed to be a group health plan, an individual health plan, or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(5) FAMILY.—

(A) IN GENERAL.—The term ''family'' means an individual, the individual's spouse, and the child of the individual (if any).

(B) CHILD.—For purposes of subparagraph (A), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN GENERAL.—The term ''group health plan'' means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.

(B) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(7) GROUP PURCHASER.—The term ''group purchaser'' means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(10) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

(11) SECRETARY.—The term ''Secretary'', unless specifically provided otherwise, means the Secretary of Labor.

(12) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) NONDISCRIMINATION.—Except as provided in subsection (b), section 102 and section 103—

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage; and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish, under the terms of such plan, eligibility, enrollment, or premium contribution requirements for individual participants or beneficiaries, except that such requirements shall not be based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall prevent an employee health benefit plan or a health plan issuer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering a group health plan may cease offering coverage to group purchasers under the plan if—

(A) the health plan issuer ceases to offer coverage to any additional group purchasers; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is required to offer coverage to additional group purchasers.

Such health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer offers coverage to group purchasers under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a particular market or to require a health plan issuer to involuntarily issue a group health plan to a group health plan purchaser in a particular market if the group health plan was specifically designed for a different market. For the purposes of this paragraph, the term ''market'' means either the large employer market or the small employer market (as defined under applicable State law, or if not so defined, an employer with more than one employee and not more than 50 employees).

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) GROUP PURCHASER.—Subject to subsections (b) and (c), a group health plan shall be renewed or continued in force by a health plan issuer at the option of the group purchaser, except that the requirement of this subparagraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the group purchaser in accordance with the terms of the group health plan or where the health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(C) the termination of the group health plan in accordance with subsection (b); or

(D) the failure of the group purchaser to meet contribution or participation requirements in accordance with paragraph (3).

(2) PARTICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit plan or group health plan shall be renewed or continued in force, if the group purchaser elects to continue to provide coverage under such plan, at the option of the participant (or beneficiary where such right exists under the terms of the plan or under applicable law), except that the requirement of this paragraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the participant or beneficiary in accordance with the terms of the employee health benefit plan or group health

plan or where such plan has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application for coverage or claim for benefits;

(C) the termination of the employee health benefit plan or group health plan;

(D) loss of eligibility for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.); or

(E) failure of a participant or beneficiary to meet requirements for eligibility for coverage under an employee health benefit plan or group health plan that are not prohibited by this Act.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection, nor in section 101(a), shall be construed to—

(A) preclude a health plan issuer from establishing employer contribution rules or group participation rules for group health plans as allowed under applicable State law;

(B) preclude a plan defined in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan, a group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the health plan issuer offers to each group purchaser covered under a group health plan of this type, the option to purchase any other group health plan currently being offered by the health plan issuer; and

(C) in exercising the option to discontinue a group health plan of this type and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS.—

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering all group health plans in a State, a group health plan may be discontinued by the health plan issuer only if—

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan; and

(ii) all group health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(B) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer—

(i) to all group health plans offered to small employers (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan issuer in the State.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any group health plan in the market sector (as described in paragraph (2)(B)) in which issuance of such group health plan was discontinued in the State involved during the 5-year period beginning on the date of the discontinuation of the last group health plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan (as defined in paragraph (2)) may deny continued participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—An employee health benefit plan or a health plan issuer offering a group health plan may, with respect to a participant or beneficiary, impose a limitation or exclusion of benefits, otherwise available under the terms of the plan only if—

(1) such limitation or exclusion is a limitation or exclusion of benefits relating to the treatment of a preexisting condition; and

(2) such limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to a participant or beneficiary described in subsection (e)(2)(A) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries whose coverage is terminated under the plan. Pursuant to regulations promulgated by the Secretary, the duty of an employee health benefit plan to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such employee health benefit plan provides documentation to a participant or beneficiary that includes the following information:

(A) the dates that the participant or beneficiary was covered under the plan; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation to such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition, subject to the limits in subsection (a), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, with respect to a participant or beneficiary enrolling in an employee health benefit plan or a group health plan during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, coverage with respect to benefits or services relating to the treatment of a preexisting condition in accordance with subsections (a) and (b) may be excluded, except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

(d) AFFILIATION PERIODS.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting condition limitation or exclusion, if such plan does not utilize a limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary not to exceed 60 days (or in the case of a late participant or beneficiary described in subsection (c), 90 days) from the date on which the participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a health plan issuer offering a group health plan may also use alternative methods to address adverse selection as approved by the applicable certifying authority

(as defined in section 202(d)). During such an affiliation period, the plan may not be required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(e) PREEXISTING CONDITION.—

(1) IN GENERAL.—For purposes of this section, the term ''preexisting condition'' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(2) BIRTH, ADOPTION AND PREGNANCY EXCLUDED.—The term ''preexisting condition'' does not apply to—

(A) an individual who, within 30 days of the date of the birth or placement for adoption of a child (as determined under section 609(c)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; or

(B) pregnancy.

(f) STATE FLEXIBILITY.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for under this section; or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 30-day period provided for under subsection (b)(3); or

(3) require health plan issuers to have a lookback period that is shorter than the period described in subsection (e)(1);

unless such laws are preempted by section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member who—

(1) through marriage, separation, divorce, death, birth or placement of a child for adoption, experiences a change in family composition affecting eligibility under a group health plan, individual health plan, or employee health benefit plan;

(2) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member;

each employee health benefit plan and each group health plan shall provide for a special enrollment period extending for a reasonable time after such event that would permit the participant to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual, participant, or beneficiary but for failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption shall be deemed to be covered under the plan as of the date of such birth or placement for adoption if such child is enrolled within 30 days of the date of such birth or placement for adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—

(1) IN GENERAL.—In connection with the offering of any group health plan to a small employer (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) the provisions of such group health plan relating to renewability of coverage;

(C) the provisions of such group health plan relating to any preexisting condition provision; and

(D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Information shall be provided to small employers under this paragraph in a manner determined to be understandable by the average small employer, and shall be sufficiently accurate and comprehensive to reasonably inform small employers, participants and beneficiaries of their rights and obligations under the group health plan.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(b) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof the following new sentences: ''If there is a modification or change described in section 102(a)(1) that is a material reduction in covered services or benefits provided, a summary description of such modification or change shall be furnished to participants not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1996, providing alternative mechanisms to delivery by mail through which employee health benefit plans may notify participants of material reductions in covered services or benefits.''.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(A) by inserting ''including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits'' after ''type of administration of the plan'';

(B) by inserting ''including the name of the organization responsible for financing claims'' after ''source of financing of the plan''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through which participants may seek assistance or information regarding their rights under this Act and the Health Insurance Reform Act of 1996 with respect to health benefits that are not offered through a group health plan.'' after ''benefits under the plan''.

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) LIMITATION ON REQUIREMENTS.—

(1) IN GENERAL.—Except as provided in subsections (c) and (d), a health plan issuer described in paragraph (3) may not, with respect to an eligible individual (described in subsection (b)) desiring to enroll in an individual health plan—

(A) decline to offer coverage to, or deny enrollment of, such individual; or

(B) impose a limitation or exclusion of benefits, otherwise available under such plan, for which coverage was available under the group health plan or employee health benefit plan in which the individual was previously enrolled.

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.

(3) HEALTH PLAN ISSUER.—A health plan issuer described in this paragraph is a health plan issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term ''eligible individual'' means an individual who—

(1) was a participant or beneficiary enrolled under one or more group health plans or employee health benefit plans for not less than 18 months (without a lapse of more than 30 days) immediately prior to the date on which such individual applies for enrollment in the individual health plan ;

(2) is not eligible for coverage under a group health plan or an employee health benefit plan;

(3) has not had coverage terminated under a group health plan or employee health benefit plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact; and

(4) has, if applicable, elected coverage and exhausted the maximum period of coverage as described in section 602(2)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) or under a State program providing an extension of such coverage.

(c) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering coverage to individuals under an individual health plan may cease enrolling individuals under the plan if—

(A) the health plan issuer ceases to enroll any new individuals; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to enroll additional individuals.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section

202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering coverage to individuals under an individual health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) MARKET REQUIREMENTS.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) CONVERSION POLICIES.—A health plan issuer offering group health plans to group purchasers under this Act shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

(4) CONSTRUCTION.—Nothing in this Act shall be construed to require that a State replace or dissolve high risk pools or other similar State mechanisms which are designed to provide individuals in such State with access to health benefits.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan;

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered by the health plan issuer to individuals; and

(C) in exercising the option to discontinue the individual health plan and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of particular individuals.

(2) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—In any case in which a health plan issuer elects to discontinue all individual health plans in a State, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each individual covered under the plan of such discontinuation at least 180 days prior to the date of the discontinuation of the plan; and

(B) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any individual health plan in the State involved during the 5-year period beginning on the date of the discontinuation of the last plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular individuals.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an individual health plan that arranges for the financing and delivery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) ADOPTION OF ALTERNATIVE MECHANISMS.—

(1) IN GENERAL.—A State, in accordance with this section, may adopt alternative mechanisms (public or private) that are designed to provide access to affordable health benefits for individuals meeting the requirements of sections 110(b) and 111 (such as mechanisms providing for guaranteed issue, open enrollment by one or more health plan issuers, high-risk pools, mandatory conversion policies, or any combination thereof).

(2) PROCEDURE FOR STATE ELECTION.—If, not later than 6 months after the date of enactment of this Act, the Governor of a State notifies the Secretary of Health and Human Services that—

(A) the State has adopted an alternative mechanism that achieves the goals of sections 110 and 111; or

(B) the State intends to implement an alternative mechanism that is designed to achieve the goals of sections 110 and 111;

such State alternative mechanism shall, except as provided in paragraphs (3) and (4), apply in lieu of the standards described in sections 110 and 111.

(3) NONAPPLICATION OF MECHANISM.—A State alternative mechanism adopted under paragraph (1) shall be presumed to achieve the goals of sections 110 and 111 and shall apply in lieu of such sections, unless the Secretary of Health and Human Services, in consultation with the Governor and Insurance Commissioner or chief insurance regulatory official of the State, finds that the State alternative mechanism fails to—

(A) offer coverage to those individuals who meet the requirements of sections 110(b) and 111;

(B) prohibit a limitation or exclusion of benefits relating to treatment of a preexisting condition that was covered under the previous group health plan or employee health benefit plan of an individual who meets the requirements of sections 110(b) and 111;

(C) offer individuals who meet the requirements of sections 110(b) and 111 a choice of individual health plans, including at least one plan comparable to comprehensive plans offered in the individual market in such State or a plan comparable to a standard option plan available under the group or individual health insurance laws of such State; or

(D) except as provided in paragraph (4), implement a risk spreading mechanism, cross subsidy mechanism, risk adjustment mechanism, rating limitation or other mechanism (such as mechanisms described in the NAIC Model Health Plan for Uninsurable Individuals Act) designed to reduce the variation among the cost of such plans and other individual health plans offered by the carrier or available in such State.

(4) CHOICE OF PLANS.—The Secretary of Health and Human Services shall waive the requirement in subparagraph (D) of paragraph (3) with respect to a State if individuals who meet the requirements of sections 110(b) and 111 in such State are provided with a choice of all individual health plans otherwise available in the individual market.

(5) FUTURE ADOPTION OF MECHANISMS.—With respect to a State that implements an alternative mechanism under paragraph (1) after the period referred to in paragraph (2)—

(A) the State shall provide notice to the Secretary that such alternative mechanism achieves the goals of sections 110 and 111;

(B) the State alternative mechanism shall apply in lieu of sections 110 and 111;

(C) except as provided in subsections (d) and (e), the Secretary may make a determination as provided for in paragraph (3); and

(D) the procedures described in subsection (c) shall apply.

(b) TIMEFRAME FOR SECRETARIAL DETERMINATION.—

(1) IN GENERAL.—With respect to a State election under subsection (a)(2)(B), the Secretary of Health and Human Services shall not make a determination under subsection (a)(3) until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1998, whichever is later.

(2) RULE APPLICABLE TO CERTAIN STATES.—With respect to a State that makes an election under subsection (a)(2)(B) and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary of Health and Human Services shall not make a determination under subsection (a) prior to January 1, 1999.

(c) NOTICE TO STATE.—If the Secretary of Health and Human Services determines that a State alternative mechanism fails to meet the criteria described in subsection (a)(3), or that such mechanism is no longer being implemented, the Secretary of Health and Human Services shall notify the Governor of such State of such preliminary determination and permit the State a reasonable opportunity in which to modify the alternative mechanism or to adopt another mechanism that is designed to meet the goals of sections 110 and 111. If, after an opportunity to modify such State alternative mechanism, the mechanism fails to meet the criteria described in subsection (a)(3), the Secretary shall notify the Governor of such State that sections 110 and 111 shall apply in the State.

(d) ADOPTION OF NAIC MODEL.—If, not later than 9 months after the date of enactment of this Act—

(1) the National Association of Insurance Commissioners (hereafter referred to as the ''NAIC''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, has adopted a model act or acts including provisions addressing portability from a group health plan or employee health benefit plan into the individual health insurance market; and

(2) the Secretary of Health and Human Services determines, within 30 days of the

adoption of such NAIC model act or acts, that such act or acts comply with the goals of sections 110 and 111;

a State that elects to adopt such model act or acts shall be deemed to have met the requirements of sections 110 and 111 and shall not be subject to a determination under subsection (a)(3).

(e) STATE HIGH RISK POOLS DEEMED IN COMPLIANCE.—If the Governor of a State notifies the Secretary of Health and Human Services in a timeframe consistent with either subsection (a)(2) or (a)(5) that such State has a high risk pool open to those individuals meeting the requirements of sections 110(b) and 111, that limits preexisting condition waiting periods consistent with section 110(a)(1)(B) and that with respect to premium rates and covered benefits is consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act, such State high risk pool shall be deemed to have met the requirements of sections 110 and 111 and shall not be subject to a determination under subsection (a)(3).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used in this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan under section 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(3) Coverage issued as a supplement to liability insurance.

(4) Liability insurance, including general liability insurance and automobile liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital or fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(II) by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(2) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb-6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(3) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb-8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(ii) by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(2) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(3)) is amended by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(3) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section'';

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this subsection because of the provision of the Health Insurance Reform Act of 1995''; and

(C) in clause (v), by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(2) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(3) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of the enactment of this Act for plan years beginning after December 31, 1997.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effective, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this Act, the term ''health plan purchasing cooperative'' means a group of employees or a group of individuals and employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing individual health plans or group health plans offered by health plan issuers.

(b) CERTIFICATION.—

(1) REQUIREMENT.—If a group described in subsection (a), desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion and shall oversee the operations of such cooperative in order to ensure continued compliance with the requirements of this section. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—

(A) IN GENERAL.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this Act, the Secretary shall certify and oversee the operations of such cooperatives in such State.

(B) EXCEPTION.—The Secretary shall not certify a health plan purchasing cooperative described in this section if, upon the submission of an application by the State to the Secretary, the Secretary determines that under a State law in effect on the date of enactment of this Act, all small employers have a means readily available that ensures—

(i) that individuals and employees have a choice of multiple, unaffiliated health plan issuers;

(ii) that health plan coverage is subject to State premium rating requirements that are not based on the factors described in subsection (f)(3) and that contains a mandatory minimum loss ratio; and

(iii) that comparative health plan materials are disseminated consistent with subsection (e)(1)(D);

and that otherwise meets the objectives of this Act.

(3) INTERSTATE COOPERATIVES.—For purposes of this section, a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a broad cross-section of representatives of employers, employees, and individuals participating in the cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

(d) MEMBERSHIP AND MARKETING AREA.—

(1) MEMBERSHIP.—A health plan purchasing cooperative may establish limits on the maximum size of employers who may become members of the cooperative, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the cooperative shall, except as provided in subparagraph (B), accept all employers (or individuals) residing within the area served by the cooperative who meet such requirements as members on a first come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by health plan purchasing cooperatives to ensure that cooperatives do not discriminate on the basis of the health status or insurability of the populations that reside in the area served. A State may not use such rules to arbitrarily limit the number of health plan purchasing cooperatives.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN GENERAL.—A health plan purchasing cooperative shall—

(A) objectively evaluate potential health plan issuers and enter into agreements with multiple, unaffiliated health plan issuers, except that the requirement of this subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible;

(B) enter into agreements with employers and individuals who become members of the cooperative;

(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State;

(D) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning group health plans and individual health plans offered through the cooperative);

(E) broadly solicit and actively market to all eligible employers and individuals residing within the service area; and

(F) act as an ombudsman for group health plan or individual health plan enrollees.

(2) PERMISSIBLE ACTIVITIES.—A health plan purchasing cooperative may perform such other functions as necessary to further the purposes of this Act, including—

(A) collecting and distributing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;

(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers;

(D) cooperating with (or accepting as members) employers who provide health benefits directly to participants and beneficiaries only for the purpose of negotiating with providers; and

(E) negotiating with health care providers and health plan issuers.

(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers;

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;

(3) establish eligibility, enrollment, or premium contribution requirements for individual participants or beneficiaries based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability;

(4) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization or organizations—

(A) in which membership in such organization is not based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability; and

(B) that accepts as members all employers or individuals on a first-come, first-served basis, subject to any established limit on the maximum size of an employer that may become a member; or

(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this Act.

(g) CONFLICT OF INTEREST.—

(1) PROHIBITION.—No individual, partnership, or corporation shall serve on the board of a health plan purchasing cooperative, be employed by such a cooperative, receive compensation from such a cooperative, or initiate or finance such a cooperative if such individual, partnership, or corporation—

(A) fails to discharge the duties and responsibilities of such individual, partnership or corporation in a manner that is solely in the interest of the members of the cooperative; or

(B) derives personal benefit (other than in the form of ordinary compensation received) from the sale of, or has a financial interest in, health plans, services or products sold by or distributed through that cooperative.

(2) CONTRACTS WITH THIRD PARTIES.—Nothing in paragraph (1) shall be construed to prohibit the board of directors of a health plan purchasing cooperative, or its officers, at the initiative and under this direction of the board, from contracting with third parties to provide administrative, marketing, consultive, or other services to the cooperative.

(h) LIMITED PREEMPTION OF CERTAIN STATE LAWS.—

(1) IN GENERAL.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State fictitious group laws shall be preempted.

(2) HEALTH PLAN ISSUERS.—

(A) RATING.—Except as provided in subparagraph (B), a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative that meets the requirements of this section shall comply with all State rating requirements that would otherwise apply if the health plan were offered outside of the cooperative.

(B) EXCEPTION.—A State shall permit a health plan issuer to reduce premium rates negotiated with a health plan purchasing cooperative that meets the requirements of this section to reflect savings derived from administrative costs, marketing costs, profit margins, economies of scale, or other factors, except that any such reduction in premium rates may not be based on the health status, demographic factors, industry type, duration, or other indicators of health risk of the members of the cooperative.

(C) BENEFITS.—Except as provided in subparagraph (D), a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative shall comply with all State mandated benefit laws that require the offering of any services, category of care, or services of any class or type of provider.

(D) EXCEPTION.—In those States that have enacted laws authorizing the issuance of alternative benefit plans to small employers, health plan issuers may offer such alternative benefit plans through a health plan purchasing cooperative that meets the requirements of this section.

(i) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to—

(1) require that a State organize, operate, or otherwise create health plan purchasing cooperatives;

(2) otherwise require the establishment of health plan purchasing cooperatives;

(3) require individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) preempt a State from requiring licensure for individuals who are involved in directly supplying advice or selling health plans on behalf of a purchasing cooperative;

(5) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State;

(6) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans;

(7) confer authority upon a State (or the Federal Government) that the State (or Federal Government) would not otherwise have to regulate group purchasing arrangements, coalitions, association plans, or other similar entities that do not desire to become a health plan purchasing cooperative in accordance with this section; or

(8) except as specifically provided otherwise in this subsection, prevent the application of State laws and regulations otherwise applicable to health plan issuers offering group health plans or individual health plans through a health plan purchasing cooperative.

(j) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 and 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101) shall apply to a health

plan purchasing cooperative as if such plan were an employee welfare benefit plan.

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 201. APPLICABILITY.

(a) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) IN GENERAL.—A requirement or standard imposed under this Act on a group health plan or individual health plan offered by a health plan issuer shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act. In the case of a group health plan offered by a health plan issuer in connection with an employee health benefit plan, the requirements or standards imposed under this Act shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this Act as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a State enforce the requirements or standards of this Act as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this Act shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this Act; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this Act and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(c) CONTINUATION.—Nothing in this Act shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular participant or beneficiary, to all participants or beneficiaries, or to any class or group of participants or beneficiaries, in excess of or other than those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this Act pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the State enforcement plan.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—With respect to employee health benefit plans, the Secretary shall enforce the reform standards established under this Act in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State to substantially enforce the standards and requirements set forth in this Act with respect to group health plans and individual health plans as provided for under the State enforcement plan filed under subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this Act in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this Act, each health plan issuer operating in such State shall be subject to civil enforcement as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(d) APPLICABLE CERTIFYING AUTHORITY.—As used in this title, the term ''applicable certifying authority'' means, with respect to—

(1) health plan issuers, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this Act for the State involved; and

(2) an employee health benefit plan, the Secretary.

(e) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this Act.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1996'' before the period.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. HMOS ALLOWED TO OFFER PLANS WITH DEDUCTIBLES TO INDIVIDUALS WITH MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 1301(b) of the Public Health Service Act (42 U.S.C. 300e(b)) is amended by adding at the end the following new paragraph:

''(6)(A) If a member certifies that a medical savings account has been established for the benefit of such member, a health maintenance organization may, at the request of such member reduce the basic health services payment otherwise determined under paragraph (1) by requiring the payment of a deductible by the member for basic health services.

''(B) For purposes of this paragraph, the term 'medical savings account' means an account which, by its terms, allows the deposit of funds and the use of such funds and income derived from the investment of such funds for the payment of the deductible described in subparagraph (A).''.

(b) MEDICAL SAVINGS ACCOUNTS.—It is the sense of the Committee on Labor and Human Resources of the Senate that the establishment of medical savings accounts, including those defined in section 1301(b)(6)(B) of the Public Health Service Act (42 U.S.C. 300e(b)(6)(B)), should be encouraged as part of any health insurance reform legislation passed by the Senate through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, such accounts.

(c) SENSE OF THE SENATE.—It is the sense of the Senate that the Congress should take measures to further the purposes of this Act, including any necessary changes to the Internal Revenue Code of 1986 to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits.

SEC. 302. HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, shall conduct a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—Not later than January 1, 1998, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning—

(1) an evaluation, based on the experience of States, expert opinions, and such additional data as may be available, of the various mechanisms used to ensure the availability of reasonably priced health coverage to employers purchasing group coverage and to individuals purchasing coverage on a nongroup basis; and

(2) whether standards that limit the variation in premiums will further the purposes of this Act.

(c) EVALUATION OF EFFECTIVENESS.—Not later than January 1, 1999, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning the effectiveness of the provisions of this Act and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a nongroup basis.

SEC. 303. SENSE OF THE COMMITTEE CONCERNING MEDICARE.

(a) FINDINGS.—The Committee on Labor and Human Resources of the Senate finds that the Public Trustees of Medicare concluded in their 1995 Annual Report that—

(1) the Medicare program is clearly unsustainable in its present form;

(2) ''the Hospital Insurance Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range''; and

(3) the Public Trustees ''strongly recommend that the crisis presented by the financial condition of the Medicare trust fund be urgently addressed on a comprehensive basis, including a review of the programs's financing methods, benefit provisions, and delivery mechanisms''.

(b) SENSE OF THE COMMITTEE.—It is the Sense of the Committee on Labor and Human Resources of the Senate that the Senate should take measures necessary to reform the Medicare program, to provide increased choice for seniors, and to respond to the findings of the Public Trustees by protecting the short-term solvency and long-term sustainability of the Medicare program.

SEC. 304. EFFECTIVE DATE.

Except as otherwise provided for in this Act, the provisions of this Act shall apply as follows:

(1) With respect to group health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1997.

(2) With respect to individual health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after the date that is 6 months after the date of enactment of this Act, or January 1, 1997, whichever is later.

(3) With respect to employee health benefit plans, such provisions shall apply to such plans on the first day of the first plan year beginning on or after January 1, 1997.

SEC. 305. SEVERABILITY.

If any provision of this Act or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this Act and the application of the provisions of such to any person

or circumstance shall not be affected thereby.

DOLE (AND OTHERS) AMENDMENT NO. 3676

Mr. DOLE (for himself, Mr. ROTH, Mr. NICKLES, Mr. PRESSLER, Mr. LOTT, Mr. CRAIG, Mr. MCCONNELL, Mr. COVERDELL, Mr. GRASSLEY, Mr. D'AMATO, Mr. GREGG, Mr. SANTORUM, Mr. SHELBY, Mr. FAIRCLOTH, Mr. GRAMS, and Mr. WARNER) proposed an amendment to amendment No. 3675 proposed by Mrs. KASSEBAUM to the bill S. 1028, supra; as follows:

At the end, add the following new titles:

TITLE IV—TAX-RELATED HEALTH PROVISIONS

SEC. 400. SHORT TITLE; AMENDMENT OF 1986 CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Health Insurance and Long-Term Care Affordability Act of 1996''.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(c) TABLE OF CONTENTS.—

TITLE IV—TAX-RELATED HEALTH PROVISIONS

Sec. 400. Short title; amendment of 1986 Code; table of contents.

Subtitle A—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

Sec. 401. Increase in self-employed individuals' deduction for health insurance costs.

Subtitle B—Long-Term Care Provisions

CHAPTER 1—LONG-TERM CARE SERVICES AND CONTRACTS

SUBCHAPTER A—GENERAL PROVISIONS

Sec. 411. Treatment of long-term care insurance.

Sec. 412. Qualified long-term care services treated as medical care.

Sec. 413. Certain exchanges of life insurance contracts for qualified long-term care insurance contracts not taxable.

Sec. 414. Exception from penalty tax for amounts withdrawn from certain retirement plans for qualified long-term care insurance.

Sec. 415. Reporting requirements.

SUBCHAPTER B—CONSUMER PROTECTION PROVISIONS

Sec. 421. Policy requirements.

Sec. 422. Requirements for issuers of long-term care insurance policies.

Sec. 423. Coordination with State requirements.

Sec. 424. Effective dates.

CHAPTER 2—TREATMENT OF ACCELERATED DEATH BENEFITS

Sec. 431. Treatment of accelerated death benefits by recipient.

Sec. 432. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle C—Medical Savings Accounts

Sec. 441. Medical savings accounts.

Subtitle D—High-Risk Pools

Sec. 451. Exemption from income tax for State-sponsored organizations providing health coverage for high-risk individuals.

Subtitle E—Penalty-Free IRA Distributions

Sec. 461. Distributions from certain plans may be used without penalty to pay financially devastating medical expenses.

Subtitle F—Revenue Offsets

CHAPTER 1—TREATMENT OF INDIVIDUALS WHO EXPATRIATE

Sec. 471. Revision of tax rules on expatriation.

Sec. 472. Information on individuals expatriating.

Sec. 473. Report on tax compliance by United States citizens and residents living abroad.

CHAPTER 2—REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS

Sec. 481. Repeal of bad debt reserve method for thrift savings associations.

CHAPTER 3—REFORM OF THE EARNED INCOME CREDIT

Sec. 491. Earned income credit denied to individuals not authorized to be employed in the United States.

CHAPTER 4—COMPANY-OWNED INSURANCE

Sec. 495. Denial of deduction for interest on loans with respect to company-owned insurance.

Subtitle A—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 401. INCREASE IN SELF-EMPLOYED INDIVIDUALS' DEDUCTION FOR HEALTH INSURANCE COSTS.

(a) IN GENERAL.—Section 162(l) (relating to special rules for health insurance costs of self-employed individuals) is amended—

(1) by striking ''30 percent'' in paragraph (1) and inserting ''the applicable percentage'', and

(2) by adding at the end the following new paragraph:

''(6) APPLICABLE PERCENTAGE.—For purposes of this subsection, the term 'applicable percentage' means the percentage determined in accordance with the following table:

''In the case of taxable years beginning in:	The applicable percentage is:
1997	35
1998	40
1999	45
2000	50
2001	55
2002	60
2003	65
2004	70
2005	75
2006 and thereafter	80.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle B—Long-Term Care Provisions

CHAPTER 1—LONG-TERM CARE SERVICES AND CONTRACTS

Subchapter A—General Provisions

SEC. 411. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

''SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

''(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

''(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(C) such contract is guaranteed renewable,

''(D) such contract does not provide for a cash surrender value or other money that can be—

''(i) paid, assigned, or pledged as collateral for a loan, or

''(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C), and

''(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

''(2) SPECIAL RULES.—

''(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

''(B) SPECIAL RULES RELATING TO MEDICARE.—

''(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

''(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

''(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

''(ii) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

''(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) Eating.

''(ii) Toileting.

''(iii) Transferring.

''(iv) Bathing.

''(v) Dressing.

''(vi) Continence.

Nothing in this section shall be construed to require a contract to take into account all of the preceding activities of daily living.

''(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

''(4) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

''(1) IN GENERAL.—If the aggregate amount of periodic payments under all qualified long-term care insurance contracts with respect to an insured for any period exceeds the dollar amount in effect for such period under paragraph (3), such excess payments shall be treated as made for qualified long-term care services only to the extent of the costs incurred by the payee (not otherwise compensated for by insurance or otherwise) for qualified long-term care services provided during such period for such insured.

''(2) PERIODIC PAYMENTS.—For purposes of paragraph (1), the term 'periodic payment' means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

''(3) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

''(4) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (3) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(11).

''(e) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as a part of a life insurance contract—

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract.

''(2) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

''(A) by the sum of any charges (but not premium payments) against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage made to that date under the contract, less

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(3) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

''(4) PORTION DEFINED.—For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a qualified long-term care insurance contract.''

(b) RESERVE METHOD.—Clause (iii) of section 807(d)(3)(A) is amended by inserting ''(other than a qualified long-term care insurance contract, as defined in section 7702B(b))'' after ''insurance contract''.

(c) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: ''Such term shall not include any long-term care insurance contract (as defined in section 4980C).''

(2) FLEXIBLE SPENDING ARRANGEMENTS.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

''(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

''(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

''(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.''

(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Subsection (f) of section 4980B is amended by adding at the end the following new paragraph:

''(9) CONTINUATION OF LONG-TERM CARE COVERAGE NOT REQUIRED.—A group health plan shall not be treated as failing to meet the requirements of this subsection solely by reason of failing to provide coverage under any qualified long-term care insurance contract (as defined in section 7702B(b)).''

(e) AMOUNTS PAID TO SPOUSE OR RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—Section 213(d) is amended by adding at the end the following new paragraph:

''(10) CERTAIN PAYMENTS TO SPOUSE OR RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

''(A) by the spouse of the individual or a relative (directly or through a partnership, corporation, or other entity) unless the spouse or relative is a licensed professional with respect to such services, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.''

(f) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of qualified long-term care insurance.''.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1996.

(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was issued at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act and before January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a rider which is treated as a qualified long-term care insurance contract under section 7702B, and

(B) the addition of any provision required to conform any other long-term care rider to be so treated,

shall not be treated as a modification or material change of such contract.

SEC. 412. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 7702B(c)), or''.

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(2)(A) Paragraph (1) of section 213(d) is amended by adding at the end the following new flush sentence:

''In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (11)) shall be taken into account under subparagraph (D).''

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

''(11) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

''In the case of an individual with an attained age before the close of the taxable year of:	The limitation is
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500.

''(B) INDEXING.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.''

(3) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 413. CERTAIN EXCHANGES OF LIFE INSURANCE CONTRACTS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS NOT TAXABLE.

(a) IN GENERAL.—Subsection (a) of section 1035 (relating to certain exchanges of insurance contracts) is amended by striking the period at the end of paragraph (3) and inserting ''; or'', and by adding at the end the following new paragraph:

''(4) a contract of life insurance or an endowment or annuity contract for a qualified long-term care insurance contract (as defined in section 7702B(b)).''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1997.

SEC. 414. EXCEPTION FROM PENALTY TAX FOR AMOUNTS WITHDRAWN FROM CERTAIN RETIREMENT PLANS FOR QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Paragraph (2) of section 72(t) is amended by adding at the end the following new subparagraph:

''(D) PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—Distributions to an individual from an individual retirement plan, or from amounts attributable to employer contributions made pursuant to elective deferrals described in subparagraph (A) or (C) of section 402(g)(3), to the extent such distributions do not exceed the premiums for a qualified long-term care insurance contract (as defined in section 7702B(b)) for such individual or the spouse of such individual. In applying subparagraph (B), such premiums shall be treated as amounts not paid for medical care.''

(b) DISTRIBUTIONS PERMITTED FROM CERTAIN PLANS TO PAY LONG-TERM CARE PREMIUMS.—

(1) Section 401(k)(2)(B)(i) is amended by striking ''or'' at the end of subclause (III), by striking ''and'' at the end of subclause (IV) and inserting ''or'', and by inserting after subclause (IV) the following new subclause:

''(V) the date distributions for premiums for a long-term care insurance contract (as defined in section 7702B(b)) for coverage of such individual or the spouse of such individual are made, and''.

(2) Section 403(b)(11) is amended by striking ''or'' at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting '', or'', and by inserting after subparagraph (B) the following new subparagraph:

''(C) for the payment of premiums for a long-term care insurance contract (as defined in section 7702B(b)) for coverage of the employee or the spouse of the employee.''

(3) Subparagraph (A) of section 457(d)(1) is amended by striking ''or'' at the end of clause (ii), by striking ''and'' at the end of clause (iii) and inserting ''or'', and by inserting after clause (iii) the following new clause:

''(iv) the date distributions for premiums for a long-term care insurance contract (as defined in section 7702B(b)) for coverage of such individual or the spouse of such individual are made, and''.

(c) CONFORMING AMENDMENT.—Section 72t(2)(B) is amended by striking ''subparagraph (A) or (C))'' and inserting ''subparagraph (A), (C), or (D))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and distributions after December 31, 1996.

SEC. 415. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new section:

''SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

''(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

''(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year, and

''(2) the name, address, and TIN of such individual.

''(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name of the person making the payments, and

''(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term 'long-term care benefit' means any amount paid under a long-term care insurance policy (within the meaning of section 4980C(e)).''.

(b) PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by redesignating clauses (ix) through (xiv) as clauses (x) through (xv), respectively, and by inserting after clause (viii) the following new clause:

''(ix) section 6050Q (relating to certain long-term care benefits),''.

(2) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

''(Q) section 6050Q(b) (relating to certain long-term care benefits),''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050Q. Certain long-term care benefits.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits paid after December 31, 1996.

Subchapter B—Consumer Protection Provisions

SEC. 421. POLICY REQUIREMENTS.

Section 7702B (as added by section 411) is amended by adding at the end the following new subsection:

''(f) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3), and

''(C) the requirements relating to nonforfeitability under paragraph (4).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980C(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the appropriate State regulatory authority for the same policy form.

''(iii) The nonforfeiture provision shall provide at least one of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(5) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term 'long-term care insurance policy' has the meaning given such term by section 4980C(e).''.

SEC. 422. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

''SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c) or (d) are not met with respect to each long-term care insurance policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(f)(2)(B).

''(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

''(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance.''.

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Requirements for issuers of long-term care insurance policies.''.

SEC. 423. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this subchapter shall prevent a State from establishing, implementing, or continuing in effect standards related to the protection of policyholders of long-term care insurance policies (as defined in section 4980C(e) of the Internal Revenue Code of 1986), if such standards are not in conflict with or inconsistent with the standards established under such Code.

SEC. 424. EFFECTIVE DATES.

(a) IN GENERAL.—The provisions of, and amendments made by, this subchapter shall apply to contracts issued after December 31, 1996. The provisions of section 411(g) of this Act (relating to transition rule) shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 422 shall apply to actions taken after December 31, 1996.

CHAPTER 2—TREATMENT OF ACCELERATED DEATH BENEFITS

SEC. 431. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) IN GENERAL.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated

as an amount paid by reason of the death of an insured:

''(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

''(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual (as defined in section 7702B(c)(2)) but only if such amount is received under a rider or other provision of such contract which is treated as a qualified long-term care insurance contract under section 7702B.

''(2) TREATMENT OF VIATICAL SETTLEMENTS.—

''(A) IN GENERAL.—In the case of a life insurance contract on the life of an insured described in paragraph (1), if—

''(i) any portion of such contract is sold to any viatical settlement provider, or

''(ii) any portion of the death benefit is assigned to such a provider,

the amount paid for such sale or assignment shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

''(B) VIATICAL SETTLEMENT PROVIDER.—The term 'viatical settlement provider' means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

''(i) such person is licensed for such purposes in the State in which the insured resides, or

''(ii) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes—

''(I) such person meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

''(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.

''(3) DEFINITIONS.—For purposes of this subsection—

''(A) TERMINALLY ILL INDIVIDUAL.—The term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

''(B) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

''(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 432. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

''(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)), and

(B) the addition of any provision required to conform an accelerated death benefit rider to the requirements of such section 818(g),

shall not be treated as a modification or material change of such contract.

Subtitle C—Medical Savings Accounts

SEC. 441. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

''SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed—

''(A) except as provided in subparagraph (B), the lesser of—

''(i) $2,000, or

''(ii) the annual deductible limit for any individual covered under the high deductible health plan, or

''(B) in the case of a high deductible health plan covering the taxpayer and any other eligible individual who is the spouse or any dependent (as defined in section 152) of the taxpayer, the lesser of—

''(i) $4,000, or

''(ii) the annual limit under the plan on the aggregate amount of deductibles required to be paid by all individuals.

The preceding sentence shall not apply if the spouse of such individual is covered under any other high deductible health plan.

''(2) SPECIAL RULE FOR MARRIED INDIVIDUALS.—

''(A) IN GENERAL.—This subsection shall be applied separately for each married individual.

''(B) SPECIAL RULE.—If individuals who are married to each other are covered under the same high deductible health plan, then the amounts applicable under paragraph (1)(B) shall be divided equally between them unless they agree on a different division.

''(3) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

''(A) any amount is paid to any medical savings account of such individual which is excludable from gross income under section 106(b) for such year, or

''(B) in a case described in paragraph (2)(B), any amount is paid to any medical savings account of either spouse which is so excludable for such year.

''(4) PRORATION OF LIMITATION.—

''(A) IN GENERAL.—The limitation under paragraph (1) shall be the sum of the monthly limitations for months during the taxable year that the individual is an eligible individual if—

''(i) such individual is not an eligible individual for all months of the taxable year,

''(ii) the deductible under the high deductible health plan covering such individual is not the same throughout such taxable year, or

''(iii) such limitation is determined under paragraph (1)(B) for some but not all months during such taxable year.

''(B) MONTHLY LIMITATION.—The monthly limitation for any month shall be an amount equal to 1/12 of the limitation which would (but for this paragraph and paragraph (3)) be determined under paragraph (1) if the facts and circumstances as of the first day of such month that such individual is covered under a high deductible health plan were true for the entire taxable year.

''(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual—

''(i) who is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) who is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.

''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

''(i) coverage for any benefit provided by permitted insurance, and

''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' means a health plan which—

''(A) has an annual deductible limit for each individual covered by the plan which is not less than $1,500, and

''(B) has an annual limit on the aggregate amount of deductibles required to be paid with respect to all individuals covered by the plan which is not less than $3,000.

Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

''(3) PERMITTED INSURANCE.—The term 'permitted insurance' means—

''(A) Medicare supplemental insurance,

''(B) insurance if substantially all of the coverage provided under such insurance relates to—

''(i) liabilities incurred under workers' compensation laws,

''(ii) tort liabilities,

''(iii) liabilities relating to ownership or use of property, or

''(iv) such other similar liabilities as the Secretary may specify by regulations,

''(C) insurance for a specified disease or illness, and

''(D) insurance paying a fixed amount per day (or other period) of hospitalization.

''(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

''(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

''(i) unless it is in cash, or

''(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds $4,000.

''(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(2) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

''(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

''(I) a health plan during any period of continuation coverage required under any Federal law,

''(II) a qualified long-term care insurance contract (as defined in section 7702B), or

''(III) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law.

''(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) Section 219(f)(3) (relating to time when contributions deemed made).

''(C) Except as provided in section 106(c), section 219(f)(5) (relating to employer payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder (or any spouse or dependent of the holder) shall not be includible in gross income.

''(B) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

''(i) TREATMENT IF HOLDER IS SPOUSE.—If, after the death of the account holder, the account holder's interest is payable to (or for the benefit of) the holder's spouse, the medical savings account shall be treated as if the spouse were the account holder.

''(ii) TREATMENT IF DESIGNATED HOLDER IS NOT SPOUSE.—In the case of an account holder's interest in a medical savings account which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

''(I) such account shall cease to be a medical savings account as of the date of death, and

''(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder or of the spouse or dependents of such holder shall be included in the gross income of such holder.

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all medical savings accounts of the account holder shall be treated as 1 account,

''(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—If the aggregate contributions (other than rollover contributions) for a taxable year to the medical savings accounts of an individual exceed the amount allowable as a deduction under this section for such contributions, paragraph (2) shall not apply to distributions from such accounts (in an amount not greater than such excess) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

''(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 59½.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains age 59½.

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received is paid into a medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

''(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which the spouse is the account holder.

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount in subsection (b)(1), (c)(2), or (d)(1)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(B) such component for August of 1996.

''(h) REPORTS.—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by

this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting after paragraph (15) the following new paragraph:

''(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—Section 106 (relating to contributions by employer to accident and health plans), as amended by this Act, is amended by adding at the end the following new subsection:

''(c) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee.

''(2) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

''(3) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

''(4) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

''(5) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220''.

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c).''

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c) of the Internal Revenue Code of 1986.''

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c).''

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c).''

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c).''

(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection (f) of section 125 is amended by inserting ''106(c),'' before ''117''.

(e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 is amended by adding at the end the following new section:

''SEC. 2057. MEDICAL SAVINGS ACCOUNTS.

''For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any medical savings account (as defined in section 220(d)) included in the gross estate.''

(f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''medical savings accounts,'' after ''accounts,'' in the heading of such section,

(2) by striking ''or'' at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)), or'', and

(4) by adding at the end the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 220(d)), the term 'excess contributions' means the sum of—

''(1) the amount by which the amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) exceeds the amount allowable as a deduction under section 220 for such contributions, and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of distributions out of the account included in gross income under section 220(f) (2) or (3) and the excess (if any) of the maximum amount allowable as a deduction under section 220 for the taxable year over the amount contributed to the accounts.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed.''

(g) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.''

(2) Paragraph (1) of section 4975(e) is amended to read as follows:

''(1) PLAN.—For purposes of this section, the term 'plan' means—

''(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

''(B) an individual retirement account described in section 408(a),

''(C) an individual retirement annuity described in section 408(b),

''(D) a medical savings account described in section 220(d), or

''(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.''

(h) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—

(1) Subsection (a) of section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

''(a) REPORTS.—

''(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

''(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

''(B) section 220(h) (relating to medical savings accounts).''

(i) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) (defining specified insurance contract) is amended by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by adding at the end the following new clause:

''(iv) any contract which is a medical savings account (as defined in section 220(d)).''.

(j) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.

''Sec. 221. Cross reference.''

(2) The table of sections for part IV of subchapter A of chapter 11 is amended by adding at the end the following new item:

''Sec. 2057. Medical savings accounts.''.

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle D—High-Risk Pools

SEC. 451. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

''(26) Any membership organization if—

''(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in section 213(d)) on a not-for-profit basis to individuals described in subparagraph (B) through—

''(i) insurance issued by the organization, or

''(ii) a health maintenance organization under an arrangement with the organization,

''(B) the only individuals receiving such coverage through the organization are individuals—

''(i) who are residents of such State, and

''(ii) who, by reason of the existence or history of a medical condition, are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization or are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

''(C) the composition of the membership in such organization is specified by such State, and

''(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle E—Penalty-Free IRA Distributions

SEC. 461. DISTRIBUTIONS FROM CERTAIN PLANS MAY BE USED WITHOUT PENALTY TO PAY FINANCIALLY DEVASTATING MEDICAL EXPENSES.

(a) IN GENERAL.—Section 72(t)(3)(A) is amended by striking ''(B),''.

(b) PENALTY-FREE DISTRIBUTIONS FOR PAYMENT OF HEALTH INSURANCE PREMIUMS OF CERTAIN UNEMPLOYED INDIVIDUALS.—Paragraph (2) of section 72(t), as amended by section 414, is amended by adding at the end the following new subparagraph:

''(E) DISTRIBUTIONS TO UNEMPLOYED INDIVIDUALS FOR HEALTH INSURANCE PREMIUMS.—Distributions from an individual retirement plan to an individual after separation from employment—

''(i) if such individual has received unemployment compensation for 12 consecutive weeks under any Federal or State unemployment compensation law by reason of such separation,

''(ii) if such distributions are made during any taxable year during which such unemployment compensation is paid or the succeeding taxable year, and

''(iii) to the extent such distributions do not exceed the amount paid during the taxable year for insurance described in section 213(d)(1)(D) with respect to the individual and the individual's spouse and dependents (as defined in section 152).

To the extent provided in regulations, a self-employed individual shall be treated as meeting the requirements of clause (i) if, under Federal or State law, the individual would have received unemployment compensation but for the fact the individual was self-employed.''.

(c) CONFORMING AMENDMENT.—Subparagraph (B) of section 72(t)(2), as amended by section 414, is amended by striking ''or (D)'' and inserting '', (D), or (E)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle F—Revenue Offsets

CHAPTER 1—Treatment of Individuals Who Expatriate

SEC. 471. REVISION OF TAX RULES ON EXPATRIATION.

(a) IN GENERAL.—Subpart A of part II of subchapter N of chapter 1 is amended by inserting after section 877 the following new section:

''SEC. 877A. TAX RESPONSIBILITIES OF EXPATRIATION.

''(a) GENERAL RULES.—For purposes of this subtitle—

''(1) MARK TO MARKET.—Except as provided in subsection (f), all property of a covered expatriate to which this section applies shall be treated as sold on the expatriation date for its fair market value.

''(2) RECOGNITION OF GAIN OR LOSS.—In the case of any sale under paragraph (1)—

''(A) notwithstanding any other provision of this title, any gain arising from such sale shall be taken into account for the taxable year of the sale unless such gain is excluded from gross income under part III of subchapter B, and

''(B) any loss arising from such sale shall be taken into account for the taxable year of the sale to the extent otherwise provided by this title, except that section 1091 shall not apply (and section 1092 shall apply) to any such loss.

''(3) EXCLUSION FOR CERTAIN GAIN.—The amount which would (but for this paragraph) be includible in the gross income of any individual by reason of this section shall be reduced (but not below zero) by $600,000. For purposes of this paragraph, allocable expatriation gain taken into account under subsection (f)(2) shall be treated in the same manner as an amount required to be includible in gross income.

''(4) ELECTION TO CONTINUE TO BE TAXED AS UNITED STATES CITIZEN.—

''(A) IN GENERAL.—If an expatriate elects the application of this paragraph—

''(i) this section (other than this paragraph) shall not apply to the expatriate, but

''(ii) the expatriate shall be subject to tax under this title, with respect to property to which this section would apply but for such election, in the same manner as if the individual were a United States citizen.

''(B) LIMITATION ON AMOUNT OF ESTATE, GIFT, AND GENERATION-SKIPPING TRANSFER TAXES.—The aggregate amount of taxes imposed under subtitle B with respect to any transfer of property by reason of an election under subparagraph (A) shall not exceed the amount of income tax which would be due if the property were sold for its fair market value immediately before the time of the transfer or death (taking into account the rules of paragraph (2)).

''(C) REQUIREMENTS.—Subparagraph (A) shall not apply to an individual unless the individual—

''(i) provides security for payment of tax in such form and manner, and in such amount, as the Secretary may require,

''(ii) consents to the waiver of any right of the individual under any treaty of the United States which would preclude assessment or collection of any tax which may be imposed by reason of this paragraph, and

''(iii) complies with such other requirements as the Secretary may prescribe.

''(D) ELECTION.—An election under subparagraph (A) shall apply to all property to which this section would apply but for the election and, once made, shall be irrevocable. Such election shall also apply to property the basis of which is determined in whole or in part by reference to the property with respect to which the election was made.

''(b) ELECTION TO DEFER TAX.—

''(1) IN GENERAL.—If the taxpayer elects the application of this subsection with respect to any property—

''(A) no amount shall be required to be included in gross income under subsection (a)(1) with respect to the gain from such property for the taxable year of the sale, but

''(B) the taxpayer's tax for the taxable year in which such property is disposed of shall be increased by the deferred tax amount with respect to the property.

Except to the extent provided in regulations, subparagraph (B) shall apply to a disposition whether or not gain or loss is recognized in whole or in part on the disposition.

''(2) DEFERRED TAX AMOUNT.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'deferred tax amount' means, with respect to any property, an amount equal to the sum of—

''(i) the difference between the amount of tax paid for the taxable year described in paragraph (1)(A) and the amount which would have been paid for such taxable year if the election under paragraph (1) had not applied to such property, plus

''(ii) an amount of interest on the amount described in clause (i) determined for the period—

''(I) beginning on the 91st day after the expatriation date, and

''(II) ending on the due date for the taxable year described in paragraph (1)(B),

by using the rates and method applicable under section 6621 for underpayments of tax for such period.

For purposes of clause (ii), the due date is the date prescribed by law (determined without regard to extension) for filing the return of the tax imposed by this chapter for the taxable year.

''(B) ALLOCATION OF LOSSES.—For purposes of subparagraph (A), any losses described in subsection (a)(2)(B) shall be allocated ratably among the gains described in subsection (a)(2)(A).

''(3) SECURITY.—

''(A) IN GENERAL.—No election may be made under paragraph (1) with respect to any property unless adequate security is provided with respect to such property.

''(B) ADEQUATE SECURITY.—For purposes of subparagraph (A), security with respect to any property shall be treated as adequate security if—

''(i) it is a bond in an amount equal to the deferred tax amount under paragraph (2)(A) for the property, or

''(ii) the taxpayer otherwise establishes to the satisfaction of the Secretary that the security is adequate.

''(4) WAIVER OF CERTAIN RIGHTS.—No election may be made under paragraph (1) unless the taxpayer consents to the waiver of any right under any treaty of the United States which would preclude assessment or collection of any tax imposed by reason of this section.

''(5) DISPOSITIONS.—For purposes of this subsection, a taxpayer making an election under this subsection with respect to any property shall be treated as having disposed of such property—

''(A) immediately before death if such property is held at such time, and

''(B) at any time the security provided with respect to the property fails to meet the requirements of paragraph (3) and the taxpayer does not correct such failure within the time specified by the Secretary.

''(6) ELECTIONS.—An election under paragraph (1) shall only apply to property described in the election and, once made, is irrevocable. An election may be under paragraph (1) with respect to an interest in a trust with respect to which gain is required to be recognized under subsection (f)(1).

''(c) COVERED EXPATRIATE.—For purposes of this section—

''(1) IN GENERAL.—The term 'covered expatriate' means an expatriate—

''(A) whose average annual net income tax (as defined in section 38(c)(1)) for the period of 5 taxable years ending before the expatriation date is greater than $100,000, or

''(B) whose net worth as of such date is $500,000 or more.

If the expatriation date is after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting '1995' for

'1992' in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

''(2) EXCEPTIONS.—An individual shall not be treated as a covered expatriate if—

''(A) the individual—

''(i) became at birth a citizen of the United States and a citizen of another country and, as of the expatriation date, continues to be a citizen of, and is taxed as a resident of, such other country, and

''(ii) has been a resident of the United States (as defined in section 7701(b)(1)(A)(ii)) for not more than 8 taxable years during the 15-taxable year period ending with the taxable year during which the expatriation date occurs, or

''(B)(i) the individual's relinquishment of United States citizenship occurs before such individual attains age 18½, and

''(ii) the individual has been a resident of the United States (as so defined) for not more than 5 taxable years before the date of relinquishment.

''(d) PROPERTY TO WHICH SECTION APPLIES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided by the Secretary, this section shall apply to—

''(A) any interest in property held by a covered expatriate on the expatriation date the gain from which would be includible in the gross income of the expatriate if such interest had been sold for its fair market value on such date in a transaction in which gain is recognized in whole or in part, and

''(B) any other interest in a trust to which subsection (f) applies.

''(2) EXCEPTIONS.—This section shall not apply to the following property:

''(A) UNITED STATES REAL PROPERTY INTERESTS.—Any United States real property interest (as defined in section 897(c)(1)), other than stock of a United States real property holding corporation which does not, on the expatriation date, meet the requirements of section 897(c)(2).

''(B) INTEREST IN CERTAIN RETIREMENT PLANS.—

''(i) IN GENERAL.—Any interest in a qualified retirement plan (as defined in section 4974(c)), other than any interest attributable to contributions which are in excess of any limitation or which violate any condition for tax-favored treatment.

''(ii) FOREIGN PENSION PLANS.—

''(I) IN GENERAL.—Under regulations prescribed by the Secretary, interests in foreign pension plans or similar retirement arrangements or programs.

''(II) LIMITATION.—The value of property which is treated as not sold by reason of this subparagraph shall not exceed $500,000.

''(e) DEFINITIONS.—For purposes of this section—

''(1) EXPATRIATE.—The term 'expatriate' means—

''(A) any United States citizen who relinquishes his citizenship, or

''(B) any long-term resident of the United States who—

''(i) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

''(ii) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country.

''(2) EXPATRIATION DATE.—The term 'expatriation date' means—

''(A) the date an individual relinquishes United States citizenship, or

''(B) in the case of a long-term resident of the United States, the date of the event described in clause (i) or (ii) of paragraph (1)(B).

''(3) RELINQUISHMENT OF CITIZENSHIP.—A citizen shall be treated as relinquishing his United States citizenship on the earliest of—

''(A) the date the individual renounces his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

''(B) the date the individual furnishes to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

''(C) the date the United States Department of State issues to the individual a certificate of loss of nationality, or

''(D) the date a court of the United States cancels a naturalized citizen's certificate of naturalization.

Subparagraph (A) or (B) shall not apply to any individual unless the renunciation or voluntary relinquishment is subsequently approved by the issuance to the individual of a certificate of loss of nationality by the United States Department of State.

''(4) LONG-TERM RESIDENT.—

''(A) IN GENERAL.—The term 'long-term resident' means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the expatriation date occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

''(B) SPECIAL RULE.—For purposes of subparagraph (A), there shall not be taken into account—

''(i) any taxable year during which any prior sale is treated under subsection (a)(1) as occurring, or

''(ii) any taxable year prior to the taxable year referred to in clause (i).

''(f) SPECIAL RULES APPLICABLE TO BENEFICIARIES' INTERESTS IN TRUST.—

''(1) IN GENERAL.—Except as provided in paragraph (2), if an individual is determined under paragraph (3) to hold an interest in a trust—

''(A) the individual shall not be treated as having sold such interest,

''(B) such interest shall be treated as a separate share in the trust, and

''(C)(i) such separate share shall be treated as a separate trust consisting of the assets allocable to such share,

''(ii) the separate trust shall be treated as having sold its assets immediately before the expatriation date for their fair market value and as having distributed all of its assets to the individual as of such time, and

''(iii) the individual shall be treated as having recontributed the assets to the separate trust.

Subsection (a)(2) shall apply to any income, gain, or loss of the individual arising from a distribution described in subparagraph (C)(ii).

''(2) SPECIAL RULES FOR INTERESTS IN QUALIFIED TRUSTS.—

''(A) IN GENERAL.—If the trust interest described in paragraph (1) is an interest in a qualified trust—

''(i) paragraph (1) and subsection (a) shall not apply, and

''(ii) in addition to any other tax imposed by this title, there is hereby imposed on each distribution with respect to such interest a tax in the amount determined under subparagraph (B).

''(B) AMOUNT OF TAX.—The amount of tax under subparagraph (A)(ii) shall be equal to the lesser of—

''(i) the highest rate of tax imposed by section 1(e) for the taxable year in which the expatriation date occurs, multiplied by the amount of the distribution, or

''(ii) the balance in the deferred tax account immediately before the distribution determined without regard to any increases under subparagraph (C)(ii) after the 30th day preceding the distribution.

''(C) DEFERRED TAX ACCOUNT.—For purposes of subparagraph (B)(ii)—

''(i) OPENING BALANCE.—The opening balance in a deferred tax account with respect to any trust interest is an amount equal to the tax which would have been imposed on the allocable expatriation gain with respect to the trust interest if such gain had been included in gross income under subsection (a).

''(ii) INCREASE FOR INTEREST.—The balance in the deferred tax account shall be increased by the amount of interest determined (on the balance in the account at the time the interest accrues), for periods after the 90th day after the expatriation date, by using the rates and method applicable under section 6621 for underpayments of tax for such periods.

''(iii) DECREASE FOR TAXES PREVIOUSLY PAID.—The balance in the tax deferred account shall be reduced—

''(I) by the amount of taxes imposed by subparagraph (A) on any distribution to the person holding the trust interest, and

''(II) in the case of a person holding a nonvested interest, to the extent provided in regulations, by the amount of taxes imposed by subparagraph (A) on distributions from the trust with respect to nonvested interests not held by such person.

''(D) ALLOCABLE EXPATRIATION GAIN.—For purposes of this paragraph, the allocable expatriation gain with respect to any beneficiary's interest in a trust is the amount of gain which would be allocable to such beneficiary's vested and nonvested interests in the trust if the beneficiary held directly all assets allocable to such interests.

''(E) TAX DEDUCTED AND WITHHELD.—

''(i) IN GENERAL.—The tax imposed by subparagraph (A)(ii) shall be deducted and withheld by the trustees from the distribution to which it relates.

''(ii) EXCEPTION WHERE FAILURE TO WAIVE TREATY RIGHTS.—If an amount may not be deducted and withheld under clause (i) by reason of the distributee failing to waive any treaty right with respect to such distribution—

''(I) the tax imposed by subparagraph (A)(ii) shall be imposed on the trust and each trustee shall be personally liable for the amount of such tax, and

''(II) any other beneficiary of the trust shall be entitled to recover from the distributee the amount of such tax imposed on the other beneficiary.

''(F) DISPOSITION.—If a trust ceases to be a qualified trust at any time, a covered expatriate disposes of an interest in a qualified trust, or a covered expatriate holding an interest in a qualified trust dies, then, in lieu of the tax imposed by subparagraph (A)(ii), there is hereby imposed a tax equal to the lesser of—

''(i) the tax determined under paragraph (1) as if the expatriation date were the date of such cessation, disposition, or death, whichever is applicable, or

''(ii) the balance in the tax deferred account immediately before such date.

Such tax shall be imposed on the trust and each trustee shall be personally liable for the amount of such tax and any other beneficiary of the trust shall be entitled to recover from the covered expatriate or the estate the amount of such tax imposed on the other beneficiary.

''(G) DEFINITIONS AND SPECIAL RULE.—For purposes of this paragraph—

''(i) QUALIFIED TRUST.—The term 'qualified trust' means a trust—

''(I) which is organized under, and governed by, the laws of the United States or a State, and

''(II) with respect to which the trust instrument requires that at least 1 trustee of the trust be an individual citizen of the United States or a domestic corporation.

''(ii) VESTED INTEREST.—The term 'vested interest' means any interest which, as of the expatriation date, is vested in the beneficiary.

''(iii) NONVESTED INTEREST.—The term 'nonvested interest' means, with respect to any beneficiary, any interest in a trust which is not a vested interest. Such interest shall be determined by assuming the maximum exercise of discretion in favor of the beneficiary and the occurrence of all contingencies in favor of the beneficiary.

''(iv) ADJUSTMENTS.—The Secretary may provide for such adjustments to the bases of assets in a trust or a deferred tax account, and the timing of such adjustments, in order to ensure that gain is taxed only once.

''(3) DETERMINATION OF BENEFICIARIES' INTEREST IN TRUST.—

''(A) DETERMINATIONS UNDER PARAGRAPH (1).—For purposes of paragraph (1), a beneficiary's interest in a trust shall be based upon all relevant facts and circumstances, including the terms of the trust instrument and any letter of wishes or similar document, historical patterns of trust distributions, and the existence of and functions performed by a trust protector or any similar advisor.

''(B) OTHER DETERMINATIONS.—For purposes of this section—

''(i) CONSTRUCTIVE OWNERSHIP.—If a beneficiary of a trust is a corporation, partnership, trust, or estate, the shareholders, partners, or beneficiaries shall be deemed to be the trust beneficiaries for purposes of this section.

''(ii) TAXPAYER RETURN POSITION.—A taxpayer shall clearly indicate on its income tax return—

''(I) the methodology used to determine that taxpayer's trust interest under this section, and

''(II) if the taxpayer knows (or has reason to know) that any other beneficiary of such trust is using a different methodology to determine such beneficiary's trust interest under this section.

''(g) TERMINATION OF DEFERRALS, ETC.—On the date any property held by an individual is treated as sold under subsection (a), notwithstanding any other provision of this title—

''(1) any period during which recognition of income or gain is deferred shall terminate, and

''(2) any extension of time for payment of tax shall cease to apply and the unpaid portion of such tax shall be due and payable at the time and in the manner prescribed by the Secretary.

''(h) IMPOSITION OF TENTATIVE TAX.—

''(1) IN GENERAL.—If an individual is required to include any amount in gross income under subsection (a) for any taxable year, there is hereby imposed, immediately before the expatriation date, a tax in an amount equal to the amount of tax which would be imposed if the taxable year were a short taxable year ending on the expatriation date.

''(2) DUE DATE.—The due date for any tax imposed by paragraph (1) shall be the 90th day after the expatriation date.

''(3) TREATMENT OF TAX.—Any tax paid under paragraph (1) shall be treated as a payment of the tax imposed by this chapter for the taxable year to which subsection (a) applies.

''(4) DEFERRAL OF TAX.—The provisions of subsection (b) shall apply to the tax imposed by this subsection to the extent attributable to gain includible in gross income by reason of this section.

''(i) COORDINATION WITH ESTATE AND GIFT TAXES.—If subsection (a) applies to property held by an individual for any taxable year and—

''(1) such property is includible in the gross estate of such individual solely by reason of section 2107, or

''(2) section 2501 applies to a transfer of such property by such individual solely by reason of section 2501(a)(3),

then there shall be allowed as a credit against the additional tax imposed by section 2101 or 2501, whichever is applicable, solely by reason of section 2107 or 2501(a)(3) an amount equal to the increase in the tax imposed by this chapter for such taxable year by reason of this section.

''(j) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section, including regulations—

''(1) to prevent double taxation by ensuring that—

''(A) appropriate adjustments are made to basis to reflect gain recognized by reason of subsection (a) and the exclusion provided by subsection (a)(3), and

''(B) any gain by reason of a deemed sale under subsection (a) of an interest in a corporation, partnership, trust, or estate is reduced to reflect that portion of such gain which is attributable to an interest in a trust which a shareholder, partner, or beneficiary is treated as holding directly under subsection (f)(3)(B)(i), and

''(2) which provide for the proper allocation of the exclusion under subsection (a)(3) to property to which this section applies.

''(k) CROSS REFERENCE.—

"For income tax treatment of individuals who terminate United States citizenship, see section 7701(a)(47).".

(b) INCLUSION IN INCOME OF GIFTS AND INHERITANCES FROM COVERED EXPATRIATES.—Section 102 (relating to gifts, etc. not included in gross income) is amended by adding at the end the following new subsection:

''(d) GIFTS AND INHERITANCES FROM COVERED EXPATRIATES.—Subsection (a) shall not exclude from gross income the value of any property acquired by gift, bequest, devise, or inheritance from a covered expatriate after the expatriation date. For purposes of this subsection, any term used in this subsection which is also used in section 877A shall have the same meaning as when used in section 877A.''.

(c) DEFINITION OF TERMINATION OF UNITED STATES CITIZENSHIP.—Section 7701(a) is amended by adding at the end the following new paragraph:

''(47) TERMINATION OF UNITED STATES CITIZENSHIP.—An individual shall not cease to be treated as a United States citizen before the date on which the individual's citizenship is treated as relinquished under section 877A(e)(3).''.

(d) CONFORMING AMENDMENTS.—

(1) Section 877 is amended by adding at the end the following new subsection:

''(f) APPLICATION.—This section shall not apply to any individual who relinquishes (within the meaning of section 877A(e)(3)) United States citizenship on or after February 6, 1995.''.

(2) Section 2107(c) is amended by adding at the end the following new paragraph:

''(3) CROSS REFERENCE.—For credit against the tax imposed by subsection (a) for expatriation tax, see section 877A(i).''.

(3) Section 2501(a)(3) is amended by adding at the end the following new flush sentence: ''For credit against the tax imposed under this section by reason of this paragraph, see section 877A(i).''.

(4) Paragraph (10) of section 7701(b) is amended by adding at the end the following new sentence: ''This paragraph shall not apply to any long-term resident of the United States who is an expatriate (as defined in section 877A(e)(1)).''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart A of part II of subchapter N of chapter 1 is amended by inserting after the item relating to section 877 the following new item:

''Sec. 877A. Tax responsibilities of expatriation.''.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall apply to expatriates (within the meaning of section 877A(e) of the Internal Revenue Code of 1986, as added by this section) whose expatriation date (as so defined) occurs on or after February 6, 1995.

(2) GIFTS AND BEQUESTS.—Section 102(d) of the Internal Revenue Code of 1986 (as added by subsection (b)) shall apply to amounts received from expatriates (as so defined) whose expatriation date (as so defined) occurs on and after February 6, 1995.

(3) SPECIAL RULES RELATING TO CERTAIN ACTS OCCURRING BEFORE FEBRUARY 6, 1995.—In the case of an individual who took an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a) (1)–(4)) before February 6, 1995, but whose expatriation date (as so defined) occurs after February 6, 1995—

(A) the amendment made by subsection (c) shall not apply,

(B) the amendment made by subsection (d)(1) shall not apply for any period prior to the expatriation date, and

(C) the other amendments made by this section shall apply as of the expatriation date.

(4) DUE DATE FOR TENTATIVE TAX.—The due date under section 877A(h)(2) of such Code shall in no event occur before the 90th day after the date of the enactment of this Act.

SEC. 472. INFORMATION ON INDIVIDUALS EXPATRIATING.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

"SEC. 6039F. INFORMATION ON INDIVIDUALS EXPATRIATING.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, any expatriate (within the meaning of section 877A(e)(1)) shall provide a statement which includes the information described in subsection (b).

''(2) TIMING.—

''(A) CITIZENS.—In the case of an expatriate described in section 877(e)(1)(A), such statement shall be—

''(i) provided not later than the expatriation date (within the meaning of section 877A(e)(2)), and

''(ii) provided to the person or court referred to in section 877A(e)(3).

''(B) NONCITIZENS.—In the case of an expatriate described in section 877A(e)(1)(B), such statement shall be provided to the Secretary

with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

''(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

''(1) the taxpayer's TIN,

''(2) the mailing address of such individual's principal foreign residence,

''(3) the foreign country in which such individual is residing,

''(4) the foreign country of which such individual is a citizen,

''(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877A(c)(1)(B), information detailing the assets and liabilities of such individual, and

''(6) such other information as the Secretary may prescribe.

''(c) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year during any portion of which such failure continues in an amount equal to the greater of—

''(1) 5 percent of the additional tax required to be paid under section 877A for such year, or

''(2) $1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

''(d) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

''(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

''(A) a copy of any such statement, and

''(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

''(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

''(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual relinquishing United States citizenship (within the meaning of section 877A(e)(3)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

''(e) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if the Secretary determines that applying this section to such individuals is not necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Information on individuals expatriating.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to individuals to whom section 877A of the Internal Revenue Code of 1986 applies and whose expatriation date (as defined in section 877A(e)(2)) occurs on or after February 6, 1995, except that no statement shall be required by such amendments before the 90th day after the date of the enactment of this Act.

SEC. 473. REPORT ON TAX COMPLIANCE BY UNITED STATES CITIZENS AND RESIDENTS LIVING ABROAD.

Not later than 90 days after the date of the enactment of this Act, the Secretary of the Treasury shall prepare and submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report—

(1) describing the compliance with subtitle A of the Internal Revenue Code of 1986 by citizens and lawful permanent residents of the United States (within the meaning of section 7701(b)(6) of such Code) residing outside the United States, and

(2) recommending measures to improve such compliance (including improved coordination between executive branch agencies).

CHAPTER 2—REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS

SEC. 481. REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS.

(a) IN GENERAL.—Section 593 (relating to reserves for losses on loans) is amended by adding at the end the following new subsections:

''(f) TERMINATION OF RESERVE METHOD.—Subsections (a), (b), (c), and (d) shall not apply to any taxable year beginning after December 31, 1995.

''(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

''(1) IN GENERAL.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts—

''(A) such change shall be treated as a change in a method of accounting,

''(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

''(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a)—

''(i) shall be determined by taking into account only applicable excess reserves, and

''(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

''(2) APPLICABLE EXCESS RESERVES.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable excess reserves' means the excess (if any) of—

''(i) the balance of the reserves described in subsection (c)(1) (other than the supplemental reserve) as of the close of the taxpayer's last taxable year beginning before January 1, 1996, over

''(ii) the lesser of—

''(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

''(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) on the basis of the taxable years described in clause (i) and this clause.

''(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581) which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

''(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserves as of the close of its last taxable year beginning before such date if the additions to such reserves for all taxable years had been determined under section 585(b)(2)(A), and

''(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

''(3) RECAPTURE OF PRE-1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve; except that such reserves shall be taken into account ratably over the 6-taxable year period beginning with such taxable year.

''(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

''(A) IN GENERAL.—In the case of a bank which meets the residential loan requirement of subparagraph (B) for the first taxable year beginning after December 31, 1995, or for the following taxable year—

''(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

''(ii) such taxable year shall be disregarded in determining—

''(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

''(II) the amount of such adjustment.

''(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

''(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term 'residential loan' means any loan described in clause (v) of section 7701(a)(19)(C) but only if such loan is incurred in acquiring, constructing, or improving the property described in such clause.

''(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to the taxable year in which such principal amount was the highest and the taxable year in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and, if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary.

''(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

''(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995:

''(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii), there shall be taken into account only the excess (if any) of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

''(B) TREATMENT UNDER ELECTIVE CUT-OFF METHOD.—For purposes of applying section 585(c)(4)—

''(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

''(ii) no amount shall be includible in gross income by reason of such reduction.

''(6) SUSPENDED RESERVE INCLUDED AS SECTION 381(c) ITEMS.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 381(c).

''(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c) and exempt from taxation under section 501(a)—

''(A) any amount required to be included in the gross income of the credit union by reason of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

''(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

''(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and subsection (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spin-offs, and other reorganizations.''.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 50 is amended by adding at the end the following new sentence:

''Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995.''

(2) Subsection (e) of section 52 is amended by striking paragraph (1) and by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking ''or to which section 593 applies''.

(6) Subparagraph (A) of section 585(a)(2) is amended by striking ''other than an organization to which section 593 applies''.

(7)(A) The material preceding subparagraph (A) of section 593(e)(1) is amended by striking ''by a domestic building and loan association or an institution that is treated as a mutual savings bank under section 591(b)'' and inserting ''by a taxpayer having a balance described in subsection (g)(2)(A)(ii)''.

(B) Subparagraph (B) of section 593(e)(1) is amended to read as follows:

''(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged against such reserves for taxable years beginning after December 31, 1987),''.

(C) The second sentence of section 593(e)(1) is amended by striking ''the association or an institution that is treated as a mutual savings bank under section 591(b)'' and inserting ''a taxpayer having a balance described in subsection (g)(2)(A)(ii)''.

(D) The third sentence of section 593(e)(1) is amended by striking ''an association'' and inserting ''a taxpayer having a balance described in subsection (g)(2)(A)(ii)''.

(E) Paragraph (1) of section 593(e) is amended by adding at the end the following new sentence: ''This paragraph shall not apply to any distribution of all of the stock of a bank (as defined in section 581) to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.''

(8) Section 595 is hereby repealed.

(9) Section 596 is hereby repealed.

(10) Subsection (a) of section 860E is amended—

(A) by striking ''Except as provided in paragraph (2), the'' in paragraph (1) and inserting ''The'',

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows ''subsection'' and inserting a period.

(11) Paragraph (3) of section 992(d) is amended by striking ''or 593''.

(12) Section 1038 is amended by striking subsection (f).

(13) Clause (ii) of section 1042(c)(4)(B) is amended by striking ''or 593''.

(14) Subsection (c) of section 1277 is amended by striking ''or to which section 593 applies''.

(15) Subparagraph (B) of section 1361(b)(2) is amended by striking ''or to which section 593 applies''.

(16) The table of sections for part II of subchapter H of chapter 1 is amended by striking the items relating to sections 595 and 596.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(2) SUBSECTION (b)(7)(B).—The amendments made by subsection (b)(7)(B) shall not apply to any distribution with respect to preferred stock if—

(A) such stock is outstanding at all times after October 31, 1995, and before the distribution, and

(B) such distribution is made before the date which is 1 year after the date of the enactment of this Act (or, in the case of stock which may be redeemed, if later, the date which is 30 days after the earliest date that such stock may be redeemed).

(3) SUBSECTION (b)(8).—The amendment made by subsection (b)(8) shall apply to property acquired in taxable years beginning after December 31, 1995.

(4) SUBSECTION (b)(10).—The amendments made by subsection (b)(10) shall not apply to any residual interest held by a taxpayer if such interest has been held by such taxpayer at all times after October 31, 1995.

CHAPTER 3—REFORM OF THE EARNED INCOME CREDIT

SEC. 491. EARNED INCOME CREDIT DENIED TO INDIVIDUALS NOT AUTHORIZED TO BE EMPLOYED IN THE UNITED STATES.

(a) IN GENERAL.—Section 32(c)(1) (relating to individuals eligible to claim the earned income credit) is amended by adding at the end the following new subparagraph:

''(F) IDENTIFICATION NUMBER REQUIREMENT.—The term 'eligible individual' does not include any individual who does not include on the return of tax for the taxable year—

''(i) such individual's taxpayer identification number, and

''(ii) if the individual is married (within the meaning of section 7703), the taxpayer identification number of such individual's spouse.''.

(b) SPECIAL IDENTIFICATION NUMBER.—Section 32 is amended by adding at the end the following new subsection:

''(l) IDENTIFICATION NUMBERS.—Solely for purposes of subsections (c)(1)(F) and (c)(3)(D), a taxpayer identification number means a social security number issued to an individual by the Social Security Administration (other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act).''.

(c) EXTENSION OF PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Section 6213(g)(2) (relating to the definition of mathematical or clerical errors) is amended by striking ''and'' at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting a comma, and by inserting after subparagraph (E) the following new subparagraphs:

''(F) an omission of a correct taxpayer identification number required under section 32 (relating to the earned income credit) to be included on a return, and

''(G) an entry on a return claiming the credit under section 32 with respect to net earnings from self-employment described in section 32(c)(2)(A) to the extent the tax imposed by section 1401 (relating to self-employment tax) on such net earnings has not been paid.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

CHAPTER 4—COMPANY-OWNED INSURANCE

SEC. 495. DENIAL OF DEDUCTION FOR INTEREST ON LOANS WITH RESPECT TO COMPANY-OWNED INSURANCE.

(a) IN GENERAL.—Paragraph (4) of section 264(a) is amended—

(1) by inserting '', or any endowment or annuity contracts owned by the taxpayer covering any individual,'' after ''the life of any individual'', and

(2) by striking all that follows ''carried on by the taxpayer'' and inserting a period.

(b) EXCEPTION FOR CONTRACTS RELATING TO KEY PERSONS; PERMISSIBLE INTEREST RATES.—Section 264 is amended—

(1) by striking ''Any'' in subsection (a)(4) and inserting ''Except as provided in subsection (d), any'', and

(2) by adding at the end the following new subsection:

''(d) SPECIAL RULES FOR APPLICATION OF SUBSECTION (a)(4).—

''(1) EXCEPTION FOR KEY PERSONS.—Subsection (a)(4) shall not apply to any interest paid or accrued on any indebtedness with respect to policies or contracts covering an individual who is a key person to the extent that the aggregate amount of such indebtedness with respect to policies and contracts covering such individual does not exceed $50,000.

''(2) INTEREST RATE CAP ON KEY PERSONS AND PRE-1986 CONTRACTS.—

''(A) IN GENERAL.—No deduction shall be allowed by reason of paragraph (1) or the last sentence of subsection (a) with respect to interest paid or accrued for any month to the extent the amount of such interest exceeds the amount which would have been determined if the applicable rate of interest were used for such month.

''(B) APPLICABLE RATE OF INTEREST.—For purposes of subparagraph (A)—

''(i) IN GENERAL.—The applicable rate of interest for any month is the rate of interest described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for such month.

''(ii) PRE-1986 CONTRACT.—In the case of indebtedness on a contract to which the last sentence of subsection (a) applies—

''(I) which is a contract providing a fixed rate of interest, the applicable rate of interest for any month shall be the Moody's rate described in clause (i) for the month in which the contract was purchased, or

''(II) which is a contract providing a variable rate of interest, the applicable rate of interest for any month in an applicable period shall be such Moody's rate for the last month preceding such period.

For purposes of subclause (II), the taxpayer shall elect an applicable period for such contract on its return of tax imposed by this chapter for its first taxable year ending on or after October 13, 1995. Such applicable period shall be for any number of months (not greater than 12) specified in the election and may not be changed by the taxpayer without the consent of the Secretary.

''(3) KEY PERSON.—For purposes of paragraph (1), the term 'key person' means an officer or 20-percent owner, except that the number of individuals who may be treated as key persons with respect to any taxpayer shall not exceed the greater of—

''(A) 5 individuals, or

''(B) the lesser of 5 percent of the total officers and employees of the taxpayer or 10 individuals.

''(4) 20-PERCENT OWNER.—For purposes of this subsection, the term '20-percent owner' means—

''(A) if the taxpayer is a corporation, any person who owns directly 20 percent or more of the outstanding stock of the corporation or stock possessing 20 percent or more of the total combined voting power of all stock of the corporation, or

''(B) if the taxpayer is not a corporation, any person who owns 20 percent or more of the capital or profits interest in the employer.

''(5) AGGREGATION RULES.—

''(A) IN GENERAL.—For purposes of paragraph (4)(A) and applying the $50,000 limitation in paragraph (1)—

''(i) all members of a controlled group shall be treated as 1 taxpayer, and

''(ii) such limitation shall be allocated among the members of such group in such manner as the Secretary may prescribe.

''(B) CONTROLLED GROUP.—For purposes of this paragraph, all persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as members of a controlled group.''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to interest paid or accrued after December 31, 1995.

(2) TRANSITION RULE FOR EXISTING INDEBTEDNESS.—

(A) IN GENERAL.—In the case of—

(i) indebtedness incurred before January 1, 1996, or

(ii) indebtedness incurred before January 1, 1997 with respect to any contract or policy entered into in 1994 or 1995,

the amendments made by this section shall not apply to qualified interest paid or accrued on such indebtedness after October 13, 1995, and before January 1, 1999.

(B) QUALIFIED INTEREST.—For purposes of subparagraph (A), the qualified interest with respect to any indebtedness for any month is the amount of interest which would be paid or accrued for such month on such indebtedness if—

(i) in the case of any interest paid or accrued after December 31, 1995, indebtedness with respect to no more than 20,000 insured individuals were taken into account, and

(ii) the lesser of the following rates of interest were used for such month:

(I) The rate of interest specified under the terms of the indebtedness as in effect on October 13, 1995 (and without regard to modification of such terms after such date).

(II) The applicable percentage rate of interest described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for such month.

For purposes of clause (i), all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as one person.

(C) APPLICABLE PERCENTAGE.—For purposes of subparagraph (B), the applicable percentage is as follows:

For calendar year:	The percentage is:
1995	100 percent
1996	90 percent
1997	80 percent
1998	70 percent.

(3) SPECIAL RULE FOR GRANDFATHERED CONTRACTS.—This section shall not apply to any contract purchased on or before June 20, 1986, except that section 264(d)(2) of the Internal Revenue Code of 1986 shall apply to interest paid or accrued after October 13, 1995.

(d) SPREAD OF INCOME INCLUSION ON SURRENDER, ETC. OF CONTRACTS.—

(1) IN GENERAL.—If any amount is received under any life insurance policy or endowment or annuity contract described in paragraph (4) of section 264(a) of the Internal Revenue Code of 1986—

(A) on the complete surrender, redemption, or maturity of such policy or contract during calendar year 1996, 1997, or 1998, or

(B) in full discharge during any such calendar year of the obligation under the policy or contract which is in the nature of a refund of the consideration paid for the policy or contract,

then (in lieu of any other inclusion in gross income) such amount shall be includible in gross income ratably over the 4-taxable year period beginning with the taxable year such amount would (but for this paragraph) be includible. The preceding sentence shall only apply to the extent the amount is includible in gross income for the taxable year in which the event described in subparagraph (A) or (B) occurs.

(2) SPECIAL RULES FOR APPLYING SECTION 264.—A contract shall not be treated as—

(A) failing to meet the requirement of section 264(c)(1) of the Internal Revenue Code of 1986, or

(B) a single premium contract under section 264(b)(1) of such Code,

solely by reason of an occurrence described in subparagraph (A) or (B) of paragraph (1) of this subsection or solely by reason of no additional premiums being received under the contract by reason of a lapse occurring after October 13, 1995.

(3) SPECIAL RULE FOR DEFERRED ACQUISITION COSTS.—In the case of the occurrence of any event described in subparagraph (A) or (B) of paragraph (1) of this subsection with respect to any policy or contract—

(A) section 848 of the Internal Revenue Code of 1986 shall not apply to the unamortized balance (if any) of the specified policy acquisition expenses attributable to such policy or contract immediately before the insurance company's taxable year in which such event occurs, and

(B) there shall be allowed as a deduction to such company for such taxable year under chapter 1 of such Code an amount equal to such unamortized balance.

TITLE V—HEALTH CARE FRAUD AND ABUSE PREVENTION

SEC. 500. AMENDMENTS AND TABLE OF CONTENTS.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

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

TITLE V—HEALTH CARE FRAUD AND ABUSE PREVENTION

Sec. 500. Amendments and table of contents.

Subtitle A—Fraud and Abuse Control Program

Sec. 501. Fraud and abuse control program.
Sec. 502. Medicare integrity program.
Sec. 503. Beneficiary incentive programs.
Sec. 504. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health care programs.
Sec. 505. Guidance regarding application of health care fraud and abuse sanctions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 511. Mandatory exclusion from participation in medicare and State health care programs.
Sec. 512. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
Sec. 513. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
Sec. 514. Sanctions against practitioners and persons for failure to comply with statutory obligations.
Sec. 515. Intermediate sanctions for medicare health maintenance organizations.
Sec. 516. Additional exceptions to anti-kickback penalties for risk-sharing arrangements.
Sec. 517. Effective date.

Subtitle C—Data Collection and Miscellaneous Provisions

Sec. 521. Establishment of the health care fraud and abuse data collection program.

Subtitle D—Civil Monetary Penalties

Sec. 531. Social Security Act civil monetary penalties.

Subtitle E—Amendments to Criminal Law

Sec. 541. Health care fraud.
Sec. 542. Forfeitures for Federal health care offenses.
Sec. 543. Injunctive relief relating to Federal health care offenses.
Sec. 544. False Statements.
Sec. 545. Obstruction of criminal investigations of Federal health care offenses.
Sec. 546. Theft or embezzlement.
Sec. 547. Laundering of monetary instruments.
Sec. 548. Authorized investigative demand procedures.

Subtitle A—Fraud and Abuse Control Program

SEC. 501. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''FRAUD AND ABUSE CONTROL PROGRAM

''SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

''(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

''(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

''(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

''(D) to provide for the modification and establishment of safe harbors and to issue interpretative rulings and special fraud alerts pursuant to section 1128D, and

''(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

''(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

''(3) GUIDELINES.—

''(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

''(B) INFORMATION GUIDELINES.—

''(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

''(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

''(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

''(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

''(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

''(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

''(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

''(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

''(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

''(1) a policy of health insurance;

''(2) a contract of a service benefit organization; and

''(3) a membership agreement with a health maintenance organization or other prepaid health plan.''.

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

''(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

''(i) such gifts and bequests as may be made as provided in subparagraph (B);

''(ii) such amounts as may be deposited in the Trust Fund as provided in sections 541(b) and 542(c) of the Health Insurance Reform Act of 1996, and title XI; and

''(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

''(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

''(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

''(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

''(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XXI, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

''(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

''(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

''(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

''(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

''(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

''(I) for fiscal year 1997, $104,000,000, and

''(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

''(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

''(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

''(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

''(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

''(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

''(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

''(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

''(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

''(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

''(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C)(i), to be available without further appropriation—

''(i) for fiscal year 1997, $47,000,000;

''(ii) for fiscal year 1998, $56,000,000;

''(iii) for fiscal year 1999, $66,000,000;

''(iv) for fiscal year 2000, $76,000,000;

''(v) for fiscal year 2001, $88,000,000;

''(vi) for fiscal year 2002, $101,000,000; and

''(vii) for each fiscal year after fiscal year 2002, $114,000,000.

''(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

''(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

''(ii) investigations;

''(iii) financial and performance audits of health care programs and operations;

''(iv) inspections and other evaluations; and

''(v) provider and consumer education regarding compliance with the provisions of title XI.

''(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

''(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

''(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

''(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.''.

SEC. 502. MEDICARE INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

''(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

''(1) the entity has demonstrated capability to carry out such activities;

''(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

''(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(4) the entity meets such other requirements as the Secretary may impose; and

''(5) in the case of any contract entered into for years prior to 2000, the entity has entered into an agreement under section 1816 or a contract under section 1842.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

''(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

''(2) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

''(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(l) No payment may be made for carrying out any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

''(6) No payment may be made for carrying out any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).''.

SEC. 503. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide an explanation of benefits under the medicare program under title XVIII of the Social Security Act with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(b) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 504. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(1) In the heading, by striking ''MEDICARE OR STATE HEALTH CARE PROGRAMS'' and inserting ''FEDERAL HEALTH CARE PROGRAMS''.

(2) In subsection (a)(1), by striking ''a program under title XVIII or a State health care program (as defined in section 1128(h))'' and inserting ''a Federal health care program''.

(3) In subsection (a)(5), by striking ''a program under title XVIII or a State health care program'' and inserting ''a Federal health care program''.

(4) In the second sentence of subsection (a)—

(A) by striking ''a State plan approved under title XIX'' and inserting ''a Federal health care program'', and

(B) by striking ''the State may at its option (notwithstanding any other provision of that title or of such plan)'' and inserting ''the administrator of such program may at its option (notwithstanding any other provision of such program)''.

(5) In subsection (b), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''a Federal health care program''.

(6) In subsection (c), by inserting ''(as defined in section 1128(h))'' after ''a State health care program''.

(7) By adding at the end the following new subsection:

''(f) For purposes of this section, the term 'Federal health care program' means—

''(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United

States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

''(2) any State health care program, as defined in section 1128(h).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 505. GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 501, is amended by inserting after section 1128C the following new section:

''GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

''SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

''(1) IN GENERAL.—

''(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

''(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

''(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

''(iii) interpretive rulings to be issued pursuant to subsection (b); and

''(iv) special fraud alerts to be issued pursuant to subsection (c).

''(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

''(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the 'Inspector General') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

''(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

''(A) An increase or decrease in access to health care services.

''(B) An increase or decrease in the quality of health care services.

''(C) An increase or decrease in patient freedom of choice among health care providers.

''(D) An increase or decrease in competition among health care providers.

''(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

''(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

''(G) An increase or decrease in the potential overutilization of health care services.

''(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

''(i) whether to order a health care item or service; or

''(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

''(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

''(b) INTERPRETIVE RULINGS.—

''(1) IN GENERAL.—

''(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B (in this section referred to as an 'interpretive ruling').

''(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

''(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling not later than 90 days after receiving a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this clause shall be published in the Federal Register or otherwise made available for public inspection.

''(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision not later than 60 days after receiving such a request and shall identify the reasons for such decision.

''(2) CRITERIA FOR INTERPRETIVE RULINGS.—

''(A) IN GENERAL.—In determining whether to issue an interpretive ruling under paragraph (1)(B), the Inspector General may consider—

''(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

''(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling (as defined in section 552 of title 5, United States Code) not authorized under this subsection.

''(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

''(c) SPECIAL FRAUD ALERTS.—

''(1) IN GENERAL.—

''(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program or a State health care program, as defined in section 1128(h) (in this subsection referred to as a 'special fraud alert').

''(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

''(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

''(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

''(B) the volume and frequency of the conduct that would be identified in the special fraud alert.''.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 511. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Insurance Reform Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

''(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Insurance Reform Act of 1996, under Federal or State law—

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

''(i) in connection with the delivery of a health care item or service, or

''(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

''(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Insurance Reform Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 512. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 513. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

''(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

''(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

''(B) For purposes of subparagraph (A), the term 'sanctioned entity' means an entity—

''(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

''(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.''.

SEC. 514. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 515. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1997.

SEC. 516. ADDITIONAL EXCEPTIONS TO ANTI-KICKBACK PENALTIES FOR RISK-SHARING ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) any remuneration between an organization and an individual or entity providing items or services pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876, or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold or capitation, or other similar risk arrangements which places the individual or entity at substantial financial risk.''.

(b) REGULATIONS.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) The Secretary, in consultation with the Attorney General, not later than 1 year after the date of enactment of Health Insurance Reform Act of 1996, and not less than every 2 years thereafter, shall promulgate regulations to define substantial financial risk as necessary to protect against program or patient abuse.''.

SEC. 517. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection and Miscellaneous Provisions

SEC. 521. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 501 and 505, is amended by inserting after section 1128D the following new section:

''HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

''SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

''(b) REPORTING OF INFORMATION.—

''(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

''(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

''(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

''(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

''(C) The nature of the final adverse action and whether such action is on appeal.

''(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

''(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

''(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

''(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

''(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

''(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

''(B) procedures in the case of disputed accuracy of the information.

''(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

''(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

''(f) COORDINATION WITH NATIONAL PRACTITIONER DATA BANK.—The Secretary shall implement this section in such a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

''(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

''(1) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—The term 'final adverse action' includes:

''(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

''(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

''(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

''(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

''(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, nonrenewability, or otherwise, or

''(III) any other negative action or finding by such Federal or State agency that is publicly available information.

''(iv) Exclusion from participation in Federal or State health care programs due to program violations.

''(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

''(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

''(2) PRACTITIONER.—The terms 'licensed health care practitioner', 'licensed practitioner', and 'practitioner' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

''(3) GOVERNMENT AGENCY.—The term 'Government agency' shall include:

''(A) The Department of Justice.

''(B) The Department of Health and Human Services.

''(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

''(D) State law enforcement agencies.

''(E) State medicaid fraud control units.

''(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

''(4) HEALTH PLAN.—The term 'health plan' has the meaning given such term by section 1128C(c).

''(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).''.

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: ''Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.''.

Subtitle D—Civil Monetary Penalties

SEC. 531. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking ''programs under title XVIII'' and inserting ''Federal health care programs (as defined in section 1128B(f)(1))''.

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Reform Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).''.

(3) In subsection (i)—

(A) in paragraph (2), by striking ''title V, XVIII, XIX, or XX of this Act'' and inserting ''a Federal health care program (as defined in section 1128B(f))'',

(B) in paragraph (4), by striking ''a health insurance or medical services program under title XVIII or XIX of this Act'' and inserting ''a Federal health care program (as so defined)'', and

(C) in paragraph (5), by striking ''title V, XVIII, XIX, or XX'' and inserting ''a Federal health care program (as so defined)''.

(4) By adding at the end the following new subsection:

''(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

''(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

''(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

''(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

''(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking ''or'' at the end of paragraph (1)(D);

(2) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(4) by inserting after paragraph (3) the following new paragraph:

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

''(i) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

''(ii) is an officer or managing employee (as defined in section 1126(b)) of such an entity;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)), as amended by subsection (b), is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking the semicolon and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or''.

(e) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting ''up to $10,000 for each instance''.

(f) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 515(a)(2), is amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).''.

(g) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended—

(A) by striking ''or'' at the end of paragraph (1)(D);

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);''.

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

''(i) the waiver is not offered as part of any advertisement or solicitation;

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Reform Act of 1996; or

''(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.''.

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1997.

Subtitle E—Amendments to Criminal Law

SEC. 541. HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1347. Health care fraud

''Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health care program, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care program in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of this title), such person may be imprisoned for any term of years.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

(b) CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 501(b), an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 542. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

''(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

''(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(i) section 1347 of this title;

''(ii) section 1128B of the Social Security Act; and

''(iii) sections 287, 371, 664, 666, 669, 1001, 1027, 1341, 1343, 1920, or 1954 of this title if the violation or conspiracy relates to health care fraud.''.

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting ''or (a)(6)'' after ''(a)(1)''.

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 501(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term ''payment of the costs of asset forfeiture'' means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services,

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

SEC. 543. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following new subparagraph:

''(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);''.

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting ''or a Federal health care offense (as defined in section 982(a)(6)(B))'' after ''title)''.

SEC. 544. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1033. False statements relating to health care matters

''Whoever, in any matter involving a health care program, knowingly and willfully—

''(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or

''(2) makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry,

shall be fined under this title or imprisoned not more than 5 years, or both.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''1033. False statements relating to health care matters.''.

SEC. 545. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1518. Obstruction of criminal investigations of Federal health care offenses

''(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section the term 'Federal health care offense' has the same meaning given such term in section 982(a)(6)(B) of this title.

''(c) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following:

''1518. Obstruction of Criminal Investigations of Federal Health Care Offenses.''.

SEC. 546. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 669. Theft or embezzlement in connection with health care

''Whoever willfully embezzles, steals, or otherwise willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care program, shall be fined under this title or imprisoned not more than 10 years, or both.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''669. Theft or Embezzlement in Connection with Health Care.''.

SEC. 547. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following new subparagraph:

''(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 982(a)(6)(B) of this title.''.

SEC. 548. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following new section:

''§ 3486. Authorized investigative demand procedures

''(a)(1)(A) In any investigation relating to functions set forth in paragraph (2), the Attorney General or designee may issue in writing and cause to be served a subpoena compelling production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control.

''(B) A custodian of records may be required to give testimony concerning the production and authentication of such records.

''(C) The production of records may be required from any place in any State or in any territory or other place subject to the jurisdiction of the United States at any designated place; except that such production shall not be required more than 500 miles distant from the place where the subpoena is served.

''(D) Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States.

''(E) A subpoena requiring the production of records shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(2) Investigative demands utilizing an administrative subpoena are authorized for any investigation with respect to any act or activity constituting or involving health care fraud, including a scheme or artifice—

''(A) to defraud any health care program, in connection with the delivery of or payment for health care benefits, items, or services; or

''(B) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care program in connection with the delivery of or payment for health care benefits, items, or services.

''(b)(1) A subpoena issued under this section may be served by any person designated in the subpoena to serve it.

''(2) Service upon a natural person may be made by personal delivery of the subpoena to such person.

''(3) Service may be made upon a domestic or foreign association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process.

''(4) The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

''(c)(1) In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which such person carries on business or may be found, to compel compliance with the subpoena.

''(2) The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony required under subsection (a)(1)(B).

''(3) Any failure to obey the order of the court may be punished by the court as a contempt thereof.

''(4) All process in any such case may be served in any judicial district in which such person may be found.

''(d) Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a subpoena under this section, who complies in good faith with the subpoena and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

''(e)(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

''(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

''(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3405 the following new item:

''3486. Authorized investigative demand procedures''.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting ''or a Department of Justice subpoena (issued under section 3486),'' after ''subpoena''.

KASSEBAUM AMENDMENT NO. 3677

Mrs. KASSEBAUM proposed an amendment to amendment No. 3676 proposed by Mr. DOLE to amendment No. 3675 proposed by Mrs. KASSEBAUM to the bill S. 1028, supra; as follows:

Strike subtitle C of title IV.

BROWN AMENDMENT NO. 3678

Mr. BROWN proposed an amendment to the bill S. 1028, supra; as follows:

At the appropriate place in title III, insert the following:

SEC. . EQUITABLE TREATMENT FOR THE GENERIC DRUG INDUSTRY.

(a) SENSE OF THE SENATE.—It is the sense of the Senate that the generic drug industry should be provided equitable relief in the same manner as other industries are provided with such relief under the patent transitional provisions of section 154(c) of title 35, United States Code, as amended by section 532 of the Uruguay Round Agreements Act of 1994 (Public Law 103–465; 108 Stat. 4983).

(b) APPROVAL OF APPLICATIONS OF GENERIC DRUGS.—For purposes of acceptance of consideration by the Secretary of an application under subsections (b), (c), and (j) of section 505, and subsections (b), (c), and (n) of section 512, of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 (b), (c), and (j), and 360b (b), (c), and (n)), the expiration date of a patent that is the subject of a certification under section 505(b)(2)(A) (ii), (iii), or (iv), section 505(j)(2)(A)(vii) (II), (III), (IV), or section 512(n)(1)(H) (ii), (iii), or (iv) of such Act, respectively, made in an application submitted prior to June 8, 1995, shall be deemed to be the date on which such patent would have expired under the law in effect on the day preceding December 8, 1994.

(c) MARKETING GENERIC DRUGS.—The remedies of section 271(e)(4) of title 35, United States Code, shall not apply to acts—

(1) that were commenced, or for which a substantial investment was made prior to June 8, 1995; and

(2) that became infringing by reason of section 154(c)(1) of such title, as amended by section 532 of the Uruguay Round Agreements Act (Public Law 103–465; 108 Stat. 4983).

(d) SUBSTANTIAL INVESTMENT.—For purposes of this Act and section 154(c)(2)(A) of title 35, United States Code, with respect to a product that is subject to the requirements of subsections (b)(2) or (j) of section 505, or of subsections (b) (2) and (n) of section 512, of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(2) and (j), and 360(b)(2) and (n), the submission of an application described in subsection (b), and only the submission of such an applications, shall constitute substantial investment.

(e) NOTICE.—

(1) IN GENERAL.—Unless the notice required by this subsection has previously been provided, when an applicant submitting an application described in subsection (b) receives notice from the Secretary that the application has been tentatively approved, such applicant shall give notice of such application to—

(A) each owner of the patent which is the subject of the certification or the representative of such owner designated to receive such notice; and

(B) the holder of the approved application under section 505(b) or section 512(c)(1), respectively, for the drug which is claimed by the patent or a use of which is claimed by the patent or the representative of such holder designated to receive such notice.

(2) CERTIFICATION OF NOTICE.—The applicant shall certify to the Secretary the date that such notice is given. The approval of such application by the Secretary shall not be made effective until 7 calendar days after the date so certified by such applicant.

(f) EQUITABLE REMUNERATION.—For acts described in subsection (c), equitable remuneration of the type described in section 154(c)(3) of title 35, United States Code, as amended by section 532 of the Uruguay Round Agreements Act (Public Law 103–465; 108 Stat. 4983) shall be awarded to a patentee only if there has been—

(1) the commercial manufacture, use, offer to sell, or sale, within the United States of an approved drug that is the subject of an application described in subsection (b); or

(2) the importation by the applicant into the United States of an approved drug or of active ingredient used in an approved drug that is the subject of an application described in subsection (b).

(g) APPLICABILITY.—The provisions of this section shall govern the approval or effective date of approval of all pending applications that have not received final approval as of the date of enactment of this Act.

JEFFORDS AMENDMENT NO. 3679

Mr. JEFFORDS proposed an amendment to the bill S. 1028, supra; as follows:

At the end of section 103, add the following new subsection:

''(g) LIMITATION ON LIFETIME AGGREGATE LIMITS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), an employee health benefit plan or a health plan issuer offering a group health plan may not impose an aggregate dollar lifetime limit of less than $10,000,000 (such amount to be adjusted for inflation in fiscal years subsequent to the fiscal year in which this subsection becomes effective) with respect to coverage under the plan.

''(2) SMALL EMPLOYERS.—Paragraph (1) shall not apply to a group health plan offered to or maintained for employees of a single employer that employs 25 or fewer employees.

''(3) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed as prohibiting the application by an employee health benefit plan or a health plan issuer offering a group health plan of any limits, exclusions, or other forms of cost containment mechanisms with respect to coverage under the plan other than the aggregate limit permitted under paragraph (1).

''(4) DISCLOSURE.—Any limits, exclusions, or other cost containment mechanisms permitted under paragraph (3) shall be disclosed as provided for in section 105(c).

''(5) APPLICATION OF SUBSECTION.—This subsection shall not apply to health maintenance organization that meets the requirements of title XIV of the Public Health Service Act.

''(6) EFFECTIVE DATE.—This paragraph shall become effective with respect to health plans on the date that is 2 years after the date of enactment of this Act.''.

At the end of section 105, add the following new subsection:

''(c) DISCLOSURE OF LIMITS AND EXCLUSIONS.—An employee health benefit plan or a health plan issuer offering a group health plan shall disclose, as part of its solicitation and sales materials and in a form and manner that is conspicuous and understandable to a reasonable individual, any limits, exclusions, or cost containment mechanisms with respect to coverage provided under the plan.''.

Section 3711 of title 31, United States Code, is amended by adding at the end the following new subsections:

''(g)(1) If a nontax debt or claim owed to the United States has been delinquent for a period of 180 days—

''(A) the head of the executive, judicial, or legislative agency that administers the program that gave rise to the debt or claim shall transfer the debt or claim to the Secretary of the Treasury; and

''(B) upon such transfer the Secretary of the Treasury shall take appropriate action to collect or terminate collection actions on the debt or claim.

''(2) Paragraph (1) shall not apply—

''(A) to any debt or claim that—

''(i) is in litigation or foreclosure;

''(ii) will be disposed of under an asset sales program within 1 year after the date the debt or claim is first delinquent, or a greater period of time if a delay would be in the best interests of the United States, as determined by the Secretary of the Treasury;

''(iii) has been referred to a private collection contractor for collection for a period of time determined by the Secretary of the Treasury;

''(iv) has been referred by, or with the consent of, the Secretary of the Treasury to a debt collection center for a period of time determined by the Secretary of the Treasury; or

''(v) will be collected under internal offset, if such offset is sufficient to collect the claim within 3 years after the date the debt or claim is first delinquent; and

''(B) to any other specific class of debt or claim, as determined by the Secretary of the Treasury at the request of the head of an executive, judicial, or legislative agency or otherwise.

''(3) For purposes of this section, the Secretary of the Treasury may designate, and withdraw such designation of debt collection centers operated by other Federal agencies. The Secretary of the Treasury shall designate such centers on the basis of their performance in collecting delinquent claims owed to the Government.

''(4) At the discretion of the Secretary of the Treasury, referral of a nontax claim may be made to—

''(A) any executive department or agency operating a debt collection center for servicing, collection, compromise, or suspension or termination of collection action;

''(B) a contractor operating under a contract for servicing or collection action; or

''(C) the Department of Justice for litigation.

''(5) nontax claims referred or transferred under this section shall be serviced, collected, or compromised, or collection action thereon suspended or terminated, in accordance with otherwise applicable statutory requirements and authorities. Executive departments and agencies operating debt collection centers may enter into agreements with the Secretary of the Treasury to carry out the purposes of this subsection. The Secretary of the Treasury shall—

''(A) maintain competition in carrying out this subsection;

''(B) maximize collections of delinquent debts by placing delinquent debts quickly;

''(C) maintain a schedule of contractors and debt collection centers eligible for referral of claims; and

''(D) refer delinquent debts to the person most appropriate to collect the type or amount of claim involved.

''(6) Any agency operating a debt collection center to which nontax claims are referred or transferred under this subsection may charge a fee sufficient to cover the full cost of implementing this subsection. The agency transferring or referring the nontax claim shall be charged the fee, and the agency charging the fee shall collect such fee by retaining the amount of the fee from amounts collected pursuant to this subsection. Agencies may agree to pay through a different method, or to fund an activity from another account or from revenue received from the procedure described under section 3720C of this title. Amounts charged under this subsection concerning delinquent claims may be considered as costs pursuant to section 3717(e) of this title.

''(7) Notwithstanding any other law concerning the depositing and collection of Federal payments, including section 3302(b) of

this title, agencies collecting fees may retain the fees from amounts collected. Any fee charged pursuant to this subsection shall be deposited into an account to be determined by the executive department or agency operating the debt collection center charging the fee (in this subsection referred to in this section as the 'Account'). Amounts deposited in the Account shall be available until expended to cover costs associated with the implementation and operation of Governmentwide debt collection activities. Costs properly chargeable to the Account include—

''(A) the costs of computer hardware and software, word processing and telecommunications equipment, and other equipment, supplies, and furniture;

''(B) personnel training and travel costs;

''(C) other personnel and administrative costs;

''(D) the costs of any contract for identification, billing, or collection services; and

''(E) reasonable costs incurred by the Secretary of the Treasury, including services and utilities provided by the Secretary, and administration of the Account.

''(8) Not later than January 1 of each year, there shall be deposited into the Treasury as miscellaneous receipts an amount equal to the amount of unobligated balances remaining in the Account at the close of business on September 30 of the preceding year, minus any part of such balance that the executive department or agency operating the debt collection center determines is necessary to cover or defray the costs under this subsection for the fiscal year in which the deposit is made.

''(9) To carry out the purposes of this subsection, the Secretary of the Treasury may prescribe such rules, regulations, and procedures as the Secretary considers necessary.

''(h)(1) The head of an executive, judicial, or legislative agency acting under subsection (a) (1), (2), or (3) of this section to collect a claim, compromise a claim, or terminate collection action on a claim may obtain a consumer report (as that term is defined in section 603 of the Fair Credit Reporting Act (15 U.S.C. 1681a)) or comparable credit information on any person who is liable for the claim.

''(2) The obtaining of a consumer report under this subsection is deemed to be a circumstance or purpose authorized or listed under section 604 of the Fair Credit Reporting Act (15 U.S.C. 1681b).''.

JEFFORDS AMENDMENT NO. 3680

Mr. JEFFORDS proposed an amendment to amendment No. 3679 proposed by him to the bill S. 1028, supra; as follows:

(Purpose: To reduce delinquencies and to improve debt-collection activities government-wide, and for other purposes)

Strike pages 4, 5, and 6 of amendment No. 3679, and insert:

SEC. 101. SHORT TITLE.

This Act may be cited as the ''Debt Collection Improvement Act of 1995''.

SEC. 102. EFFECTIVE DATE.

(a) Except as provided in subsection (b), the provisions of this Act and the amendments made by this Act shall become effective October 1, 1995.

(b) The amendments made by title III of this Act shall become effective for levies issued after the date of enactment of this Act.

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TITLE I—GENERAL DEBT COLLECTION INITIATIVES

Subchapter A—General Offset Authority

SEC. 201. ENHANCEMENT OF ADMINISTRATIVE OFFSET AUTHORITY.

(a) Section 3701(c) of title 31, United States Code, is amended to read as follows:

''(c) In sections 3716 and 3717 of this title, the term 'person' does not include an agency of the United States government, or of a unit of general local government.''.

(b) Section 3716 of title 31, United States Code, is amended—

(1) by amending subsection (b) to read as follows:

''(b) Before collecting a claim by administrative offset, the head of an executive, legislative, or judicial agency must either—

''(1) adopt regulations on collecting by administrative offset promulgated by the Department of Justice, the General Accounting Office and/or the Department of the Treasury without change; or

''(2) prescribe independent regulations on collecting by administrative offset consistent with the regulations promulgated under paragraph (1).'';

(2) by amending subsection (c)(2) to read as follows:

''(2) when a statute explicitly prohibits using administrative 'offset' or 'setoff' to collect the claim or type of claim involved.'';

(3) by redesignating subsection (c) as subsection (d); and

(4) by inserting after subsection (b) the following new subsection:

''(c)(1)(A) Except as provided in subparagraphs (B) or (C), a disbursing official of the Department of the Treasury, the Department of Defense, the United States Postal Service, or any disbursing official of the United States designated by the Secretary of the Treasury, is authorized to offset the amount of a payment which a payment certifying agency has certified to the disbursing official for disbursement by an amount equal to the amount of a claim which a creditor agency has certified to the Secretary of the Treasury pursuant to this subsection.

''(B) An agency that designates disbursing officials pursuant to section 3321(c) of this title is not required to certify claims arising out of its operations to the Secretary of the Treasury before such agency's disbursing officials offset such claims.

''(C) Payments certified by the Department of Education under a program administered by the Secretary of Education under Title IV of the Higher Education Act of 1965, as amended, shall not be subject to offset under this subsection.

''(2) Neither the disbursing official nor the payment certifying agency shall be liable—

(A) for the amount of the offset on the basis that the underlying obligation, represented by the payment before the offset was taken, was not satisfied; or

(B) for failure to provide timely notice under paragraph (8).

''(3)(A) Notwithstanding any other provision of law (including sections 207 and 1631(d)(1) of the Act of August 14, 1935 (42 U.S.C. 407 and 1383(d)(1)), section 413(b) of Public Law 91–173 (30 U.S.C. 923(b)) and section 14 of the Act of August 29, 1935 (45 U.S.C. 231m)), all payments due under the Social Security Act, Part B of the Black Lung Benefits Act, or under any law administered by the Railroad Retirement Board, shall be subject to offset under this section.

''(B) An amount of $10,000 which a debtor may receive under Federal benefit programs cited under subparagraph (A) within a 12-month period shall be exempt from offset under this subsection. In applying the $10,000 exemption, the disbursing official shall:

''(i) Apply a prorated amount of the exemption to each periodic benefit payment to be made to debtor during the applicable 12-month period; and

''(ii) Consider all benefit payments made during the applicable 12-month period which are exempt from offset under this subsection as part of the $10,000 exemption.

''For purposes of the preceding sentence, the amount of a periodic benefit payment shall be the amount after any reduction or deduction required under the laws authorizing the program under which such payment is authorized to be made (including any reduction or deduction to recover any overpayment under such program).

''(C) The Secretary of the Treasury shall exempt means-tested programs when notified by the head of the respective agency. The Secretary may exempt other payments from offset under this subsection upon the

written request of the head of a payment certifying agency. A written request for exemption of other payments must provide justification for the exemption under the standards prescribed by the Secretary. Such standards shall give due consideration to whether offset would tend to interfere substantially with or defeat the purposes of the payment certifying agency's program.

''(D) The provisions of section 205(b)(1) or 1631(c)(1) of the Social Security Act shall not apply to any offset executed pursuant to this section against benefits authorized by either title II or title XVI of the Social Security Act respectively.

''(4) The Secretary of the Treasury is authorized to charge a fee sufficient to cover the full cost of implementing this subsection. The fee may be collected either by the retention of a portion of amounts collected pursuant to this subsection, or by billing the agency referring or transferring the claim. Fees charged to the agencies shall be based on actual offsets completed. Fees charged under this subsection concerning delinquent claims may be considered as costs pursuant to section 3717(e) of this title. Fees charged under this subsection shall be deposited into the 'Account' determined by the Secretary of the Treasury in accordance with section 3711(g) of this title, and shall be collected and accounted for in accordance with the provisions of that section.

''(5) The Secretary of the Treasury may disclose to a creditor agency the current address of any payee and any data related to certifying and authorizing such payment in accordance with section 552a of title 5, United States Code, even when the payment has been exempt from offset. Where payments are made electronically, the Secretary is authorized to obtain the current address of the debtor/payee from the institution receiving the payment. Upon request by the Secretary, the institution receiving the payment shall report the current address of the debtor/payee to the Secretary.

''(6) The Secretary of the Treasury is authorized to prescribe such rules, regulations and procedures as the Secretary of the Treasury deems necessary to carry out the purposes of this subsection. The Secretary shall consult with the heads of affected agencies in the development of such rules, regulations and procedures.

''(7) (A) Any Federal agency that is owed, by a named person a past-due legally enforceable non-tax debt that is over 180 days delinquent (other than any past-due support), including non-tax debt administered by a third party acting as an agent for the Federal Government, shall notify the Secretary of the Treasury of all such non-tax debts for purposes of offset under this subsection.

''(B) An agency may delay notification under subparagraph (A) with respect to a debt that is secured by bond or other instruments in-lieu of bond, or for which there is another specific repayment source, in order to allow sufficient time to either collect the debt through normal collection processes (including collection by internal administrative offset) or render a final decision on any protest filed against the claim.

''(8) The disbursing official conducting the offset shall notify the payee in writing of—

''(A) the occurrence of an offset to satisfy a past-due legally enforceable debt, including a description of the type and amount of the payment otherwise payable to the debtor against which the offset was executed;

''(B) the identity of the creditor agency requesting the offset; and

''(C) a contact point within the creditor agency that will handle concerns regarding the offset.''.

''Where the payment to be offset is a periodic benefit payment, the disbursing official shall take reasonable steps, as determined by the Secretary of the Treasury, to provide the notice to the payee not later than the date on which the payee is otherwise scheduled to receive the payment, or as soon as practical thereafter, but no later than the date of the offset. Notwithstanding the preceding sentence, the failure of the debtor to receive such notice shall not impair the legality of such offset.

''(9) A levy pursuant to the Internal Revenue Code of 1986 shall take precedence over requests for offset received from other agencies.

(c) Section 3701(a) of title 31, U.S.C., is amended by adding at the end the following new paragraph:

''(8) 'non-tax claim' means any claim from any agency of the Federal Government other than a claim by the Internal Revenue Service under the Internal Revenue Code of 1986.''.

SEC. 202. HOUSE OF REPRESENTATIVES AS LEGISLATIVE AGENCY.

(a) Section 3701(a) of title 31, United States Code, is amended by adding the following new paragraphs after paragraph (7)—

''(8) For purposes of subchapters I and II of chapter 37 of title 31, United States Code (relating to claims of or against the United States Government), the United States House of Representatives shall be considered to be a legislative agency (as defined in section 3701(a)(4) of such title), and the Clerk of the House of Representatives shall be deemed to be the head of such legislative agency.

''(9) Regulations prescribed by the Clerk of the House of Representatives pursuant to section 3716 of title 31, United States Code, shall not become effective until they are approved by the Committee on Rules of the House of Representatives.''

SEC. 203. EXEMPTION FROM COMPUTER MATCHING REQUIREMENTS UNDER THE PRIVACY ACT OF 1974.

Section 552a(a) of title 5, United States Code, is amended—

(1) in paragraph (2), by inserting ''acting in an individual, not a business capacity'' after ''residence'';

(2) in paragraph (8)(B)—

(A) by striking ''or'' at the end of clause (vi);

(B) by inserting ''or'' at the end of clause (vii); and

(C) by adding after clause (vii) the following new clause:

''(viii) matches for administrative offset or claims collection pursuant to subsection 3716(c) of title 31, section 5514 of this title, or any other payment intercept or offset program authorized by statute;''.

SEC. 204 TECHNICAL AND CONFORMING AMENDMENTS.

(a) Title 31, United States Code, is amended—

(1) in section 3322(a), by inserting ''section 3716 and section 3720A of this title, section 6331 of title 26, and'' after ''Except as provided in''; and

(2) in section 3325(a)(3), by inserting ''or pursuant to payment intercepts or offsets pursuant to section 3716 or 3720A, or pursuant to levies executed under 26 U.S.C. 6331,'' after ''voucher''; and

(3) in sections 3711, 3716, 3717 and 3718, by striking ''the head of an executive or legislative agency'' each place it appears and inserting instead ''the head of an executive, judicial or legislative agency''.

(b) Subsection 6103(*1*)(10) of title 26, United States Code is amended—

(1) in subparagraph (A), by inserting ''and to officers and employees of the Department of the Treasury in connection with such reduction'' adding after ''6402''; and

(2) in subparagraph (B), by adding ''and to officers and employees of the Department of the Treasury in connection with such reduction'' after ''agency''.

Subchapter B—Salary Offset Authority

SEC. 301. ENHANCEMENT OF SALARY OFFSET AUTHORITY.

Section 5514 of title 5, United States Code, is amended—

(1) in subsection (a)—

(A) by adding at the end of paragraph (1) the following: ''All Federal agencies to which debts are owed and are delinquent in repayment, shall participate in a computer match at least annually of their delinquent debt records with records of Federal employees to identify those employees who are delinquent in repayment of those debts. Matched Federal employee records shall include, but shall not be limited to, active Civil Service employees government-wide, military active duty personnel, military reservists, United States Postal Service employees, and records of seasonal and temporary employees. The Secretary of the Treasury shall establish and maintain an interagency consortium to implement centralized salary offset computer matching, and promulgate regulations for this program. Agencies that perform centralized salary offset computer matching services under this subsection are authorized to charge a fee sufficient to cover the full cost for such services.'';

(B) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively;

(C) by inserting after paragraph (2) the following new paragraph:

''(3) The provisions of paragraph (2) shall not apply to routine intra-agency adjustments of pay that are attributable to clerical or administrative errors or delays in processing pay documents that have occurred within the four pay periods preceding the adjustment and to any adjustment that amounts to $50 or less, provided that at the time of such adjustment, or as soon thereafter as practical, the individual is provided written notice of the nature and the amount of the adjustment and a point of contact for contesting such adjustment.'';

(D) by amending paragraph (5)(B) (as redesignated) to read as follows:

''(B) For purposes of this section, 'agency' includes executive departments and agencies, the United States Postal Service, the Postal Rate Commission, the United States Senate, the United States House of Representatives, and any court, court administrative office, or instrumentality in the judicial or legislative branches of government, and government corporations.'';

(2) by adding at the end of subsection (b) the following new paragraphs:

''(3) For purposes of this section, the Clerk of the House of Representatives shall be deemed to be the head of the agency. Regulations prescribed by the Clerk of the House of Representatives pursuant to subsection (b)(1) shall be subject to the approval of the Committee on Rules of the House of Representatives.

''(4) For purposes of his section, the Secretary of the Senate shall be deemed to be the head of the agency. Regulations prescribed by the Secretary of the Senate pursuant to subsection (b)(1) shall be subject to the approval of the Committee on Rules and Administration of the Senate.''.

(3) by adding after subsection (c) the following new subsection:

''(d) A levy pursuant to the Internal Revenue Code of 1986 shall take precedence over requests for offset received from other agencies.''.

Subchapter C—Taxpayer Identifying Numbers

SEC. 401. ACCESS TO TAXPAYER IDENTIFYING NUMBERS; BARRING DELINQUENT DEBTORS FROM CREDIT ASSISTANCE.

Section 4 of the Debt Collection Act of 1982 (Pub. L. 97–365, 96 Stat. 1749, 26 U.S.C. 6103 note) is amended—

(1) in subsection (b), by striking ''For purposes of this section'' and inserting instead ''For purposes of subsection (a)''; and

(2) by at the end thereof the following new subsections:

''(c) FEDERAL AGENCIES.—Each Federal agency shall require each person doing business with that agency to furnish to that agency such person's taxpayer identifying number.

''(1) For purposes of this subsection, a person is considered to be 'doing business' with a Federal agency if the person is—

''(A) is a lender or servicer in a Federal guaranteed or insured loan program;

''(B) an applicant for, or recipient of—

''(i) a Federal guaranteed, insured, or direct loan; or

''(ii) a Federal license, permit, right-of-way, grant, benefit payment or insurance;

''(C) a contractor of the agency;

''(D) assessed a fine, fee, royalty or penalty by that agency;

''(E) in a relationship with a Federal agency that may give rise to a receivable due to that agency, such as a partner of a borrower in or a guarantor of a Federal direct or insured loan; and

''(F) is a joint holder of any account to which Federal benefit payments are transferred electronically.

''(2) Each agency shall disclose to the person required to furnish a taxpayer identifying number under this subsection its intent to use such number of purposes of collecting and reporting on any delinquent amounts arising out of such person's relationship with the government.

''(3) For purposes of this subsection—

''(A) The term 'taxpayer identifying number' has the meaning given such term in section 6109 of title 26, United States Code.

''(B) The term 'person' means an individual, sole proprietorship, partnership, corporation, non-profit organization, or any other form of business association, but with the exception of debtors owing claims resulting from petroleum pricing violations does not include debtors under third party claims of the United States.

''(d) ACCESS TO SOCIAL SECURITY NUMBERS.—Notwithstanding 5 U.S.C. 552a, creditor agencies to which a delinquent claim is owed, and their agents, may match their debtor records with the Social Security Administration records to verify name, name control, Social Security number, address, and date of birth.''.

SEC. 402. BARRING DELINQUENT FEDERAL DEBTORS FROM OBTAINING FEDERAL LOANS OR LOAN GUARANTEES.

(a) Title 31, United States Code, is amended by adding after section 3720A the following new section:

''SEC. 3720B. BARRING DELINQUENT FEDERAL DEBTORS FROM OBTAINING FEDERAL LOANS OR LOAN GUARANTEES.

''(a) Unless waived by the head of the agency, no person may obtain any Federal financial assistance in the form of a loan or a loan guarantee if such person has an outstanding Federal non-tax debt which is in a delinquent status, as determined under the standards prescribed by the Secretary of the Treasury, with a Federal agency. Any such person may obtain additional Federal financial assistance only after such delinquency is received, pursuant to these standards. This section shall not apply to loans or loan guarantees where a statute specifically permits extension of Federal financial assistance to borrowers in delinquent status.

''(b) The head of the agency may delegate the waiver authority described in (a) to the Chief Financial Officer of the agency. The waiver authority may be redelegated only to the Deputy Chief Financial Officer of the agency.

''(c) For purposes of this section, 'person' means an individual; or sole proprietorship, partnership, corporation, nonprofit organization, or any other form of business association.''

(b) The table of sections for subchapter II of chapter 37 of title 31, United States Code, is amended by inserting after the item relating to section 3720A the following new item:

''3720B. Barring Delinquent Federal Debtors from Obtaining Federal loans or Loan Guarantees.''.

Subchapter D—Expanding Collection Authorities and Governmentwide Cross-Servicing

SEC. 501. EXPANDING COLLECTION AUTHORITIES UNDER THE DEBT COLLECTION ACT OF 1982.

(a) Subsection 8(e) of the Debt Collection Act of 1982 (Public Law 97–365, 31 U.S.C. 3701(d) and 5 U.S.C. 5514 note) is repealed.

(b) Section 5 of the Social Security Domestic Employment Reform Act of 1994 (P.L. 103–387) is repealed.

(c) Section 631 of the Tariff Act of 1930, as amended (19 U.S.C. 1631) is repealed.

(d) Title 31, United States Code, is amended—

(1) in section 3701—

(A) by amending subsection (a)(4) to read as follows:

''(4) 'executive, judicial or legislative agency' means a department, military department, agency, court, court administrative office, or instrumentality in the executive, judicial or legislative branches of government, including government corporations.''; and

(B) by adding at the end the following new subsection:

''(d) Sections 3711(f) and 3716–3719 of this title do not apply to a claim or debt under, or to an amount payable under, the Internal Revenue Code of 1986;

(2) by amending section 3711(f) to read as follows:

''(f)(1) When trying to collect a claim of the Government, the head of an executive or legislative agency may disclose to a consumer reporting agency information from a system of records that an individual is responsible for a claim if notice required by section 552a(e)(4) of title 5, United States Code, indicates that information in the system may be disclosed to a consumer reporting agency.

''(2) The information disclosed to a consumer reporting agency shall be limited to—

''(A) information necessary to establish the identity of the individual, including name, address and taxpayer identifying number;

''(B) the amount, status, and history of the claim; and

''(C) the agency or program under which the claim arose.''; and

(3) in section 3718—

(A) in subsection (a), by striking the first sentence and inserting instead the following: ''Under conditions the head of an executive, legislative or judicial agency considers appropriate, the head of an agency may make a contract with a person for collection service to recover indebtedness owed, or to locate or recover assets of, the United States Government. No head of an agency may enter into a contract to locate or recover assets of the United States held by a state government or financial institution unless that agency has established procedures approved by the Secretary of the Treasury to identify and recover such assets; and

(B) in subsection (d), by inserting '', or to locate or recover assets of ,'' after ''owed''.

SEC. 502. GOVERNMENTWIDE CROSS-SERVICING.

Section 3711 of title 31, United States Code, is amended by adding at the end the following new subsection:

''(g)(1) At the discretion of the head of an executive, judicial or legislative agency, referral of a non-tax claim may be made to any executive department or agency operating a debt collection center for servicing and collection in accordance with an agreement entered into under paragraph (2). Referral or transfer of a claim may also be made to the Secretary of the Treasury for servicing, collection, compromise, and/or suspension or termination of collection action. Non-tax claims referred or transferred under this section shall be serviced, collected, compromised, and/or collection action suspended or terminated in accordance with existing statutory requirements and authorities.

''(2) Executive departments and agencies operating debt collection centers are authorized to enter into agreements with the heads of executive, judicial, or legislative agencies to service and/or collect non-tax claims referred or transferred under this subsection. The heads of other executive departments and agencies are authorized to enter into agreements with the Secretary of the Treasury for servicing or collection of referred or transferred non-tax claims or other Federal agencies operating debt collection centers to obtain debt collection services from those agencies.

''(3) Any agency to which non-tax claims are referred or transferred under this subsection is authorized to charge a fee sufficient to cover the full cost of implementing this subsection. The agency transferring or referring the non-tax claim shall be charged the fee, and the agency charging the fee shall collect such fee by retaining the amount of the fee from amounts collected pursuant to this subsection. Agencies may agree to pay through a different method, or to fund the activity from an account. Amounts charged under this subsection concerning delinquent claims may be considered as costs pursuant to section 3717(e) of this title.

''(4) Notwithstanding any other law concerning the depositing and collection of federal payments, including section 3302(b) of this title, agencies collecting fees may retain the fees from amounts collected. Any fee charged pursuant to this subsection shall be deposited into an account to be determined by the executive department or agency operating the debt collection center charging the fee (hereafter referred to in this section as the 'Account'). Amounts deposited in the Account shall be available until expended to cover costs associated with the implementation and operation of governmentwide debt collection activities. Costs properly chargeable to the Account include, but are not limited to:

''(A) the costs of computer hardware and software, word processing and telecommunications equipment, other equipment, supplies, and furniture;

''(B) personnel training and travel costs;

''(C) other personnel and administrative costs;

''(D) the costs of any contract for identification, billing, or collection services; and

''(E) reasonable costs incurred by the Secretary of the Treasury, including but not limited to, services and utilities provided by the Secretary, and administration of the Account.

''(5) Not later than January 1 of each year, there shall be deposited into the Treasury as miscellaneous receipts, an amount equal to the amount of unobligated balances remaining in the Account at the close of business on September 30 of the preceding year minus any part of such balance that the executive department or agency operating the debt collection center determines is necessary to cover or defray the costs under this subsection for the fiscal year in which the deposit is made.

''(6)(A) The head of an executive, legislative or judicial agency shall transfer to the Secretary of the Treasury all non-tax claims over 180 days delinquent for additional collection action and/or closeout.

''(B) Subparagraph (A) shall not apply—

''(i) to claims that—

''(I) are in litigation or foreclosure;

''(II) are eligible for disposition under the loan sales programs of a Federal department or agency;

''(III) have been referred to a private collection contractor for collection;

''(IV) are being collected under internal offset procedures;

''(V) have been referred to the Department of the Treasury, the Department of Defense, the United States Postal Service, or disbursing official of the United States designated by Secretary of the Treasury for administrative offset;

''(VI) have been retained by an executive agency in a debt collection center; or

''(VII) have been referred to another agency for collection;

''(ii) to claims which may be collected after the 180 day period in accordance with specific statutory authority or procedural guidelines, provided that the head of an executive, legislative or judicial agency provides notice of such claims to the Secretary of the Treasury; and

''(iii) to other specific class of claims as determined by the Secretary of the Treasury at the request of the head of an agency or otherwise.

''(C) The head of an executive, legislative or judicial agency shall transfer to the Secretary of the Treasury all non-tax claims on which the agency has ceased collection activity. The Secretary may exempt specific classes of claims from this requirement, at the request of the head of an agency, or otherwise. The Secretary shall review transferred claims to determine if additional collection action is warranted. The Secretary may, in accordance with section 6050P of title 26, United States Code, report to the Internal Revenue Service on behalf of the creditor agency any claims that have been discharged within the meaning of such section.

''(7) At the end of each calendar year, the head of an executive, legislative or judicial agency which, regarding a claim owed to the agency, is required to report a discharge of indebtedness as income under the 6050P of title 26, United States Code, shall either complete the appropriate form 1099 or submit to the Secretary of the Treasury such information as is necessary for the Secretary of the Treasury to complete the appropriate form 1099. The Secretary of the Treasury shall incorporate this information into the appropriate form and submit the information to the taxpayer and Internal Revenue Service.

''(8) To carry out the purposes of this subsection, the Secretary of the Treasury is authorized

''(A) to prescribe such rules, regulations and procedures as the Secretary deems necessary; and

''(B) to designate debt collection centers operated by other Federal agencies.''

SEC. 503. COMPROMISE OF CLAIMS.

Section 11 of the Administrative Dispute Resolution Act (Public Law 101–552, 104 Stat. 2736, 5 U.S.C. 581 note) is amended by adding at the end thereof the following sentence:

''This section shall not apply to section 8(b) of this Act''.

Subchapter E—Federal Civil Monetary Penalties

SEC. 601. ADJUSTING FEDERAL CIVIL MONETARY PENALTIES FOR INFLATION.

(a) The Federal Civil Penalties Inflation Adjustment Act of 1990 (Pub. L. 101–410. 104 Stat. 890, (28 U.S.C. 2461 note) is amended—

(1) by amending section 4 to read as follows:

''SEC. 4. The head of each agency shall, not later than 180 days after the date of enactment of the Debt Collection Improvement Act of 1995, and at least once every 4 years thereafter, by regulation adjust each civil monetary penalty provided by law within the jurisdiction of the Federal agency, except for any penalty under title 26, United States Code, by the inflation adjustment described under section 5 of this Act and publish each such regulation in the Federal Register.'';

(2) in section 5(a), by striking ''The adjustment described under paragraphs (4) and (5)(A) of section 4'' and inserting ''The inflation adjustment''; and

(3) by adding at the end the following new section:

''SEC. 7. Any increase to a civil monetary penalty resulting from this Act shall apply only to violations which occur after the date any such increase takes effect.''.

(b) The initial adjustment of a civil monetary penalty made pursuant to section 4 of Federal Civil Penalties Inflation Adjustment Act of 1990 (as amended by subsection (a)) may not exceed 10 percent of such penalty.

Subchapter F—Gain Sharing

SEC. 701. DEBT COLLECTION IMPROVEMENT ACCOUNT.

(a) Title 31, United States Code, is amended by inserting after section 3720B the following new section:

''SEC. 3720C. Debt Collection Improvement Account

''(a)(1) There is here by established in the Treasury a special fund to be known as the 'Debt Collection Improvement Account' (hereinafter referred to as the 'Account').

''(2) The Account shall be maintained and managed by the Secretary of the Treasury, who shall ensure that programs are credited with the amounts described in subsection (b) and with allocations described in subsection (c).

''(b)(1) Not later than 30 days after the end of a fiscal year, an agency other than the Department of Justice is authorized to transfer to the Account a dividend not to exceed one percent of the debt collection improvement amount as described in paragraph (3).

(2) Agency transfers to the Account may include collections from

''(A) salary, administrative and tax referral offsets;

''(B) automated levy authority;

''(C) the Department of Justice; and

''(D) private collection agencies.

''(3) For purposes of this section, the term 'debt collection improvement amount' means the amount by which the collection of delinquent debt with respect to a particular program during a fiscal year exceeds the delinquent debt baseline for such program for such fiscal year. The Office of Management and Budget shall determine the baseline from which increased collections are measured over the prior fiscal year, taking into account the recommendations made by the Secretary of the Treasury in consultation with creditor agencies.

''(c)(1) The Secretary of the Treasury is authorized to make payments from the Account solely to reimburse agencies for qualified expenses. For agencies with franchise funds, payments may be credited to subaccounts designated for debt collection.

''(2) For purposes of this paragraph, the term 'qualified expenses' means expenditures for the improvement of tax administration and agency debt collection and debt recovery activities including, but not limited to, account servicing (including cross-servicing under Section 502 of the Debt Collection Improvement Act of 1995), automatic data processing equipment acquisitions, delinquent debt collection, measures to minimize delinquent debt, asset disposition, and training of personnel involved in credit and debt management.

''(3) Payments made to agencies pursuant to paragraph (1) shall be in proportion to their contributions to the Account.

''(4)(A) Amounts in the Account shall be available to the Secretary of the Treasury to the extent and in the amounts provided in advance in appropriation acts, for purposes of this section. Such amounts are authorized to be appropriated without fiscal year limitation.

''(B) As soon as practical after the end of third fiscal year after which appropriations are made pursuant to this section, and every 3 years thereafter, any unappropriated balance in the account as determined by the Secretary of the Treasury in consultation with agencies, shall be transferred to the Treasury general fund as miscellaneous receipts.

''(d) For direct loan and loan guarantee programs subject to Title V of the Congressional Budget Act of 1974, amounts credited in accordance with section (c) shall be considered administrative costs and shall not be included in the estimated payments to the Government for the purpose of calculating the costs of such programs.

''(e) The Secretary of the Treasury shall prescribe such rules, regulation, and procedures as the Secretary deems necessary or appropriate to carry out the purposes of this section.''.

(b) The table of sections for subchapter II of chapter 37 of title 31, United States Code, is amended by inserting after the item relating to section 3720B the following new item:

''3720C. Debt Collection Improvement Account.''.

Subchapter G—Tax Refund Offset Authority

SEC. 801. OFFSET OF TAX REFUND PAYMENT BY DISBURSING OFFICIALS.

Section 3720A(h) of title 31, United States Code, is amended to read as follows:

''(h)(1) The term 'Secretary of the Treasury' may include the disbursing official of the Department of the Treasury.

''(2) The disbursing official of the Department of the Treasury—

''(A) shall notify a taxpayer in writing of—

''(i) the occurrence of an offset to satisfy a past-due legally enforceable non-tax debt;

''(ii) the identity of the creditor agency requesting the offset; and

''(iii) a contact point within the creditor agency that will handle concerns regarding the offset;

''(B) shall notify the Internal Revenue Service on a weekly basis of—

''(i) the occurrence of an offset to satisfy a past-due legally enforceable non-tax debt;

''(ii) the amount of such offset; and

''(iii) any other information required by regulations; and

''(C) shall match payment records with requests for offset by using a name control, taxpayer identifying number (as defined in 26 U.S.C. 6109), and any other necessary identifiers.''.

SEC. 802. EXPANDING TAX REFUND OFFSET AUTHORITY.

(a) Section 3720A of title 31, United States Code, is amended by adding after subsection (h) the following new subsection:

''(i) An agency subject to section 9 of the Act of May 18, 1933 (16 U.S.C. 831h) may implement this section at its discretion.''.

(b) Section 6402(f) of title 26, United States Code, is amended to read as follows:

''(f) FEDERAL AGENCY.—For purposes of this section, the term 'Federal agency' means a department, agency, or instrumentality of the United States, and includes a government corporation (as such term is defined in section 103 of title 5, United States Code).''.

SEC. 803. EXPANDING AUTHORITY TO COLLECT PAST-DUE SUPPORT.

(a) Subsection 3720A(a) of title 31, United States Code, is amended to read as follows:

''(a) Any Federal agency that is owed by a named person a past-due, legally enforceable debt (including past-due support and debt administered by a third party acting as an agent for the Federal government) shall, in accordance with regulations issued pursuant to subsections (b) and (d), notify the Secretary of the Treasury at least once a year of the amount of such debt.''.

(b) Section 664(a) of the Act of August 13, 1935, as amended (42 U.S.C. section 664(a)) is amended—

(1) in paragraph (1), by adding at the end thereof the following: ''This subsection may be implemented by the Secretary of the Treasury in accordance with section 3720A of title 31, United States Code.''; and

(2) in paragraph (2)(A), by adding at the end thereof the following: ''This subsection may be implemented by the Secretary of the Treasury in accordance with section 3720A of title 31, United States Code.''.

Subchapter H—Definitions, Due Process Rights, and Severability

SEC. 901. TECHNICAL AMENDMENTS TO DEFINITIONS.

Section 3701 of title 31, United States Code, is amended—

(1) by amending subsection (a)(1) to read as follows:

''(1) 'administrative offset' means withholding money payable by the United States (including money payable by the United States on behalf of a State government) to, or held by the United States for, a person to satisfy a claim.'';

(2) by amending subsection (a)(4) to read as follows:

''(4) 'executive, judicial or legislative agency' means a department, agency, court, court administrative office, or instrumentality in the executive, judicial or legislative branches of government, including government corporations.'';

(3) by amending subsection (b) to read as follows:

''(b)(1) The term 'claim' or 'debt' means any amount of money or property that has been determined by an appropriate official of the Federal Government to be owed to the United States by a person, organization, or entity other than another Federal agency. A claim includes, without limitation, money owed on account of loans insured or guaranteed by the Government, non-appropriated funds, over-payments, any amount the United States is authorized by statute to collect for the benefit of any person, and other amounts of money or property due the Government.

''(2) For purposes of section 3716 of this title, the term 'claim' also includes an amount of money or property owed by a person to a State, the District of Columbia, American Samoa, the United States Virgin Islands, the Commonwealth of the Northern Mariana Islands, or the Commonwealth of Puerto Rico.'';

(3) by adding after subsection (d) the following new subsection:

''(e) In section 3716 of this title—

''(1) 'creditor agency' means any entity owed a claim that seeks to collect that claim through administrative offset.

''(2) 'payment certifying agency' means any Federal department, agency or instrumentality and government corporation, that has transmitted a voucher to a disbursing official for disbursement.''.

SEC. 902. SEVERABILITY.

If any provision of this title, or the amendments made by this title, or the application of any provision to any entity, person, or circumstance is for any reason adjudged by a court of competent jurisdiction to be invalid, the remainder of this title, and the amendments made by this title, or its application shall not be affected.

SEC. 903. SCOPE.

This Act, the Federal Claims Collection Act of 1966, as amended, the Debt Collection Act of 1982, as amended, and the remaining provisions of chapter 37 of title 31, United States Code shall not be deemed to apply to claims or debts involving foreign persons. For purposes of this section, 'foreign person' means any person, sole proprietorship, partnership, corporation, organization or other entity that is an agency, department or instrumentality of a government of a foreign country, is owned, controlled, operated or managed by a government of a foreign country or any agency, department or instrumentality thereof, is a citizen of a foreign country, is organized under the laws of a foreign country, or has its principal place of business outside the United States, and 'foreign country' means a country other than the United States.

Subchapter I—Reporting

SEC. 1001. MONITORING AND REPORTING.

(a) The Secretary of the Treasury, in consultation with concerned Federal agencies, is authorized to establish guidelines, including information on outstanding debt, to assist agencies in the performance and monitoring of debt collection activities.

(b) Not later three years after the date of enactment of this Act, the Secretary of the Treasury shall report to the Congress on collection services provided by Federal agencies or entities collecting debt on behalf of other Federal agencies under the authorities contained in section 3711(g) of title 31, United States Code, as added by section 502 of this Act.

(c) Section 3719 of title 31, United States Code, is amended—

(1) in subsection (a)—

(A) by amending the first sentence to read as follows: ''In consultation with the Comptroller General, the Secretary of the Treasury shall prescribe regulations requiring the head of each agency with outstanding non-tax claims to prepare and submit to the Secretary at least once a year a report summarizing the status of loans and accounts receivable managed by the head of the agency.''; and

(B) in paragraph (3), by striking ''Director'' and inserting instead ''Secretary''; and

(2) in subsection (b), by striking ''Director'' and inserting instead ''Secretary''.

(d) Notwithstanding any other provision of law, the Secretary of the Treasury is authorized to consolidate all reports concerning debt collection into one annual report.

TITLE II—JUSTICE DEBT MANAGEMENT

Subchapter A—Private Attorneys

SEC. 1101. EXPANDED USE OF PRIVATE ATTORNEYS.

(a) Section 3718(b)(1)(A) of title 31, United States Code, is amended by striking the fourth sentence.

(b) Sections 3 and 5 of the Federal Debt Recovery Act (Pub. L. 99–578, 100 Stat. 3305) are hereby repealed.

Subchapter B—Nonjudicial Foreclosure

SEC. 1201. NONJUDICIAL FORECLOSURE OF MORTGAGES.

Chapter 176 of title 28 of the United States Code is amended by adding at the end thereof the following:

''Subchapter E—Nonjudicial Foreclosure

''3401. Definitions.
''3402. Rules of construction.
''3403. Election of procedure.
''3404. Designation of foreclosure trustee.
''3405. Notice of foreclosure sale; Statute of limitations.
''3406. Service of notice of foreclosure sale.
''3407. Cancellation of foreclosure sale.
''3408. Stay.
''3409. Conduct of sale; postponement.
''3410. Transfer of title and possession.
''3411. Record of foreclosure and sale.
''3412. Effect of sale.
''3413. Disposition of sale proceeds.
''3414. Deficiency judgment.

''SEC. 3401. DEFINITIONS.

''As used in this subchapter—

''(1) 'agency' means—

''(A) an executive department as defined in section 101 of title 5, United States Code;

''(B) an independent establishment as defined in section 104 of title 5, United States Code (except that it shall not include the General Accounting Office);

''(C) a military department as defined in section 102 of title 5, United States Code; and

''(D) a wholly owned government corporation as defined in section 9101(3) of title 31, United States Code.

''(2) 'agency head' means the head and any assistant head of an agency, and may upon the designation by the head of an agency include the chief official of any principal division of an agency or any other employee of an agency.

''(3) 'bona fide purchaser' means a purchaser for value in good faith and without notice of any adverse claim who acquires the seller's interest free of any adverse claim.

''(4) 'debt instrument' means a note, mortgage bond, guaranty or other instrument creating a debt or other obligation, including any instrument incorporated by reference therein and any instrument or agreement amending or modifying a debt instrument.

''(5) 'file' or 'filing' means docketing, indexing, recording, or registering, or any other requirement for perfecting a mortgage or a judgment.

''(6) 'foreclosure trustee' means an individual, partnership, association, or corporation, or any employee thereof, including a successor, appointed by the agency head to conduct a foreclosure sale pursuant to this subchapter.

''(7) 'mortgage' means a deed of trust, deed to secure debt, security agreement, or any other form of instrument under which any interest in real property, including leaseholds, life estates, reversionary interests, and any other estates under applicable law is conveyed in trust, mortgaged, encumbered, pledged or otherwise rendered subject to a lien, for the purpose of securing the payment of money or the performance of any other obligation.

''(8) 'of record' means an interest recorded pursuant to Federal or State statutes that provide for official recording of deeds, mortgages and judgments, and that establish the effect of such records as notice to creditors, purchasers, and other interested persons.

''(9) 'owner' means nay person who has an ownership interest in property and includes heirs, devisees, executors, administrators, and other personal representatives, and trustees of testamentary trusts if the owner of record is deceased.

''(10) 'sale' means a sale conducted pursuant to this subchapter, unless the context requires otherwise.

''(11) 'security property' means real property, or any interest in real property including leaseholds life estates, reversionary interests, and any other estates under applicable State law that secure a mortgage.

''SEC. 3402. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—If an agency head elects to proceed under this subchapter, this subchapter shall apply and the provisions of this subchapter shall govern in the event of a conflict with any other provision of Federal law or State law.

''(b) LIMITATION.—This subchapter shall not be construed to supersede or modify the operation of—

''(1) the lease-back/buy-back provisions under section 1985 of title 7, United States Code, or regulations promulgated thereunder; or

''(2) The Multifamily Mortgage Foreclosure Act of 1981 (Chapter 38 of title 12, United States Code).

''(c) EFFECT ON OTHER LAWS.—This subchapter shall not be construed to curtail or limit the rights of the United States or any of its agencies—

''(1) to foreclose a mortgage under any other provision of Federal law or State law; or

''(2) to enforce any right under Federal law or State law in lieu of or in addition to foreclosure, including any right to obtain a monetary judgment.

''(d) APPLICATION TO MORTGAGES.—The provisions of this subchapter may be used to foreclose any mortgage, whether executed prior or subsequent to the effective date of this subchapter.

''SEC. 3403. ELECTION OF PROCEDURE.

''(a) SECURITY PROPERTY SUBJECT TO FORECLOSURE.—An agency head may foreclose a mortgage upon the breach of a covenant or condition in a debt instrument or mortgage for which acceleration or foreclosure is authorized. An agency head may not institute foreclosure proceedings on the mortgage under any other provision of law, or refer such mortgage for litigation, during the pendency of foreclosure proceedings pursuant to this subchapter.

''(b) EFFECT OF CANCELLATION OF SALE.—If a foreclosure sale is canceled pursuant to section 3407, the agency head may thereafter foreclose on the security property in any manner authorized by law.

''SEC. 3404. DESIGNATION OF FORECLOSURE TRUSTEE.

''(a) IN GENERAL.—An agency head shall designate a foreclosure trustee who shall supersede any trustee designated in the mortgage. A foreclosure trustee designated under this section shall have a nonjudicial power of sale pursuant to this subchapter.

''(b) DESIGNATION OF FORECLOSURE TRUSTEE.—

''(1) An agency head may designate as foreclosure trustee—

''(A) an officer or employee of the agency; or

''(B) an individual who is a resident of the State in which the security property is located or

''(C) a partnership, association, or corporation, provided such entity is authorized to transact business under the laws of the State in which the security property is located.

''(2) The agency head is authorized to enter into personal services and other contracts not inconsistent with this subchapter.

''(c) METHOD OF DESIGNATION.—An agency head shall designate the foreclosure trustee in writing. The foreclosure trustee may be designated by name, title or position. An agency head may designate one or more foreclosure trustees for the purpose of proceeding with multiple foreclosures or a class of foreclosures.

''(d) AVAILABILITY OF DESIGNATION.—An agency head may designate such foreclosure trustees as the agency head deems necessary to carry out the purposes of this subchapter.

''(3) MULTIPLE FORECLOSURE TRUSTEES AUTHORIZED.—An agency head may designate multiple foreclosure trustees for different tracts of a secured property.

''(f) REMOVAL OF FORECLOSURE TRUSTEES; SUCCESSOR FORECLOSURE TRUSTEES.—An agency head may, with or without cause or notice, remove a foreclosure trustee and designate a successor trustee as provided in this section. The foreclosure sale shall continue without prejudice notwithstanding the removal of the foreclosure trustee and designation of a successor foreclosure trustee. Nothing in this section shall be construed to prohibit a successor foreclosure trustee from postponing the foreclosure sale in accordance with this subchapter.

''SEC. 3405. NOTICE OF FORECLOSURE SALE; STATUTE OF LIMITATIONS.

''(a) IN GENERAL.—

''(1) Not earlier than 21 days nor later than ten years after acceleration of a debt instrument or demand on a guaranty, the foreclosure trustee shall serve a notice of foreclosure sale in accordance with this subchapter.

''(2) For purposes of computing the time period under paragraph (1), there shall be excluded all periods during which there is in effect—

''(A) a judicially imposed stay of foreclosure; or

''(B) a stay imposed by section 362 of title 11, United States Code.

''(3) In the event of partial payment or written acknowledgement of the debt after acceleration of the debt instrument, the right to foreclose shall be deemed to accrue again at the time of each such payment or acknowledgement.

''(b) NOTICE OF FORECLOSURE SALE.—The notice of foreclosure sale shall include the following:

''(1) the name, title, and business address of the foreclosure trustee as of the date of the notice;

''(2) the names of the original parties to the debt instrument and the mortgage, and any assignees of the mortgagor of record;

''(3) the street address or location of the security property, and a generally accepted designation used to describe the security property, or so much thereof as is to be offered for sale, sufficient to identify the property to be sold;

''(4) the date of the mortgage, the office in which the mortgage is filed, and the location of the filing of the mortgage;

''(5) the default or defaults upon which foreclosure is based, and the date of the acceleration of the debt instrument;

''(6) the date, time, and place of the foreclosure sale;

''(7) a statement that the foreclosure is being conducted in accordance with this subchapter;

''(8) the types of costs, if any, to be paid by the purchaser upon transfer of title; and

''(9) the terms and conditions of sale, including the method and time of payment of the foreclosure purchase price.

''SEC. 3406. SERVICE OF NOTICE OF FORECLOSURE SALE.

''(a) RECORD NOTICE.—At least 21 days prior to the date of the foreclosure sale, the notice of foreclosure sale required by section 3405 shall be filed in the manner authorized for filing a notice of an action concerning real property according to the law of the State where the security property is located or, if none, in the manner authorized by section 3201 of this chapter.

''(b) NOTICE BY MAIL.—

''(1) At least 21 days prior to the date of the foreclosure sale, the notice set forth in section 3405 shall be sent by registered or certified mail, return receipt requested—

''(A) to the current owner of record of the security property as the record appears on the date that the notice of foreclosure sale is recorded pursuant to subsection (a);

''(B) to all debtors, including the mortgagor, assignees of the mortgagor and guarantors of the debt instrument;

''(C) to all persons having liens, interests or encumbrances of record upon the security property, as the record appears on the date that the notice of foreclosure sale is recorded pursuant to subsection (a); and

''(D) to any occupants of the security property. If the names of the occupants of the security property are not known to the agency, or the security property has more than one dwelling unit, the notice shall be posted at the security property.

''(2) The notice shall be sent to the debtor at the address, if any, set forth in the debt instrument or mortgage as the place to which notice is to be sent, and if different, to the debtor's last known address as shown in the mortgage record of the agency. The notice shall be sent to any person other than the debtor to that person's address of record or, if there is no address of record, to any address at which the agency in good faith believes the notice is likely to come to that person's attention.

''(3) Notice by mail pursuant to this subsection shall be effective upon mailing.

''(c) NOTICE BY PUBLICATION.—Notice of the foreclosure sale shall be published at least once a week for each of three successive weeks prior to the sale in at least one newspaper of general circulation in any county or counties in which the security property is located. If there is no newspaper published at least weekly that has a general circulation in at least one county in which the security property is located, copies of the notice of foreclosure sale shall instead be posted at least 21 days prior to the sale at the courthouse of any county or counties in which the property is located and at the place where the sale is to be held.

''SEC. 3407. CANCELLATION OF FORECLOSURE SALE.

''(a) IN GENERAL.—At any time prior to the foreclosure sale, the foreclosure trustee shall cancel the sale—

''(1) if the debtor or the holder of any subordinate interest in the security property tenders the performance due under the debt instrument and mortgage, including any amounts due because of the exercise of the right to accelerate, and the expenses of proceeding to foreclosure incurred to the time of tender; or

''(2) if the security property is a dwelling of four units or fewer, and the debtor:

''(A) pays or tenders all sums which would have been due at the time of tender in the absence of any acceleration;

''(B) performs any other obligation which would have been required in the absence of any acceleration; and

''(C) pays or tenders all costs of foreclosure incurred for which payment from the proceeds of the sale would be allowed; or

''(3) for any reason approved by the agency head.

''(b) LIMITATION.—The debtor may not, without the approval of the agency head, cure the default under subsection (a)(2) if, within the preceding 12 months, the debtor has cured a default after being served with a notice of foreclosure sale pursuant to this subchapter.

''(c) NOTICE OF CANCELLATION.—The foreclosure trustee shall file a notice of the cancellation in the same place and manner provided for the filing of the notice of foreclosure sale under section 3406(a).

"SEC. 3408. STAY.

"If, prior to the time of sale, foreclosure proceedings under this subchapter are stayed in any manner, including the filing of bankruptcy, no person may thereafter cure the default under the provisions of section 3407(a)(2). If the default is not cured at the time a stay is terminated, the foreclosure trustee shall proceed to sell the security property as provided in this subchapter.

"SEC. 3409. CONDUCT OF SALE; POSTPONEMENT.

"(a) SALE PROCEDURES.—Foreclosure sale pursuant to this subchapter shall be at public auction and shall be scheduled to begin at a time between the hours of 9:00 a.m. and 4:00 p.m. local time. The foreclosure sale shall be held at the location specified in the notice of foreclosure sale, which shall be a location where real estate foreclosure auctions are customarily held in the county or one of the counties in which the property to be sold is located or at a courthouse therein, or upon the property to be sold. Sale of security property situated in two or more counties may be held in any one of the counties in which any part of the security property is situated. The foreclosure trustee may designate the order in which multiple tracts of security property are sold.

"(b) BIDDING REQUIREMENTS.—Written one-price sealed bids shall be accepted by the foreclosure trustee, if submitted by the agency head or other persons for entry by announcement by the foreclosure trustee at the sale. The sealed bids shall be submitted in accordance with the terms set forth in the notice of foreclosure sale. The agency head or any other person may bid at the foreclosure sale, even if the agency head or other person previously submitted a written one-price bid. The agency head may bid a credit against the debt due without the tender or payment of cash. The foreclosure trustee may serve as auctioneer, or may employ an auctioneer who may be paid from the sale proceeds. If an auctioneer is employed, the foreclosure trustee is not required to attend the sale. The foreclosure trustee or an auctioneer may bid as directed by the agency head.

"(c) POSTPONEMENT OF SALE.—The foreclosure trustee shall have discretion, prior to or at the time of sale, to postpone the foreclosure sale. The foreclosure trustee may postpone a sale to a later hour the same day by announcing or posting the new time and place of the foreclosure sale at the time and place originally scheduled for the foreclosure sale. The foreclosure trustee may instead postpone the foreclosure sale for not fewer than 9 nor more than 31 days, by serving notice that the foreclosure sale has been postponed to a specified date, and the notice may include any revisions the foreclosure trustee deems appropriate. The notice shall be served by publication, mailing, and posting in accordance with subsections 3406 (b) and (c), except that publication may be made on any of three separate days prior to the new date of the foreclosure sale, and mailing may be made at any time at least 7 days prior to the new data of the foreclosure sale.

"(d) LIABILITY OF SUCCESSFUL BIDDER WHO FAILS TO COMPLY.—The foreclosure trustee may require a bidder to make a cash deposit before the bid is accepted. The amount or percentage of the cash deposit shall be stated by the foreclosure trustee in the notice of foreclosure sale. A successful bidder at the foreclosure sale who fails to comply with the terms of the sale shall forfeit the cash deposit or, at the election of the foreclosure trustee, shall be liable to the agency on a subsequent sale of the property for all net losses incurred by the agency as a result of such failure.

"(e) EFFECT OF SALE.—Any foreclosure sale held in accordance with this subchapter shall be conclusively presumed to have been conducted in a legal, fair and commercially reasonable manner. The sale price shall be conclusively presumed to constitute the reasonably equivalent value of the security property.

"SEC. 3410 TRANSFER OF TITLE AND POSSESSION.

"(a) DEED.—After receipt of the purchase price in accordance with the terms of the sale as provided in the notice of foreclosure sale, the foreclosure trustee shall execute and deliver to the purchaser a deed conveying the security property to the purchaser that grants and conveys title to the security property without warranty or covenants to the purchaser. The execution of the foreclosure trustee's deed shall have the effect of conveying all of the right, title, and interest in the security property covered by the mortgage. Notwithstanding any other law to the contrary, the foreclosure trustee's deed shall be a conveyance of the security property and not a quitclaim. No judicial proceeding shall be required ancillary or supplementary to the procedures provided in this chapter to establish the validity of the conveyance.

"(b) DEATH OF PURCHASER PRIOR TO CONSUMMATION OF SALE.—If a purchaser dies before execution and delivery of the deed conveying the security property to the purchaser, the foreclosure trustee shall execute and deliver the deed to the representative of the purchaser's estate upon payment of the purchase price in accordance with the terms of sale. Such delivery to the representative of the purchaser's estate shall have the same effect as if accomplished during the lifetime of the purchaser.

"(c) PURCHASER CONSIDERED BONA FIDE PURCHASER WITHOUT NOTICE.—The purchaser of property under this subchapter shall be presumed to be a bona fide purchaser without notice of defects, if any, in the title conveyed to the purchaser.

"(d) POSSESSION BY PURCHASER; CONTINUING INTERESTS.—A purchaser at a foreclosure sale conducted pursuant to this subchapter shall be entitled to possession upon passage of title to the security property, subject to any interest or interests senior to that of the mortgage. The right to possession of any person without an interest senior to the mortgage who is in possession of the property shall terminate immediately upon the passage of title to the security property, and the person shall vacate the security property immediately. The purchaser shall be entitled to take any steps available under Federal law or State law to obtain possession.

"(e) RIGHT OF REDEMPTION; RIGHT OF POSSESSION.—This subchapter shall preempt all Federal and State rights of redemption, statutory of common law. Upon conclusion of the public auction of the security property, no person shall have a right of redemption.

"(f) PROHIBITION OF IMPOSITION OF TAX ON CONVEYANCE BY THE UNITED STATES OR AGENCY THEREOF.—No tax, or fee in the nature of a tax, for the transfer of title to the security property by the foreclosure trustee's deed shall be imposed upon or collected from the foreclosure trustee or the purchaser by any State or political subdivision thereof.

"SEC. 3411. RECORD OF FORECLOSURE AND SALE.

"(a) RECITAL REQUIREMENTS.—The foreclosure trustee shall recite in the deed to the purchaser, or in an addendum to the foreclosure trustee's deed, or shall prepare an affidavit stating—

"(1) the date, time, and place of sale;

"(2) the date of the mortgage, the office in which the mortgage is filed, and the location of the filing of the mortgage;

"(3) the persons served with the notice of foreclosure sale;

"(4) the date and place of filing of the notice of foreclosure sale under section 3406(a);

"(5) that the foreclosure was conducted in accordance with the provisions of this subchapter, and

"(6) the sale amount.

"(b) EFFECT OF RECITALS.—The recitals set forth in subsection (a) shall be prima facie evidence of the truth of such recitals. Compliance with the requirements of subsection (a) shall create a conclusive presumption of the validity of the sale in favor of bona fide purchasers and encumbrancers for value without notice.

"(c) DEED TO BE ACCEPTED FOR FILING.—The register of deeds or other appropriate official of the county or counties where real estate deeds are regularly filed shall accept for filing and shall file the foreclosure trustee's deed and affidavit, if any, and any other instruments submitted for filing in relation to the foreclosure of the security property under this subchapter.

"SEC. 3412. EFFECT OF SALE.

"A sale conducted under this subchapter to a bona fide purchaser shall bar all claims upon the security property by—

"(1) any person to whom the notice of foreclosure sale was mailed as provided in this subchapter who claims an interest in the property subordinate to that of the mortgage, and the heir, devisee, executor, administrator, successor or assignee claiming under any such person;

"(2) any person claiming any interest in the property subordinate to that of the mortgage, if such person had actual knowledge of the sale;

"(3) any person so claiming, whose assignment, mortgage, or other conveyance was not filed in the proper place for filing, or whose judgment or decree was not filed in the proper place for filing, prior to the date of filing of the notice of foreclosure sale as required by section 3406(a), and the heir, devisee, executor, administrator, successor or assignee of such a person; or

"(4) any other person claiming under a statutory lien or encumbrance not required to be filed and attaching to the title or interest of any person designated in any of the foregoing subsections of this section.

"SEC. 3413. DISPOSITION OF SALE PROCEEDS.

"(a) DISTRIBUTION OF SALE PROCEEDS.—The foreclosure trustee shall distribute the proceeds of the foreclosure sale in the following order—

"(1)(A) to pay the commission of the foreclosure trustee, other than an agency employee, the greater of—

"(i) the sum of—

"(I) 3 percent of the first $1,000 collected, plus

"(II) 1.5 percent on the excess of any sum collected over $1,000; or

"(ii) $250; and

"(B) the amounts described in subparagraph (A)(i) shall be computed on the gross proceeds of all security property sold at a single sale;

"(2) to pay the expense of any auctioneer employed by the foreclosure trustee, if any, except that the commission payable to the foreclosure trustee pursuant to paragraph (1) shall be reduced by the amount paid to an auctioneer, unless the agency head determines that such reduction would adversely affect the ability of the agency head to retain qualified foreclosure trustees or auctioneers;

"(3) to pay for the costs of foreclosure, including—

"(A) reasonable and necessary advertising costs and postage incurred in giving notice pursuant to section 3406;

"(B) mileage for posting notices and for the foreclosure trustee's or auctioneer's attendance at the sale at the rate provided in

section 1921 of title 28, United States Code, for mileage by the most reasonable road distance;

''(C) reasonable and necessary costs actually incurred in connection with any search of title and lien records; and

''(D) necessary costs incurred by the foreclosure trustee to file documents;

''(4) to pay valid real property tax liens or assessments, if required by the notice of foreclosure sale;

''(5) to pay any liens senior to the mortgage, if required by the notice of foreclosure sale;

''(6) to pay service charges and advancements for taxes, assessments, and property insurance premiums;

''(7) to pay late charges and other administrative costs and the principal and interest balances secured by the mortgage, including expenditures for the necessary protection, preservation, and repair of the security property as authorized under the debt instrument or mortgage and interest thereon if provided for in the debt instrument or mortgage, pursuant to the agency's procedure.

''(b) INSUFFICIENT PROCEEDS.—In the event there are no proceeds of sale or the proceeds are insufficient to pay the costs and expenses set forth in subsection (a), the agency head shall pay such costs and expenses as authorized by applicable law.

''(c) SURPLUS MONIES.—

''(1) After making the payments required by subsection (a), the foreclosure trustee shall—

''(A) distribute any surplus to pay liens in the order of priority under Federal law or the law of the State where the security property is located; and

''(B) pay to the person who was the owner of record on the date the notice of foreclosure sale was filed the balance, if any, after any payments made pursuant to paragraph (1).

''(2) If the person to whom such surplus is to be paid cannot be located, or if the surplus available is insufficient to pay all claimants and the claimants cannot agree on the distribution of the surplus, that portion of the sale proceeds may be deposited by the foreclosure trustee with an appropriate official authorized under law to receive funds under such circumstances. If such a procedure for the deposit of disputed funds is not available, and the foreclosure trustee files a bill of interpleader or is sued as a stakeholder to determine entitlement to such funds, the foreclosure trustee's necessary costs in taking or defending such action shall be deducted first from the disputed funds.

''SEC. 3414. DEFICIENCY JUDGMENT.

''(a) IN GENERAL.—If after deducting the disbursements described in section 3413, the price at which the security property is sold at a foreclosure sale is insufficient to pay the unpaid balance of the debt secured by the security property, counsel for the United States may commence an action or actions against any or all debtors to recover the deficiency, unless specifically prohibited by the mortgage. The United States is also entitled to recover any amount authorized by section 3011 and costs of the action.

''(b) LIMITATION.—Any action commenced to recover the deficiency shall be brought within 6 years of the last sale of security property.

''(c) CREDITS.—The amount payable by a private mortgage guaranty insurer shall be credited to the account of the debtor prior to the commencement of an action for any deficiency owed by the debtor. Nothing in this subsection shall curtail or limit the subrogation rights of a private mortgage guaranty insurer.''.

TITLE III—IRS LEVY AUTHORITY

Subchapter A—Amendments to the Internal Revenue Code of 1986

SEC. 1301. PROVISION FOR CONTINUOUS LEVY.

Section 6331 of the Internal Revenue Code of 1986 (26 U.S.C. 6331) is amended—

(1) by redesignating subsection (h) as subsection (i); and

(2) by inserting after subsection (g) the following new subsection:

''(h) CONTINUING LEVY ON NON-MEANS TESTED FEDERAL PAYMENTS.—The effect of a levy on non-means tested Federal payments to or received by a taxpayer shall be continuous from the date such levy is first made until such levy is released. Notwithstanding section 6334, such levy shall attach to up to 15 percent of any salary or pension payment due to the taxpayer. For the purposes of this subsection, the term 'non-means tested Federal payment' refers to a Federal payment for which eligibility is not based on the income and/or assets of a payee, or that is not a loan.''.

SEC. 1302. MODIFICATION OF LEVY EXEMPTION

Section 6334 of the Internal Revenue Code of 1986 (26 U.S.C. 6334) is amended by adding at the end the following new subsection:

''(f) LEVY ALLOWED ON CERTAIN NON-MEANS TESTED FEDERAL PAYMENTS.—Non-means tested amounts—

(1) described in subsections (a)(7) and (a)(9) of this section; and

(2) annuity or pension payments under the Railroad Retirement Act and benefits under the Railroad Unemployment Insurance Act described in subsection (a)(6) of this section, shall not be exempt from levy if the Secretary approves the levy of such property.''.

SEC. 1303. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) Section 6103 of the Internal Revenue Code of 1986 (26 U.S.C. 6103) is amended by adding at the end of subsection (k) the following new paragraph:

''(8) LEVIES ON CERTAIN GOVERNMENT PAYMENTS.—

''(A) DISCLOSURE OF RETURN INFORMATION IN LEVIES ON FINANCIAL MANAGEMENT SERVICE.—The Secretary may disclose to officers and employees of the Financial Management Service return information, including taxpayer identity information, the amount of any unpaid liability under this title (including penalties and interest), and the type of tax and tax period to which such unpaid liability relates, in serving a notice of levy, or release of such levy, with respect to any applicable government payment.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Financial Management Service only for the purpose of, and to the extent necessary in, transferring levied funds in satisfaction of the levy, maintaining appropriate agency records in regard to such levy or the release thereof, notifying the taxpayer and the agency certifying such payment that the levy has been honored, or in the defense of any litigation ensuing from the honor of such levy.

''(C) APPLICABLE GOVERNMENT PAYMENT.—For purposes of this paragraph, the term 'applicable government payment' means any non-means tested Federal payment, as defined in section 6331(h) certified to the Financial Management Service for disbursement and any other payment certified to the Financial Management Service for disbursement and which the Commissioner designates by published notice.'';

(b) Section 6301(p) of the Internal Revenue Code of 1986 (26 U.S.C. 6301(p)), is amended—

(1) in paragraph (3)(A), by inserting ''(8)'' after ''(6),''; and

(2) in paragraph (4), by inserting ''(k)(8),'' after

''(j)(1) or (2),''.

(c) Section 552a(a)(8)(B) of title 5, United States Code, is amended by adding at the end the following new clause:

''(ix) matches performed incident to a levy described in section 6103(k)(8) of the Internal Revenue Code of 1986.''.

DOMENICI (AND WELLSTONE) AMENDMENT NO. 3681

Mr. DOMENICI (for himself and Mr. WELLSTONE) proposed an amendment to the bill S. 1028, supra; as follows:

At the end of title III, add the following:

SEC. ___. PARITY FOR MENTAL HEALTH SERVICES.

(a) PROHIBITION.—An employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, shall not impose treatment limitations or financial requirements on the coverage of mental health services if similar limitations or requirements are not imposed on coverage for services for other conditions.

(b) RULE OF CONSTRUCTION.—Nothing in subsection (a) shall be construed as prohibiting an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary.

TITLE IV—INTERNAL REVENUE CODE AND OTHER PROVISIONS

SEC. 400. REFERENCES.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Foreign Trust Tax Compliance

SEC. 401. IMPROVED INFORMATION REPORTING ON FOREIGN TRUSTS.

(a) IN GENERAL.—Section 6048 (relating to returns as to certain foreign trusts) is amended to read as follows:

''SEC. 6048. INFORMATION WITH RESPECT TO CERTAIN FOREIGN TRUSTS.

''(a) NOTICE OF CERTAIN EVENTS.—

''(1) GENERAL RULE.—On or before the 90th day (or such later day as the Secretary may prescribe) after any reportable event, the responsible party shall provide written notice of such event to the Secretary in accordance with paragraph (2).

''(2) CONTENTS OF NOTICE.—The notice required by paragraph (1) shall contain such information as the Secretary may prescribe, including—

''(A) the amount of money or other property (if any) transferred to the trust in connection with the reportable event, and

''(B) the identity of the trust and of each trustee and beneficiary (or class of beneficiaries) of the trust.

''(3) REPORTABLE EVENT.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'reportable event' means—

''(i) the creation of any foreign trust by a United States person,

''(ii) the transfer of any money or property (directly or indirectly) to a foreign trust by a United States person, including a transfer by reason of death, and

''(iii) the death of a citizen or resident of the United States if—

''(I) the decedent was treated as the owner of any portion of a foreign trust under the

rules of subpart E of part I of subchapter J of chapter 1, or

''(II) any portion of a foreign trust was included in the gross estate of the decedent.

''(B) EXCEPTIONS.—

''(i) FAIR MARKET VALUE SALES.—Subparagraph (A)(ii) shall not apply to any transfer of property to a trust in exchange for consideration of at least the fair market value of the transferred property. For purposes of the preceding sentence, consideration other than cash shall be taken into account at its fair market value and the rules of section 679(a)(3) shall apply.

''(ii) DEFERRED COMPENSATION AND CHARITABLE TRUSTS.—Subparagraph (A) shall not apply with respect to a trust which is—

''(I) described in section 402(b), 404(a)(4), or 404A, or

''(II) determined by the Secretary to be described in section 501(c)(3).

''(4) RESPONSIBLE PARTY.—For purposes of this subsection, the term 'responsible party' means—

''(A) the grantor in the case of the creation of an inter vivos trust,

''(B) the transferor in the case of a reportable event described in paragraph (3)(A)(ii) other than a transfer by reason of death, and

''(C) the executor of the decedent's estate in any other case.

''(b) UNITED STATES GRANTOR OF FOREIGN TRUST.—

''(1) IN GENERAL.—If, at any time during any taxable year of a United States person, such person is treated as the owner of any portion of a foreign trust under the rules of subpart E of part I of subchapter J of chapter 1, such person shall be responsible to ensure that—

''(A) such trust makes a return for such year which sets forth a full and complete accounting of all trust activities and operations for the year, the name of the United States agent for such trust, and such other information as the Secretary may prescribe, and

''(B) such trust furnishes such information as the Secretary may prescribe to each United States person (i) who is treated as the owner of any portion of such trust or (ii) who receives (directly or indirectly) any distribution from the trust.

''(2) TRUSTS NOT HAVING UNITED STATES AGENT.—

''(A) IN GENERAL.—If the rules of this paragraph apply to any foreign trust, the determination of amounts required to be taken into account with respect to such trust by a United States person under the rules of subpart E of part I of subchapter J of chapter 1 shall be determined by the Secretary.

''(B) UNITED STATES AGENT REQUIRED.—The rules of this paragraph shall apply to any foreign trust to which paragraph (1) applies unless such trust agrees (in such manner, subject to such conditions, and at such time as the Secretary shall prescribe) to authorize a United States person to act as such trust's limited agent solely for purposes of applying sections 7602, 7603, and 7604 with respect to—

''(i) any request by the Secretary to examine records or produce testimony related to the proper treatment of amounts required to be taken into account under the rules referred to in subparagraph (A), or

''(ii) any summons by the Secretary for such records or testimony.

The appearance of persons or production of records by reason of a United States person being such an agent shall not subject such persons or records to legal process for any purpose other than determining the correct treatment under this title of the amounts required to be taken into account under the rules referred to in subparagraph (A). A foreign trust which appoints an agent described in this subparagraph shall not be considered to have an office or a permanent establishment in the United States, or to be engaged in a trade or business in the United States, solely because of the activities of such agent pursuant to this subsection.

''(C) OTHER RULES TO APPLY.—Rules similar to the rules of paragraphs (2) and (4) of section 6038A(e) shall apply for purposes of this paragraph.

''(c) REPORTING BY UNITED STATES BENEFICIARIES OF FOREIGN TRUSTS.—

''(1) IN GENERAL.—If any United States person receives (directly or indirectly) during any taxable year of such person any distribution from a foreign trust, such person shall make a return with respect to such trust for such year which includes—

''(A) the name of such trust,

''(B) the aggregate amount of the distributions so received from such trust during such taxable year, and

''(C) such other information as the Secretary may prescribe.

''(2) INCLUSION IN INCOME IF RECORDS NOT PROVIDED.—

''(A) IN GENERAL.—If adequate records are not provided to the Secretary to determine the proper treatment of any distribution from a foreign trust, such distribution shall be treated as an accumulation distribution includible in the gross income of the distributee under chapter 1. To the extent provided in regulations, the preceding sentence shall not apply if the foreign trust elects to be subject to rules similar to the rules of subsection (b)(2)(B).

''(B) APPLICATION OF ACCUMULATION DISTRIBUTION RULES.—For purposes of applying section 668 in a case to which subparagraph (A) applies, the applicable number of years for purposes of section 668(a) shall be ½ of the number of years the trust has been in existence.

''(d) SPECIAL RULES.—

''(1) DETERMINATION OF WHETHER UNITED STATES PERSON RECEIVES DISTRIBUTION.—For purposes of this section, in determining whether a United States person receives a distribution from a foreign trust, the fact that a portion of such trust is treated as owned by another person under the rules of subpart E of part I of subchapter J of chapter 1 shall be disregarded.

''(2) DOMESTIC TRUSTS WITH FOREIGN ACTIVITIES.—To the extent provided in regulations, a trust which is a United States person shall be treated as a foreign trust for purposes of this section and section 6677 if such trust has substantial activities, or holds substantial property, outside the United States.

''(3) TIME AND MANNER OF FILING INFORMATION.—Any notice or return required under this section shall be made at such time and in such manner as the Secretary shall prescribe.

''(4) MODIFICATION OF RETURN REQUIREMENTS.—The Secretary is authorized to suspend or modify any requirement of this section if the Secretary determines that the United States has no significant tax interest in obtaining the required information.''

(b) INCREASED PENALTIES.—Section 6677 (relating to failure to file information returns with respect to certain foreign trusts) is amended to read as follows:

''SEC. 6677. FAILURE TO FILE INFORMATION WITH RESPECT TO CERTAIN FOREIGN TRUSTS.

''(a) CIVIL PENALTY.—In addition to any criminal penalty provided by law, if any notice or return required to be filed by section 6048—

''(1) is not filed on or before the time provided in such section, or

''(2) does not include all the information required pursuant to such section or includes incorrect information,

the person required to file such notice or return shall pay a penalty equal to 35 percent of the gross reportable amount. If any failure described in the preceding sentence continues for more than 90 days after the day on which the Secretary mails notice of such failure to the person required to pay such penalty, such person shall pay a penalty (in addition to the amount determined under the preceding sentence) of $10,000 for each 30-day period (or fraction thereof) during which such failure continues after the expiration of such 90-day period. In no event shall the penalty under this subsection with respect to any failure exceed the gross reportable amount.

''(b) SPECIAL RULES FOR RETURNS UNDER SECTION 6048(b).—In the case of a return required under section 6048(b)—

''(1) the United States person referred to in such section shall be liable for the penalty imposed by subsection (a), and

''(2) subsection (a) shall be applied by substituting '5 percent' for '35 percent'.

''(c) GROSS REPORTABLE AMOUNT.—For purposes of subsection (a), the term 'gross reportable amount' means—

''(1) the gross value of the property involved in the event (determined as of the date of the event) in the case of a failure relating to section 6048(a),

''(2) the gross value of the portion of the trust's assets at the close of the year treated as owned by the United States person in the case of a failure relating to section 6048(b)(1), and

''(3) the gross amount of the distributions in the case of a failure relating to section 6048(c).

''(d) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed by this section on any failure which is shown to be due to reasonable cause and not due to willful neglect. The fact that a foreign jurisdiction would impose a civil or criminal penalty on the taxpayer (or any other person) for disclosing the required information is not reasonable cause.

''(e) DEFICIENCY PROCEDURES NOT TO APPLY.—Subchapter B of chapter 63 (relating to deficiency procedures for income, estate, gift, and certain excise taxes) shall not apply in respect of the assessment or collection of any penalty imposed by subsection (a).''

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 6724(d) is amended by striking ''or'' at the end of subparagraph (S), by striking the period at the end of subparagraph (T) and inserting '', or'', and by inserting after subparagraph (T) the following new subparagraph:

''(U) section 6048(b)(1)(B) (relating to foreign trust reporting requirements).''

(2) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by striking the item relating to section 6048 and inserting the following new item:

''Sec. 6048. Information with respect to certain foreign trusts.''

(3) The table of sections for part I of subchapter B of chapter 68 is amended by striking the item relating to section 6677 and inserting the following new item:

''Sec. 6677. Failure to file information with respect to certain foreign trusts.''

(d) EFFECTIVE DATES.—

(1) REPORTABLE EVENTS.—To the extent related to subsection (a) of section 6048 of the Internal Revenue Code of 1986, as amended by this section, the amendments made by this section shall apply to reportable events (as defined in such section 6048) occurring after the date of the enactment of this Act.

(2) GRANTOR TRUST REPORTING.—To the extent related to subsection (b) of such section

6048, the amendments made by this section shall apply to taxable years of United States persons beginning after the date of the enactment of this Act.

(3) REPORTING BY UNITED STATES BENEFICIARIES.—To the extent related to subsection (c) of such section 6048, the amendments made by this section shall apply to distributions received after the date of the enactment of this Act.

SEC. 402. MODIFICATIONS OF RULES RELATING TO FOREIGN TRUSTS HAVING ONE OR MORE UNITED STATES BENEFICIARIES.

(a) TREATMENT OF TRUST OBLIGATIONS, ETC.—

(1) Paragraph (2) of section 679(a) is amended by striking subparagraph (B) and inserting the following:

''(B) TRANSFERS AT FAIR MARKET VALUE.—To any transfer of property to a trust in exchange for consideration of at least the fair market value of the transferred property. For purposes of the preceding sentence, consideration other than cash shall be taken into account at its fair market value.''

(2) Subsection (a) of section 679 (relating to foreign trusts having one or more United States beneficiaries) is amended by adding at the end the following new paragraph:

''(3) CERTAIN OBLIGATIONS NOT TAKEN INTO ACCOUNT UNDER FAIR MARKET VALUE EXCEPTION.—

''(A) IN GENERAL.—In determining whether paragraph (2)(B) applies to any transfer by a person described in clause (ii) or (iii) of subparagraph (C), there shall not be taken into account—

''(i) except as provided in regulations, any obligation of a person described in subparagraph (C), and

''(ii) to the extent provided in regulations, any obligation which is guaranteed by a person described in subparagraph (C).

''(B) TREATMENT OF PRINCIPAL PAYMENTS ON OBLIGATION.—Principal payments by the trust on any obligation referred to in subparagraph (A) shall be taken into account on and after the date of the payment in determining the portion of the trust attributable to the property transferred.

''(C) PERSONS DESCRIBED.—The persons described in this subparagraph are—

''(i) the trust,

''(ii) any grantor or beneficiary of the trust, and

''(iii) any person who is related (within the meaning of section 643(i)(2)(B)) to any grantor or beneficiary of the trust.''

(b) EXEMPTION OF TRANSFERS TO CHARITABLE TRUSTS.—Subsection (a) of section 679 is amended by striking ''section 404(a)(4) or 404A'' and inserting ''section 6048(a)(3)(B)(ii)''.

(c) OTHER MODIFICATIONS.—Subsection (a) of section 679 is amended by adding at the end the following new paragraphs:

''(4) SPECIAL RULES APPLICABLE TO FOREIGN GRANTOR WHO LATER BECOMES A UNITED STATES PERSON.—

''(A) IN GENERAL.—If a nonresident alien individual has a residency starting date within 5 years after directly or indirectly transferring property to a foreign trust, this section and section 6048 shall be applied as if such individual transferred to such trust on the residency starting date an amount equal to the portion of such trust attributable to the property transferred by such individual to such trust in such transfer.

''(B) TREATMENT OF UNDISTRIBUTED INCOME.—For purposes of this section, undistributed net income for periods before such individual's residency starting date shall be taken into account in determining the portion of the trust which is attributable to property transferred by such individual to such trust but shall not otherwise be taken into account.

''(C) RESIDENCY STARTING DATE.—For purposes of this paragraph, an individual's residency starting date is the residency starting date determined under section 7701(b)(2)(A).

''(5) OUTBOUND TRUST MIGRATIONS.—If—

''(A) an individual who is a citizen or resident of the United States transferred property to a trust which was not a foreign trust, and

''(B) such trust becomes a foreign trust while such individual is alive,

then this section and section 6048 shall be applied as if such individual transferred to such trust on the date such trust becomes a foreign trust an amount equal to the portion of such trust attributable to the property previously transferred by such individual to such trust. A rule similar to the rule of paragraph (4)(B) shall apply for purposes of this paragraph.''

(d) MODIFICATIONS RELATING TO WHETHER TRUST HAS UNITED STATES BENEFICIARIES.—Subsection (c) of section 679 is amended by adding at the end the following new paragraph:

''(3) CERTAIN UNITED STATES BENEFICIARIES DISREGARDED.—A beneficiary shall not be treated as a United States person in applying this section with respect to any transfer of property to foreign trust if such beneficiary first became a United States person more than 5 years after the date of such transfer.''

(e) TECHNICAL AMENDMENT.—Subparagraph (A) of section 679(c)(2) is amended to read as follows:

''(A) in the case of a foreign corporation, such corporation is a controlled foreign corporation (as defined in section 957(a)),''.

(f) REGULATIONS.—Section 679 is amended by adding at the end the following new subsection:

''(d) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section.''

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers of property after February 6, 1995.

SEC. 403. FOREIGN PERSONS NOT TO BE TREATED AS OWNERS UNDER GRANTOR TRUST RULES.

(a) GENERAL RULE.—

(1) Subsection (f) of section 672 (relating to special rule where grantor is foreign person) is amended to read as follows:

''(f) SUBPART NOT TO RESULT IN FOREIGN OWNERSHIP.—

''(1) IN GENERAL.—Notwithstanding any other provision of this subpart, this subpart shall apply only to the extent such application results in an amount being currently taken into account (directly or through 1 or more entities) under this chapter in computing the income of a citizen or resident of the United States or a domestic corporation.

''(2) EXCEPTIONS.—

''(A) CERTAIN REVOCABLE AND IRREVOCABLE TRUSTS.—Paragraph (1) shall not apply to any trust if—

''(i) the power to revest absolutely in the grantor title to the trust property is exercisable solely by the grantor without the approval or consent of any other person or with the consent of a related or subordinate party who is subservient to the grantor, or

''(ii) the only amounts distributable from such trust (whether income or corpus) during the lifetime of the grantor are amounts distributable to the grantor or the spouse of the grantor.

''(B) COMPENSATORY TRUSTS.—Except as provided in regulations, paragraph (1) shall not apply to any portion of a trust distributions from which are taxable as compensation for services rendered.

''(3) SPECIAL RULES.—Except as otherwise provided in regulations prescribed by the Secretary—

''(A) a controlled foreign corporation (as defined in section 957) shall be treated as a domestic corporation for purposes of paragraph (1), and

''(B) paragraph (1) shall not apply for purposes of applying section 1296.

''(4) RECHARACTERIZATION OF PURPORTED GIFTS.—In the case of any transfer directly or indirectly from a partnership or foreign corporation which the transferee treats as a gift or bequest, the Secretary may recharacterize such transfer in such circumstances as the Secretary determines to be appropriate to prevent the avoidance of the purposes of this subsection.

''(5) SPECIAL RULE WHERE GRANTOR IS FOREIGN PERSON.—If—

''(A) but for this subsection, a foreign person would be treated as the owner of any portion of a trust, and

''(B) such trust has a beneficiary who is a United States person,

such beneficiary shall be treated as the grantor of such portion to the extent such beneficiary has made transfers of property by gift (directly or indirectly) to such foreign person. For purposes of the preceding sentence, any gift shall not be taken into account to the extent such gift would be excluded from taxable gifts under section 2503(b).

''(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection, including regulations providing that paragraph (1) shall not apply in appropriate cases.''

(2) The last sentence of subsection (c) of section 672 of such Code is amended by inserting ''subsection (f) and'' before ''sections 674''.

(b) CREDIT FOR CERTAIN TAXES.—Paragraph (2) of section 665(d) is amended by adding at the end the following new sentence: ''Under rules or regulations prescribed by the Secretary, in the case of any foreign trust of which the settlor or another person would be treated as owner of any portion of the trust under subpart E but for section 672(f), the term 'taxes imposed on the trust' includes the allocable amount of any income, war profits, and excess profits taxes imposed by any foreign country or possession of the United States on the settlor or such other person in respect of trust gross income.''

(c) DISTRIBUTIONS BY CERTAIN FOREIGN TRUSTS THROUGH NOMINEES.—

(1) Section 643 is amended by adding at the end the following new subsection:

''(h) DISTRIBUTIONS BY CERTAIN FOREIGN TRUSTS THROUGH NOMINEES.—For purposes of this part, any amount paid to a United States person which is derived directly or indirectly from a foreign trust of which the payor is not the grantor shall be deemed in the year of payment to have been directly paid by the foreign trust to such United States person.''

(2) Section 665 is amended by striking subsection (c).

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided by paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTION FOR CERTAIN TRUSTS.—The amendments made by this section shall not apply to any trust—

(A) which is treated as owned by the grantor or another person under section 676 or 677 (other than subsection (a)(3) thereof) of the Internal Revenue Code of 1986, and

(B) which is in existence on September 19, 1995.

The preceding sentence shall not apply to the portion of any such trust attributable to any transfer to such trust after September 19, 1995.

(e) TRANSITIONAL RULE.—If—

(1) by reason of the amendments made by this section, any person other than a United States person ceases to be treated as the owner of a portion of a domestic trust, and

(2) before January 1, 1997, such trust becomes a foreign trust, or the assets of such trust are transferred to a foreign trust,

no tax shall be imposed by section 1491 of the Internal Revenue Code of 1986 by reason of such trust becoming a foreign trust or the assets of such trust being transferred to a foreign trust.

SEC. 404. INFORMATION REPORTING REGARDING FOREIGN GIFTS.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

"SEC. 6039F. NOTICE OF GIFTS RECEIVED FROM FOREIGN PERSONS.

''(a) IN GENERAL.—If the value of the aggregate foreign gifts received by a United States person (other than an organization described in section 501(c) and exempt from tax under section 501(a)) during any taxable year exceeds $10,000, such United States person shall furnish (at such time and in such manner as the Secretary shall prescribe) such information as the Secretary may prescribe regarding each foreign gift received during such year.

''(b) FOREIGN GIFT.—For purposes of this section, the term 'foreign gift' means any amount received from a person other than a United States person which the recipient treats as a gift or bequest. Such term shall not include any qualified transfer (within the meaning of section 2503(e)(2)).

''(c) PENALTY FOR FAILURE TO FILE INFORMATION.—

''(1) IN GENERAL.—If a United States person fails to furnish the information required by subsection (a) with respect to any foreign gift within the time prescribed therefor (including extensions)—

''(A) the tax consequences of the receipt of such gift shall be determined by the Secretary in the Secretary's sole discretion from the Secretary's own knowledge or from such information as the Secretary may obtain through testimony or otherwise, and

''(B) such United States person shall pay (upon notice and demand by the Secretary and in the same manner as tax) an amount equal to 5 percent of the amount of such foreign gift for each month for which the failure continues (not to exceed 25 percent of such amount in the aggregate).

''(2) REASONABLE CAUSE EXCEPTION.—Paragraph (1) shall not apply to any failure to report a foreign gift if the United States person shows that the failure is due to reasonable cause and not due to willful neglect.

''(d) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning after December 31, 1996, the $10,000 amount under subsection (a) shall be increased by an amount equal to the product of such amount and the cost-of-living adjustment for such taxable year under section 1(f)(3), except that subparagraph (B) thereof shall be applied by substituting '1995' for '1992'.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section.''

(b) CLERICAL AMENDMENT.—The table of sections for such subpart is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Notice of large gifts received from foreign persons.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts received after the date of the enactment of this Act in taxable years ending after such date.

SEC. 405. MODIFICATION OF RULES RELATING TO FOREIGN TRUSTS WHICH ARE NOT GRANTOR TRUSTS.

(a) MODIFICATION OF INTEREST CHARGE ON ACCUMULATION DISTRIBUTIONS.—Subsection (a) of section 668 (relating to interest charge on accumulation distributions from foreign trusts) is amended to read as follows:

''(a) GENERAL RULE.—For purposes of the tax determined under section 667(a)—

''(1) INTEREST DETERMINED USING UNDERPAYMENT RATES.—The interest charge determined under this section with respect to any distribution is the amount of interest which would be determined on the partial tax computed under section 667(b) for the period described in paragraph (2) using the rates and the method under section 6621 applicable to underpayments of tax.

''(2) PERIOD.—For purposes of paragraph (1), the period described in this paragraph is the period which begins on the date which is the applicable number of years before the date of the distribution and which ends on the date of the distribution.

''(3) APPLICABLE NUMBER OF YEARS.—For purposes of paragraph (2)—

''(A) IN GENERAL.—The applicable number of years with respect to a distribution is the number determined by dividing—

''(i) the sum of the products described in subparagraph (B) with respect to each undistributed income year, by

''(ii) the aggregate undistributed net income.

The quotient determined under the preceding sentence shall be rounded under procedures prescribed by the Secretary.

''(B) PRODUCT DESCRIBED.—For purposes of subparagraph (A), the product described in this subparagraph with respect to any undistributed income year is the product of—

''(i) the undistributed net income for such year, and

''(ii) the sum of the number of taxable years between such year and the taxable year of the distribution (counting in each case the undistributed income year but not counting the taxable year of the distribution).

''(4) UNDISTRIBUTED INCOME YEAR.—For purposes of this subsection, the term 'undistributed income year' means any prior taxable year of the trust for which there is undistributed net income, other than a taxable year during all of which the beneficiary receiving the distribution was not a citizen or resident of the United States.

''(5) DETERMINATION OF UNDISTRIBUTED NET INCOME.—Notwithstanding section 666, for purposes of this subsection, an accumulation distribution from the trust shall be treated as reducing proportionately the undistributed net income for undistributed income years.

''(6) PERIODS BEFORE 1996.—Interest for the portion of the period described in paragraph (2) which occurs before January 1, 1996, shall be determined—

''(A) by using an interest rate of 6 percent, and

''(B) without compounding until January 1, 1996.''

(b) ABUSIVE TRANSACTIONS.—Section 643(a) is amended by inserting after paragraph (6) the following new paragraph:

''(7) ABUSIVE TRANSACTIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this part, including regulations to prevent avoidance of such purposes.''

(c) TREATMENT OF LOANS FROM TRUSTS.—

(1) IN GENERAL.—Section 643 (relating to definitions applicable to subparts A, B, C, and D) is amended by adding at the end the following new subsection:

''(i) LOANS FROM FOREIGN TRUSTS.—For purposes of subparts B, C, and D—

''(1) GENERAL RULE.—Except as provided in regulations, if a foreign trust makes a loan of cash or marketable securities directly or indirectly to—

''(A) any grantor or beneficiary of such trust who is a United States person, or

''(B) any United States person not described in subparagraph (A) who is related to such grantor or beneficiary,

the amount of such loan shall be treated as a distribution by such trust to such grantor or beneficiary (as the case may be).

''(2) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) CASH.—The term 'cash' includes foreign currencies and cash equivalents.

''(B) RELATED PERSON.—

''(i) IN GENERAL.—A person is related to another person if the relationship between such persons would result in a disallowance of losses under section 267 or 707(b). In applying section 267 for purposes of the preceding sentence, section 267(c)(4) shall be applied as if the family of an individual includes the spouses of the members of the family.

''(ii) ALLOCATION.—If any person described in paragraph (1)(B) is related to more than one person, the grantor or beneficiary to whom the treatment under this subsection applies shall be determined under regulations prescribed by the Secretary.

''(C) EXCLUSION OF TAX-EXEMPTS.—The term 'United States person' does not include any entity exempt from tax under this chapter.

''(D) TRUST NOT TREATED AS SIMPLE TRUST.—Any trust which is treated under this subsection as making a distribution shall be treated as not described in section 651.

''(3) SUBSEQUENT TRANSACTIONS REGARDING LOAN PRINCIPAL.—If any loan is taken into account under paragraph (1), any subsequent transaction between the trust and the original borrower regarding the principal of the loan (by way of complete or partial repayment, satisfaction, cancellation, discharge, or otherwise) shall be disregarded for purposes of this title.''

(2) TECHNICAL AMENDMENT.—Paragraph (8) of section 7872(f) is amended by inserting '', 643(i),'' before ''or 1274'' each place it appears.

(d) EFFECTIVE DATES.—

(1) INTEREST CHARGE.—The amendment made by subsection (a) shall apply to distributions after the date of the enactment of this Act.

(2) ABUSIVE TRANSACTIONS.—The amendment made by subsection (b) shall take effect on the date of the enactment of this Act.

(3) LOANS FROM TRUSTS.—The amendment made by subsection (c) shall apply to loans of cash or marketable securities after September 19, 1995.

SEC. 406. RESIDENCE OF ESTATES AND TRUSTS, ETC.

(a) TREATMENT AS UNITED STATES PERSON.—

(1) IN GENERAL.—Paragraph (30) of section 7701(a) is amended by striking subparagraph (D) and by inserting after subparagraph (C) the following:

''(D) any estate or trust if—

''(i) a court within the United States is able to exercise primary supervision over the administration of the estate or trust, and

''(ii) in the case of a trust, one or more United States fiduciaries have the authority to control all substantial decisions of the trust.''

(2) CONFORMING AMENDMENT.—Paragraph (31) of section 7701(a) is amended to read as follows:

''(31) FOREIGN ESTATE OR TRUST.—The term 'foreign estate' or 'foreign trust' means any estate or trust other than an estate or trust described in section 7701(a)(30)(D).''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply—

(A) to taxable years beginning after December 31, 1996, or

(B) at the election of the trustee of a trust, to taxable years ending after the date of the enactment of this Act.

Such an election, once made, shall be irrevocable.

(b) DOMESTIC TRUSTS WHICH BECOME FOREIGN TRUSTS.—

(1) IN GENERAL.—Section 1491 (relating to imposition of tax on transfers to avoid income tax) is amended by adding at the end the following new flush sentence:

''If a trust which is not a foreign trust becomes a foreign trust, such trust shall be treated for purposes of this section as having transferred, immediately before becoming a foreign trust, all of its assets to a foreign trust.''

(2) PENALTY.—Section 1494 is amended by adding at the end the following new subsection:

''(c) PENALTY.—In the case of any failure to file a return required by the Secretary with respect to any transfer described in section 1491 with respect to a trust, the person required to file such return shall be liable for the penalties provided in section 6677 in the same manner as if such failure were a failure to file a return under section 6048(a).''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

Subtitle B—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

SEC. 411. REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS.

(a) IN GENERAL.—Section 593 (relating to reserves for losses on loans) is hereby repealed.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 50 is amended by adding at the end the following new sentence:

''Paragraphs (1)(A), (2)(A), and (4) of section 46(e) referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995.''

(2) Subsection (e) of section 52 is amended by striking paragraph (1) and by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking ''or to which section 593 applies''.

(6) Subparagraph (A) of section 585(a)(2) is amended by striking ''other than an organization to which section 593 applies''.

(7) Sections 595 and 596 are hereby repealed.

(8) Subsection (a) of section 860E is amended—

(A) by striking ''Except as provided in paragraph (2), the'' in paragraph (1) and inserting ''The'',

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows ''subsection'' and inserting a period.

(9) Paragraph (3) of section 992(d) is amended by striking ''or 593''.

(10) Section 1038 is amended by striking subsection (f).

(11) Clause (ii) of section 1042(c)(4)(B) is amended by striking ''or 593''.

(12) Subsection (c) of section 1277 is amended by striking ''or to which section 593 applies''.

(13) Subparagraph (B) of section 1361(b)(2) is amended by striking ''or to which section 593 applies''.

(14) The table of sections for part II of subchapter H of chapter 1 is amended by striking the items relating to sections 593, 595, and 596.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(2) REPEAL OF SECTION 595.—The repeal of section 595 under subsection (b)(7) shall apply to property acquired in taxable years beginning after December 31, 1995.

(d) 6-YEAR SPREAD OF ADJUSTMENTS.—

(1) IN GENERAL.—In the case of any taxpayer who is required by reason of the amendments made by this section to change its method of computing reserves for bad debts—

(A) such change shall be treated as a change in a method of accounting,

(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a)—

(i) shall be determined by taking into account only applicable excess reserves, and

(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

(2) APPLICABLE EXCESS RESERVES.—

(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable excess reserves' means the excess (if any) of—

(i) the balance of the reserves described in section 593(c)(1) of such Code (as in effect on the day before the date of the enactment of this Act) as of the close of the taxpayer's last taxable year beginning before January 1, 1996, over

(ii) the lesser of—

(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

(II) the balance of the reserves described in subclause (I), reduce by an amount determined in the same manner as under section 585(b)(2)(B)(ii) on the basis of the taxable years described in clause (i) and this clause.

(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581 of such Code) which is not a large bank (as defined in section 585(c)(2) of such Code) for its first taxable year beginning after December 31, 1995—

(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserve as of the close of its last taxable year beginning before January 1, 1996, if the additions to such reserve for all taxable years had been determined under section 585(b)(2)(A), and

(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5), (6), and (7).

(3) RECAPTURE OF PRE-1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in subparagraph (A)(ii) except that such reserves shall be taken into account ratably over the 6-taxable year period beginning with such taxable year.

(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

(A) IN GENERAL.—In the case of a bank which meets the residential loan requirement of subparagraph (B) for a taxable year beginning after December 31, 1995, and before January 1, 1998—

(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

(ii) such taxable year shall be disregarded in determining—

(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

(II) the amount of such adjustment.

(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term ''residential loan'' means any loan described in clause (v) of section 7701(a)(19)(C) of such Code but only if such loan is incurred in acquiring, constructing, or improving the property described in such clause.

(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning before January 1, 1996. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to the taxable year in which such principal amount was the highest and the taxable year in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after December 31, 1995, and, if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary of the Treasury or the Secretary's delegate.

(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1) of such Code, subparagraph (B) shall be applied with respect to such group.

(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2) of such Code) for its first taxable year beginning after December 31, 1995:

(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii) of such Code, there shall be taken into account only the excess of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

(B) TREATMENT UNDER ELECTIVE CUT-OFF METHOD.—For purposes of applying section 585(c)(4) of such Code—

(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

(ii) no amount shall be includible in gross income by reason of such reduction.

(6) CONTINUED APPLICATION OF SECTION 593(e).—Notwithstanding the amendments made by this section, in the case of a taxpayer to which paragraph (1) of this subsection applies, section 593(e) of such Code (as in effect on the day before the date of the enactment of this Act) shall continue to apply to such taxpayer as if such taxpayer were a domestic building and loan association but the amount of the reserves taken into account under subparagraphs (B) and (C) of section 593(e)(1) (as so in effect) shall be the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

(7) CERTAIN ITEMS INCLUDED AS SECTION 381(c) ITEMS.—The balance of the applicable excess reserves, and the balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection, shall be treated as items described in section 381(c) of such Code.

(8) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c)(14)(A)—

(A) any amount required to be included in the gross income of the credit union by reason of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

(9) REGULATIONS.—The Secretary of the Treasury or the Secretary's delegate shall prescribe such regulations as may be necessary to carry out this subsection, including regulations providing for the application of paragraphs (4) and (6) in the case of acquisitions, mergers, spin-offs, and other reorganizations.

Subtitle C—Other Provisions

SEC. 421. EXTENSION OF MEDICARE SECONDARY PAYOR PROVISIONS.

Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B), by striking clause (iii) and redesignating clause (iv) as clause (iii); and

(B) in the matter following clause (ii) of subparagraph (C), by striking '', and before October 1, 1998''; and

(2) in paragraph (5)(C), by striking clause (iii).

SEC. 422. ANNUAL ADJUSTMENT FACTORS FOR OPERATING COSTS ONLY; RESTRAINT ON RENT INCREASES.

(a) ANNUAL ADJUSTMENT FACTORS FOR OPERATING COSTS ONLY.—Section 8(c)(2)(A) of the United States Housing Act of 1937 (42 U.S.C. 1437f(c)(2)(A)) is amended—

(1) by striking ''(2)(A)'' and inserting ''(2)(A)(i)'';

(2) by striking the second sentence and all that follows through the end of the subparagraph; and

(3) by adding at the end the following new clause:

''(ii) Each assistance contract under this section shall provide that—

''(I) if the maximum monthly rent for a unit in a new construction or substantial rehabilitation project to be adjusted using an annual adjustment factor exceeds 100 percent of the fair market rent for an existing dwelling unit in the market area, the Secretary shall adjust the rent using an operating costs factor that increases the rent to reflect increases in operating costs in the market area; and

''(II) if the owner of a unit in a project described in subclause (I) demonstrates that the adjusted rent determined under subclause (I) would not exceed the rent for an unassisted unit of similar quality, type, and age in the same market area, as determined by the Secretary, the Secretary shall use the otherwise applicable annual adjustment factor.''.

(b) RESTRAINT ON SECTION 8 RENT INCREASES.—Section 8(c)(2)(A) of the United States Housing Act of 1937 (42 U.S.C. 1437f(c)(2)(A)), as amended by subsection (a) of this section, is amended by adding at the end the following new clause:

''(iii)(I) Subject to subclause (II), with respect to any unit assisted under this section that is occupied by the same family at the time of the most recent annual rental adjustment, if the assistance contract provides for the adjustment of the maximum monthly rent by applying an annual adjustment factor, and if the rent for the unit is otherwise eligible for an adjustment based on the full amount of the annual adjustment factor, 0.01 shall be subtracted from the amount of the annual adjustment factor, except that the annual adjustment factor shall not be reduced to less than 1.0.

''(II) With respect to any unit described in subclause (I) that is assisted under the certificate program, the adjusted rent shall not exceed the rent for a comparable unassisted unit of similar quality, type, and age in the market area in which the unit is located.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be construed to have become effective on October 1, 1995.

SEC. 423. FORECLOSURE AVOIDANCE AND BORROWER ASSISTANCE.

(a) EFFECTIVENESS AND APPLICABILITY.—Section 407 of The Balanced Budget Downpayment Act, I (Public Law 104–99) is amended—

(1) in subsection (c)—

(A) by striking ''Except as provided in subsection (e), the'' and inserting ''The''; and

(B) by striking ''only with respect to mortgages insured under the National Housing Act that are originated before October 1, 1995'' and inserting ''to all mortgages insured under the National Housing Act''; and

(2) by striking subsection (e).

(b) TECHNICAL AMENDMENT.—Section 230(d) of the National Housing Act (12 U.S.C. 1715u(d)) is amended by striking ''the Departments'' and all that follows through ''1996'' and inserting ''The Balanced Budget Downpayment Act, I''.

SPECTER AMENDMENT NO. 3682

Mr. SPECTER proposed an amendment to the bill S. 1028, supra; as follows:

At the appropriate place in title III, insert the following new section:

SEC. . REAUTHORIZATION OF HEALTHY START PROGRAM.

(a) AUTHORIZATION OF APPROPRIATIONS.—To enable the Secretary of Health and Human Services to carry out the healthy start program established under the authority of section 301 of the Public Health Service Act (42 U.S.C. 241), there are authorized to be appropriated $100,000,000 for each of the fiscal years 1997 through 2001.

(b) EXISTING PROJECTS.—

(1) IN GENERAL.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary of Health and Human Services shall reserve $30,000,000 for such fiscal year among demonstration projects that received funding under the healthy start program for fiscal year 1996.

(2) ELIGIBILITY.—To be eligible to receive funds under paragraph (1), an existing demonstration projects shall demonstrate to the satisfaction of Secretary of Health and Human Services that such project has been successful in serving needy areas and reducing infant mortality.

(3) USE OF PROJECTS.—A demonstration project that receives funding under paragraph (1) shall be utilized as a resource center to assist in the training of those individuals to be involved in projects established under subsection (c). It shall be the goal of such projects to become self-sustaining within the project area.

(c) NEW PROJECTS.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary of Health and Human Services shall allocate the remaining amounts for such fiscal year among up to 35 new demonstration projects. Such projects shall be community-based and shall attempt to replicate healthy start model projects that have been determined by the Secretary of Health and Human Services to be successful.

HARKIN (AND OTHERS) AMENDMENT NO. 3683

Mr. HARKIN (for himself, Mr. BAUCUS, and Mr. GRAHAM) proposed an amendment to the bill S. 1028, supra; as follows:

At the end of the bill, insert the following new title:

TITLE V—ADDITIONAL STEPS TO REDUCE HEALTH CARE FRAUD, WASTE, AND ABUSE

SEC. 500. SHORT TITLE.

This title may be cited as the ''Health Care Fraud, Waste, and Abuse Reduction Act of 1996''.

SEC. 501. MEDICARE/MEDICAID BENEFICIARY PROTECTION PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Not later than July 1, 1996, the Secretary of Health and Human Services (referred to in this title as the ''Secretary'') (through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall establish the Medicare/Medicaid Beneficiary Protection Program. Under such program the Secretary shall—

(1) educate medicare and medicaid beneficiaries regarding—

(A) medicare and medicaid program coverage;

(B) fraudulent and abusive practices;

(C) medically unnecessary health care items and services; and

(D) substandard health care items and services;

(2) identify and publicize fraudulent and abusive practices with respect to the delivery of health care items and services; and

(3) establish a procedure for the reporting of fraudulent and abusive health care providers, practitioners, claims, items, and services to appropriate law enforcement and payer agencies.

(b) DISSEMINATION OF INFORMATION.—The Secretary shall provide for the broad dissemination of information regarding the Medicare/Medicaid Beneficiary Protection Program.

SEC. 502. IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—Section 1804 of the Social Security Act (42 U.S.C. 1395b-2) is amended by adding at the end the following new subsection:

''(c)(1) The Secretary shall provide a statement which explains the benefits provided under this title with respect to each item or service for which payment may be made under this title which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to such item or service.

''(2) Each explanation of benefits provided under paragraph (1) shall include—

''(A) a statement that, because billing errors do occur and because medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any statement of benefits received for accuracy and report any questionable charges;

''(B) a clear and understandable summary of—

''(i) how payments for items and services are determined under this title; and

''(ii) the beneficiary's right to request a itemized bill (as provided in section 1128A(n)); and

''(C) a toll-free telephone number for reporting questionable charges or other acts that would constitute medicare fraud, waste, or abuse, which may be the same number as described in subsection (b).''.

(b) REQUEST FOR ITEMIZED BILL FOR MEDICARE ITEMS AND SERVICES.—

(1) IN GENERAL.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

''(m) WRITTEN REQUEST FOR ITEMIZED BILL.—

''(1) IN GENERAL.—A beneficiary may submit a written request for an itemized bill for medical or other items or services provided to such beneficiary by any person (including an organization, agency, or other entity) that receives payment under title XVIII for providing such items or services to such beneficiary.

''(2) 30-DAY PERIOD TO RECEIVE BILL.—

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been received, a person described in such paragraph shall furnish an itemized bill describing each medical or other item or service provided to the beneficiary requesting the itemized bill.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized bill in accordance with subparagraph (A) shall be subject to a civil fine of not more than $100 for each such failure.

''(3) REVIEW OF ITEMIZED BILL.—

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized bill furnished under paragraph (1), a beneficiary may submit a written request for a review of the itemized bill to the appropriate fiscal intermediary or carrier with a contract under section 1816 or 1842.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized bill shall identify—

''(i) specific medical or other items or services that the beneficiary believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF FISCAL INTERMEDIARY OR CARRIER.—Each fiscal intermediary or carrier with a contract under section 1816 or 1842 shall, with respect to each written request submitted to the fiscal intermediary or carrier under paragraph (3), determine whether the itemized bill identifies specific medical or other items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under title XVIII.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall require fiscal intermediaries and carriers to take all appropriate measures to recover amounts unnecessarily paid under title XVIII with respect to a bill described in paragraph (4).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical or other items or services provided on or after July 1, 1996.

SEC. 503. REWARDS FOR INFORMATION LEADING TO HEALTH CARE FRAUD PROSECUTION AND CONVICTION.

(a) IN GENERAL.—In special circumstances, the Secretary and the Attorney General of the United States may jointly make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution for health care fraud.

(b) INELIGIBLE PERSONS.—A person is not eligible for a payment under subsection (a) if—

(1) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

(2) the person knowingly participated in the offense;

(3) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

(A) in a criminal, civil, or administrative proceeding;

(B) in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation; or

(C) by the news media, unless the person is the original source of the information; or

(4) in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

(c) DEFINITIONS.—

(1) HEALTH CARE FRAUD.—For purposes of this section, the term ''health care fraud'' means health care fraud within the meaning of section 1347 of title 18, United States Code.

(2) ORIGINAL SOURCE.—For the purposes of subsection (b)(3)(C), the term ''original source'' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

(d) NO JUDICIAL REVIEW.—Neither the failure of the Secretary of Health and Human Services and the Attorney General to authorize a payment under subsection (a) nor the amount authorized shall be subject to judicial review.

SEC. 504. UNIFORM MEDICARE/MEDICAID APPLICATION PROCESS.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish procedures and a uniform application form for use by any individual or entity that seeks to participate in the programs under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.). The procedures established shall include the following:

(1) Execution of a standard authorization form by all individuals and entities prior to submission of claims for payment which shall include the social security number of the beneficiary and the TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner providing items or services under the claim.

(2) Assumption of responsibility and liability for all claims submitted.

(3) A right of access by the Secretary to provider records relating to items and services rendered to beneficiaries of such programs.

(4) Retention of source documentation.

(5) Provision of complete and accurate documentation to support all claims for payment.

(6) A statement of the legal consequences for the submission of false or fraudulent claims for payment.

SEC. 505. STANDARDS FOR UNIFORM CLAIMS.

(a) ESTABLISHMENT OF STANDARDS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish standards for the form and submission of claims for payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(b) ENSURING PROVIDER RESPONSIBILITY.—In establishing standards under subsection (a), the Secretary, in consultation with appropriate agencies including the Department of Justice, shall include such methods of ensuring provider responsibility and accountability for claims submitted as necessary to control fraud and abuse.

(c) USE OF ELECTRONIC MEDIA.—The Secretary shall develop specific standards which govern the submission of claims through electronic media in order to control fraud and abuse in the submission of such claims.

SEC. 506. UNIQUE PROVIDER IDENTIFICATION CODE.

(a) ESTABLISHMENT OF SYSTEM.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a system which provides for the issuance of a unique identifier code for each individual or entity furnishing items or services for which payment may be made under title XVIII or XIX of the Social Security (42 U.S.C. 1395 et seq.; 1396 et seq.), and the notation of such unique identifier codes on all claims for payment.

(b) APPLICATION FEE.—The Secretary shall require an individual applying for a unique identifier code under subsection (a) to submit a fee in an amount determined by the Secretary to be sufficient to cover the cost of investigating the information on the application and the individual's suitability for receiving such a code.

SEC. 507. USE OF NEW PROCEDURES.

No payment may be made under either title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.) for any item or service furnished by an individual or entity unless the requirements of sections 505 and 506 are satisfied.

SEC. 508. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Notwithstanding any other provision of law, including any regulation or payment policy, the following categories of charges shall not be reimbursable under title XVIII of the Social Security Act:

(1) Tickets to sporting or other entertainment events.

(2) Gifts or donations.

(3) Costs related to team sports.

(4) Personal use of motor vehicles.

(5) Costs for fines and penalties resulting from violations of Federal, State, or local laws.

(6) Tuition or other education fees for spouses or dependents of providers of services, their employees, or contractors.

SEC. 509. REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) of the Social Security Act (42 U.S.C. 1395m(a)(15)) is amended by striking ''Secretary may'' both places it appears and inserting ''Secretary shall''.

SEC. 510. IMPROVED CARRIER AUTHORITY TO REDUCE EXCESSIVE MEDICARE PAYMENTS.

(a) GENERAL RULE.—Section 1834(a)(10)(B) of the Social Security Act (42 U.S.C. 1395m(a)(10)(B)) is amended by striking ''paragraphs (8) and (9)'' and all that follows through the end of the sentence and inserting ''section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions (relating to determinations of grossly excessive payment amounts) apply to items and services and entities and a reasonable charge under section 1842(b)''.

(b) REPEAL OF OBSOLETE PROVISIONS.—

(1) Section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) is amended—

(A) by striking subparagraphs (B) and (C),

(B) by striking ''(8)(A)'' and inserting ''(8)'', and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(2) Section 1842(b)(9) of such Act (42 U.S.C. 1395u(b)(9)) is repealed.

(c) PAYMENT FOR SURGICAL DRESSINGS.—Section 1834(i) of the Social Security Act (42 U.S.C. 1395m(i)) is amended by adding at the end the following new paragraph:

''(3) GROSSLY EXCESSIVE PAYMENT AMOUNTS.—Notwithstanding paragraph (1), the Secretary may apply the provisions of section 1842(b)(8) to payments under this subsection.''.

SEC. 511. REQUIRED BILLING, PAYMENT, AND COST LIMIT CALCULATION TO BE BASED ON SITE WHERE SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 of the Social Security Act (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) A home health agency shall submit claims for payment of home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

SEC. 512. STANDARDS FOR PHYSICAL THERAPY SERVICES FURNISHED BY PHYSICIANS.

(a) APPLICATION OF STANDARDS FOR OTHER PROVIDERS OF PHYSICAL THERAPY SERVICES TO SERVICES FURNISHED BY PHYSICIANS.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph 14;

(2) by striking the period at the end of paragraph (15) and inserting ''; or''; and

(3) by adding at the end the following new paragraph:

''(16) in the case of physicians' services under 1848(j)(3) consisting of outpatient physical therapy services or outpatient occupational therapy services, which are furnished by a physician who does not meet the requirements applicable under section 1861(p) to a clinic or rehabilitation agency furnishing such services.''.

(b) CONFORMING AMENDMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting ''(subject to section 1862(a)(16))'' after ''(2)(D)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after July 1, 1996.

SEC. 513. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

''(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

''(i) $5,000, or

''(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

''(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

SEC. 514. ITEMIZATION OF SURGICAL DRESSING BILLS SUBMITTED BY HOME HEALTH AGENCIES.

Section 1834(i)(2) (42 U.S.C. 1395m(i)(2) is amended to read as follows:

''(2) EXCEPTION.—Paragraph (1) shall not apply to surgical dressings that are furnished as an incident to a physician's professional service.''.

SEC. 515. IMPLEMENTATION OF GENERAL ACCOUNTING OFFICE RECOMMENDATIONS REGARDING MEDICARE CLAIMS PROCESSING.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall, by regulation, contract, change order, or otherwise, require medicare carriers to acquire commercial automatic data processing equipment (in this title referred to as ''ADPE'') meeting the requirements of section 516 to process medicare part B claims for the purpose of identifying billing code abuse.

(b) SUPPLEMENTATION.—Any ADPE acquired in accordance with subsection (a) shall be used as a supplement to any other ADPE used in claims processing by medicare carriers.

(c) STANDARDIZATION.—In order to ensure uniformity, the Secretary may require that medicare carriers that use a common claims processing system acquire common ADPE in implementing subsection (a).

(d) IMPLEMENTATION DATE.—Any ADPE acquired in accordance with subsection (a) shall be in use by medicare carriers not later than 180 days after the date of the enactment of this Act.

SEC. 516. MINIMUM SOFTWARE REQUIREMENTS.

(a) IN GENERAL.—The requirements described in this section are as follows:

(1) The ADPE shall be a commercial item.

(2) The ADPE shall surpass the capability of ADPE used in the processing of medicare part B claims for identification of code manipulation on the day before the date of the enactment of this Act.

(3) The ADPE shall be capable of being modified to—

(A) satisfy pertinent statutory requirements of the medicare program; and

(B) conform to general policies of the Health Care Financing Administration regarding claims processing.

(b) MINIMUM STANDARDS.—Nothing in this title shall be construed as preventing the use of ADPE which exceeds the minimum requirements described in subsection (a).

SEC. 517. DISCLOSURE.

(a) IN GENERAL.—Notwithstanding any other provision of law, and except as provided in subsection (b), any ADPE or data related thereto acquired by medicare carriers in accordance with section 515(a) shall not be subject to public disclosure.

(b) EXCEPTION.—The Secretary may authorize the public disclosure of any ADPE or data related thereto acquired by medicare carriers in accordance with section 515(a) if the Secretary determines that—

(1) release of such information is in the public interest; and

(2) the information to be released is not protected from disclosure under section 552(b) of title 5, United States Code.

SEC. 518. REVIEW AND MODIFICATION OF REGULATIONS.

Not later than 30 days after the date of the enactment of this Act, the Secretary shall order a review of existing regulations, guidelines, and other guidance governing medicare payment policies and billing code abuse to determine if revision of or addition to those regulations, guidelines, or guidance is necessary to maximize the benefits to the Federal Government of the use of ADPE acquired pursuant to section 515.

SEC. 519. DEFINITIONS.

For purposes of this title—

(1) The term ''automatic data processing equipment'' (ADPE) has the same meaning as in section 111(a)(2) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 759(a)(2)).

(2) The term ''billing code abuse'' means the submission to medicare carriers of claims for services that include procedure codes that do not appropriately describe the total services provided or otherwise violate medicare payment policies.

(3) The term ''commercial item'' has the same meaning as in section 4(12) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(12)).

(4) The term ''medicare part B'' means the supplementary medical insurance program authorized under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j–1395w–4).

(5) The term ''medicare carrier'' means an entity that has a contract with the Health Care Financing Administration to determine and make medicare payments for medicare part B benefits payable on a charge basis and to perform other related functions.

(6) The term ''payment policies'' means regulations and other rules that govern billing code abuses such as unbundling, global service violations, double billing, and unnecessary use of assistants at surgery.

(7) The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 520. NONDISCHARGEABILITY OF CERTAIN MEDICARE DEBTS.

(a) PAYMENT TO PROVIDERS.—Section 1815(d) of the Social Security Act (42 U.S.C. 1395g(d)) is amended by adding at the end thereof the following new sentence: ''Notwithstanding any other provision of law, amounts due to the program under this subsection are not dischargeable under any provision of title 11, United States Code.''.

(b) PAYMENT OF BENEFITS.—Section 1833(j) of the Social Security Act (42 U.S.C. 1395l(j)) is amended by adding at the end thereof the following new sentence: ''Notwithstanding any other provision of law, amounts due to the program under this subsection are not dischargeable under any provision of title 11, United States Code.''.

SEC. 521. APPLICABILITY OF THE BANKRUPTCY CODE TO PROGRAM SANCTIONS.

(a) EXCLUSION OF INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended by adding at the end the following new subsection:

''(j) APPLICABILITY OF BANKRUPTCY PROVISIONS.—An exclusion imposed under this section is not subject to the automatic stay imposed under section 362 of title 11, United States Code.''.

(b) CIVIL MONETARY PENALTIES.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by adding at the end the following sentence: ''An exclusion imposed under this subsection is not subject to the automatic stay imposed under section 362 of title 11, United States Code, and any penalties and assessments imposed under this section shall be nondischargeable under the provisions of such title.''.

(c) OFFSET OF PAYMENTS TO INDIVIDUALS.—Section 1892(a)(4) of the Social Security Act (42 U.S.C. 1395ccc(a)(4)) is amended by adding at the end the following sentence: ''An exclusion imposed under paragraph (2)(C)(ii) or

paragraph (3)(B) is not subject to the automatic stay imposed under section 362 of title 11, United States Code.''

CONARD AMENDMENT NO. 3684

Mr. CONARD proposed an amendment to the bill S. 1028, supra; as follows:

At the appropriate place in the bill, insert the following:

SEC. . WAIVER OF FOREIGN COUNTRY RESIDENCE REQUIREMENT WITH RESPECT TO INTERNATIONAL MEDICAL GRADUATES.

(a) EXTENSION OF WAIVER PROGRAM.—Section 220(c) of the Immigration and Nationality Technical Corrections Act of 1994 (8 U.S.C. 1182 note) is amended by striking ''June 1, 1996'' and inserting ''June 1, 2002''.

(b) CONDITIONS ON FEDERALLY REQUESTED WAIVERS.—Section 212(e) of the Immigration and Nationality Act (8 U.S.C. 1184(e)) is amended by inserting after ''except that in the case of a waiver requested by a State Department of Public Health or its equivalent'' the following: ''or in the case of a waiver requested by an interested United States Government agency on behalf of an alien described in clause (iii)''.

(c) RESTRICTIONS ON FEDERALLY REQUESTED WAIVERS.—Section 214(k) (8 U.S.C. 1184(k)) is amended to read as follows:

''(k)(1) In the case of a request by an interested State agency or by an interested United States Government agency for a waiver of the two-year foreign residence requirement under section 212(e) with respect to an alien described in clause (iii) of that section, the Attorney General shall not grant such waiver unless—

''(A) in the case of an alien who is otherwise contractually obligated to return to a foreign country, the government of such country furnishes the Director of the United States Information Agency with a statement in writing that it has no objection to such waiver; and

''(B)(i) in the case of a request by an interested State agency—

''(I) the alien demonstrates a bona fide offer of full-time employment, agrees to begin employment with the health facility or organization named in the waiver application within 90 days of receiving such waiver, and agrees to work for a total of not less than three years (unless the Attorney General determines that extenuating circumstances exist, such as closure of the facility or hardship to the alien would justify a lesser period of time); and

''(II) the alien's employment continues to benefit the public interest; or

''(ii) in the case of a request by an interested United States Government agency—

''(I) the alien demonstrates a bona fide offer of full-time employment that has been found to be in the public interest, agrees to begin employment with the health facility or organization named in the waiver application within 90 days of receiving such waiver, and agrees to work for a total of not less than three years (unless the Attorney General determines that extenuating circumstances exist, such as closure of the facility or hardship to the alien would justify a lesser period of time); and

''(II) the alien's employment continues to benefit the public interest;

''(C) in the case of a request by an interested State agency, the alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than three years only in the geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

''(D) in the case of a request by an interested State agency, the grant of such a waiver would not cause the number of waivers allotted for that State for that fiscal year to exceed 20.

''(2)(A) Notwithstanding section 248(2) the Attorney General may change the status of an alien that qualifies under this subsection and section 212(e) to that of an alien described in section 101(a)(15)(H)(i)(b).

''(B) No person who has obtained a change of status under subparagraph (A) and who has failed to fulfill the terms of the contract with the health facility or organization named in the waiver application shall be eligible to apply for an immigrant visa, for permanent residence, or for any other change of nonimmigrant status until it is established that such person has resided and been physically present in the country of his nationality or his last residence for an aggregate of at least two years following departure from the United States.

''(3) Notwithstanding any other provisions of this subsection, the two-year foreign residence requirement under section 212(e) shall apply with respect to an alien in clause (iii) of that section who has not otherwise been accorded status under section 101(a)(27)(H)—

''(A) in the case of a request by an interested State agency, if at any time the alien practices medicine in an area other than an area described in paragraph (1)(C); and

''(B) in the case of a request by an interested United States Government agency, if at any time the alien engages in employment for a health facility or organization not named in the waiver application.''.

COATS AMENDMENT NO. 3685

Mr. COATS proposed an amendment to the bill S. 1028, supra; as follows:

At the appropriate place in title III, insert the following new section:

SEC. . MEDICAL VOLUNTEERS.

(a) SHORT TITLE.—This title may be cited as the ''Medical Volunteer Act''.

(b) TORT CLAIM IMMUNITY.—

(1) GENERAL RULE.—A health care professional who provides a health care service to a medically underserved person without receiving compensation for such health care service, shall be regarded, for purposes of any medical malpractice claim that may arise in connection with the provision of such service, as an employee of the Federal Government for purposes of the Federal tort claims provisions in title 28, United States Code.

(2) COMPENSATION.—For purposes of paragraph (1), a health care professional shall be deemed to have provided a health care service without compensation only if, prior to furnishing a health care service, the health care professional—

(A) agrees to furnish the health care service without charge to any person, including any health insurance plan or program under which the recipient is covered; and

(B) provides the recipient of the health care service with adequate notice (as determined by the Secretary) of the limited liability of the health care professional with respect to the service.

(c) PREEMPTION.—The provisions of this section shall preempt any State law to the extent that such law is inconsistent with such provisions. The provisions of this section shall not preempt any State law that provides greater incentives or protections to a health care professional rendering a health care service.

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

(1) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means a person who, at the time the person provides a health care service, is licensed or certified by the appropriate authorities for practice in a State to furnish health care services.

(2) HEALTH CARE SERVICE.—The term ''health care service'' means any medical assistance to the extent it is included in the plan submitted under title XIX of the Social Security Act for the State in which the service was provided.

(3) MEDICALLY UNDERSERVED PERSON.—The term ''medically underserved person'' means a person who resides in—

(A) a medically underserved area as defined for purposes of determining a medically underserved population under section 330 of the Public Health Service Act (42 U.S.C. 254c); or

(B) a health professional shortage area as defined in section 332 of such Act (42 U.S.C. 254e);

and who receives care in a health care facility substantially comparable to any of those designated in the Federally Supported Health Centers Assistance Act (42 U.S.C. 233 et seq.), as shall be determined in regulations promulgated by the Secretary.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of the Department of Health and Human Services.

BOXER AMENDMENT NO. 3686

Mrs. BOXER proposed an amendment to the bill S. 1028, supra; as follows:

At the appropriate place add:

The Senate finds that—

Patients deserve to know the full range of treatments available to them and,

Patients should know if doctors receive bonuses for withholding treatment from them.

It is the sense of the Senate that Congress should thoughtfully examine these issues to ensure that all patients get the care they deserve.

SIMON AMENDMENT No. 3687

Mr. SIMON proposed an amendment to the bill S. 1028, supra; as follows:

At the appropriate place in the bill insert the following new section:

SEC. . SENSE OF THE SENATE REGARDING ADEQUATE HEALTH CARE COVERAGE FOR ALL CHILDREN AND PREGNANT WOMEN.

(a) FINDINGS.—The Senate finds the following:

(1) The health care coverage of mothers and children in the United States is unacceptable, with more than 9,300,000 children and 500,000 expectant mothers having no health insurance.

(2) Among industrial nations, the United States ranks 1st in wealth but 18th in infant mortality, and 14th among such nations in maternal mortality.

(3) 22 percent of pregnant women do not have prenatal care in the first trimester, and 22 percent of all poor children are uninsured, despite the medicaid program under title XIX of the Social Security Act.

(4) Of the 1,100,000 net increase in uninsured persons from 1992 to 1993, 84 percent or 922,500 were children.

(5) Since 1987, the number of children covered by employment based health insurance has decreased, and many children lack health insurance despite the relative affordability of providing insurance for children.

(6) Health care coverage for children is relatively inexpensive and in 1993 the medicaid program spent an average of $1,012 per child compared to $8,220 per elderly adult.

(7) Uninsured children are generally children of lower income workers, who are less likely than higher income workers to have

health insurance for their families because they are less likely to work for a firm that offers insurance, and if such insurance is offered, it is often too costly for lower income workers to purchase.

(8) In 1993, 61 percent of uninsured children were in families with at least one parent working full time for the entire year the child was uninsured, and about 57 percent of uninsured children had a family income at or below 150 percent of the Federal poverty level.

(9) If Congress eliminates the Federal guarantee of Medicaid, an estimated 4,900,000 children may lose their guarantee of health care coverage, and those same children may be added to the currently projected 12,600,000 children who will be uninsured by the year 2002.

(10) Studies have shown that uninsured children are less likely than insured children to receive needed health and preventive care, which can affect their health status adversely throughout their lives, with such children less likely to have routine doctor visits, receive care for injuries, and have a regular source of medical care.

(11) The families of uninsured children are more likely to take the children to an emergency room than to a private physician or health maintenance organization.

(12) Children without health insurance are less likely to be appropriately immunized or receive other preventive care for childhood illnesses.

(13) Ensuring the health of children clearly increases their chances to become productive members of society and averts more serious or more expensive health conditions later in life, and ensuring that all pregnant women receive competent prenatal care also saves social costs.

(14) Although the United States has made great improvements in health care coverage through the Medicaid program, it is still the only developed nation that does not ensure that all of its children and pregnant women have health care coverage.

(15) The United States should not accept a status quo in which children in many neighborhoods are more likely to have access to drugs and guns than to doctors, or accept a status quo in which health care is ensured for all prisoners but not for all children.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the issue of adequate health care for our mothers and children is important to the future of the United States, and in consideration of the importance of such issue, the Senate should pass health care legislation in the 105th Congress that will ensure health care coverage for all of the United States's pregnant women and children.

DORGAN (AND FRIST) AMENDMENT NO. 3688

Mr. KENNEDY (for Mr. DORGAN, for himself and Mr. FRIST) proposed an amendment to the bill S. 1028, supra; as follows:

At the end of title III, add the following:

SEC. 3. ORGAN AND TISSUE DONATION INFORMATION INCLUDED WITH INCOME TAX REFUND PAYMENTS.

(a) IN GENERAL.—The Secretary of the Treasury shall include with any payment of a refund of individual income tax made during the period beginning on February 1, 1997, and ending on June 30, 1997, a copy of the document described in subsection (b).

(b) TEXT OF DOCUMENT.—The Secretary of the Treasury shall, after consultation with the Secretary of Health and Human Services and organizations promoting organ and tissue (including eye) donation, prepare a document suitable for inclusion with individual income tax refund payments which—

(1) encourages organ and tissue donation;

(2) includes a detachable organ and tissue donor card; and

(3) urges recipients to—

(A) sign the organ and tissue donor card;

(B) discuss organ and tissue donation with family members and tell family members about the recipient's desire to be an organ and tissue donor if the occasion arises; and

(C) encourage family members to request or authorize organ and tissue donation if the occasion arises.

WELLSTONE AMENDMENT NO. 3689

Mr. KENNEDY (for Mr. WELLSTONE) proposed an amendment to the bill S. 1028, supra; as follows:

On page 9, line 13 insert after evidence of insurability ''(including conditions arising out of acts of domestic violence);''.

HELMS (AND KASSEBAUM) AMENDMENT NO. 3690

Mrs. KASSEBAUM (for Mr. HELMS, for himself and Mrs. KASSEBAUM) proposed an amendment to the bill S. 1028, supra; as follows:

Amend Title III—Miscellaneous Provisions, Section 302(a) by striking ''two part study'' on line 19, and inserting ''three-part study'' and adding Section 302(d):

''(d) EVALUATION OF ACCESS AND CHOICE.—Not later than June 1, 1998, the Secretary of Health and Human Services shall prepare and submit to the appropriate Committees of Congress a report concerning—

(1) an evaluation of the extent to which patients have direct access to, and choice of, health care provider, including specialty providers, within a network of providers, as well as the opportunity to utilize providers outside of the network, under the various types of coverage offered under the provisions of this Act;

(2) an evaluation of the cost to the insurer of providing out-of-network access to providers, and the feasibility of providing out-of-network access in all health plans offered under provisions of this Act.

(3) an evaluation of the percent of premium dollar utilized for medical care and administration of the various types of coverage offered, including coverage which permits out-of-network access and choice of provider, under provisions of this Act.

BURNS (AND HARKIN) AMENDMENT NO. 3691

Mr. BURNS (for himself and Mr. HARKIN) proposed an amendment to the bill S. 1028, supra; as follows:

On Page 71, line 19, add the following:

"SEC. 302.5. REIMBURSEMENT OF TELEMEDICINE.

The Health Care Financing Administration is directed to complete their ongoing study of reimbursement of all telemedicine services and submit a report to Congress with a proposal for reimbursement of fee-for-service medicine by March 1, 1997. The report shall utilize data compiled from the current demonstration projects already under review and gather data from other ongoing telemedicine networks. This report shall include an analysis of the cost of services provided via telemedicine.

NOTICE OF HEARING

SUBCOMMITTEE ON FORESTS AND PUBLIC LAND MANAGEMENT

Mr. CRAIG. Mr. President, I would like to announce for the information of the Senate and the public that the hearing previously scheduled before the Subcommittee on Forests and Public Land Management on S. 1401, Surface Mining Control and Reclamation Amendments Act of 1995 on Tuesday, April 23, 1996, at 9:30 a.m. has been rescheduled for Thursday, May 2, 1996, at 9:30 a.m. in room SD–366 of the Dirksen Senate Office Building in Washington, DC.

In addition to S. 1401, we will receive testimony on S. 1194, to amend the Mining and Mineral Policy Act of 1970 to promote the research, identification, assessment, and exploration of marine mineral resources.

Those wishing to testify or who wish to submit written statements should write to the Committee on Energy and Natural Resources, U.S. Senate, Washington, DC 20510. For further information, please call Michael Flannigan of the subcommittee staff at 202–224–6170.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet at 5 p.m. on Thursday, April 18, 1996, to receive testimony in executive session to mark up S. 1635, the Defend America Act of 1996—National Missile Defense—and to discuss markup.

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

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on Thursday, April 18, 1996, to markup a resolution to authorize the committee to conduct an investigation of Madison Guaranty Savings and Loan Association and related matters, amend the committee's rules to facilitate the investigation and related public hearings, and to authorize the issuance of subpoenas.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be allowed to meet during the Thursday, April 18, 1996, session of the Senate for the purpose of conducting a hearing on spectrum use and management.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be granted permission to meet during the session of the Senate on

Thursday, April 18, 1996, for purposes of conducting a full committee hearing which is scheduled to begin at 9:30 a.m. The purpose of this oversight hearing is to receive testimony on the Tongass land management plan.

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

COMMITTEE ON FOREIGN RELATIONS

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, April 18, at 2 p.m. to hold a business meeting to vote on pending items.

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

COMMITTEE ON INDIAN AFFAIRS

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to conduct three consecutive hearings during the session of the Senate on Wednesday, April 17, Thursday, April 18, and Friday, April 19, 1996, on the President's budget request for fiscal year 1997 for Indian programs and related budgetary issues from fiscal year 1996. The hearings will be held at 1:30 p.m. each day in room 485 of the Russell Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on Thursday, April 18, 1996, at 10 a.m. to hold an executive business meeting.

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

COMMITTEE ON SMALL BUSINESS

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Committee on Small Business be authorized to meet during the session of the Senate for a hearing on Thursday, April 18, 1996, at 9:30 a.m., in room 428A of the Russell Senate Office Building, to conduct a hearing focusing on ''Small Business and Employee Involvement: The TEAM Act Proposal.''

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

SUBCOMMITTEE ON INTERNATIONAL ECONOMIC POLICY, EXPORT AND TRADE PROMOTION

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the Subcommittee on International Economic Policy, Export and Trade Promotion of the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, April 18, 1996, at 10 a.m.

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

ADDITIONAL STATEMENTS

NATIONAL RECORDS AND INFORMATION MANAGEMENT DAY

● Mr. FRIST. Mr. President, I rise today to note the observance of National Records and Information Management Day which occurred on April 2, 1996 while the Senate was in recess. The management and control of information are increasingly critical to every industry, business and government agency, and the systematic creation, distribution, storage and retrieval of records are of critical importance to the continued and efficient operation of any good organization.

The organizations that excel today and tomorrow will be those recognizing information as a major resource and structuring it as efficiently as they do their assets. An effective records management program assures the availability of information as a basis for sound decisionmaking by providing security and control against loss by mismanagement, natural disaster, theft or inadvertent destruction. All Americans should recognize the significant and important role that records management professionals render in maintaining appropriate business, civic, and government records. I commend businesses such as ARMA International who have brought National Records and Information Management Day to my attention and wish them every success as they educate the business community regarding the importance of records management.●

EARTH DAY/ARBOR DAY TRIBUTE TO THE CITY OF DETROIT

●Mr. LEVIN. Mr. President, I rise today to pay tribute to the city of Detroit for its efforts to beautify its neighborhoods and improve its natural environment. The city of Detroit on Earth Day/Arbor Day, Monday, April 22, 1996, is holding a ceremony kicking off a week long program to plant trees in parks around the city.

For its tree planting efforts, Detroit, for the ninth time, has been named a Tree City USA by the National Arbor Day Foundation. Detroit recognizes the importance that trees play in not only making our communities more attractive, but by providing tremendous environmental benefits as well. Trees produce oxygen, help clean the air, provide a habitat for wildlife and provide humankind with great visual beauty.

The city of Detroit recognizes the importance of tree planting and is committed to the continuation of its exemplary reforestation programs. I am proud of the efforts of my home city and I ask that my colleagues join me in congratulating the city of Detroit.●

THE ANTITERRORISM BILL

● Mr. MACK. Mr. President, I wish to apologize for my absence during consideration of the conference report to S. 735 due to the passing of my father. I believe that this is an essential piece of legislation to address the current deficiencies in our judicial system which made it that much easier for the tragedy in Oklahoma City to take place. In addition, this bill makes much-needed revisions to the current habeas corpus system in our country.●

STEVE JESSMORE

●Mr. LEVIN. Mr. President, I rise to honor Steve Jessmore of Saginaw, MI, who has been awarded the Robert F. Kennedy Journalism Award for outstanding coverage of the problems of the disadvantaged. Mr. Jessmore won the award in the photojournalism category for his photo essay, ''Blind Faith.''

''Blind Faith'' follows the life of Carl, a yellow labrador retriever puppy raised by a Carrolton Township elementary school class. Carl was trained as a leader dog for the blind and eventually placed with a visually impaired man in Kansas City, MO.

Judges for the Kennedy award included journalists from the Washington Post, Knight Ridder, CNN, the Wall Street Journal, and NBC. ''Blind Faith'' has also won the national Lincoln University of Missouri 43d Annual Unity Awards in Media, as well as several other awards in State, regional, and national contests.

''Blind Faith'' marks the first time that someone has followed the story of a leader dog since 1939, when the Rochester-based nonprofit organization that trained Carl was founded. The photos from ''Blind Faith'' will now be permanently on display in the Robert F. Kennedy collection of the John F. Kennedy Library in Boston.

On hearing that he had won the award, Jessmore said, ''I'm real happy that so many other people get to see it now, because it's such a tremendous, positive story—kids learning early how to help other people.''

I know my Senate colleagues join me in honoring Steve Jessmore for his outstanding work in the field of photojournalism.●

WHITEWATER INVESTIGATION

● Mr. GLENN. The Whitewater investigation is the longest running congressional inquiry in the recent past. At 20 months, it exceeds Abscam—9 months—the POW/MIA hearings 17—months and Watergate 16—months. It has cost the American taxpayers over $30 million which could have vaccinated 107,000 children, paid the Medicare costs of 9,200 seniors, and provided health care for nearly 7,000 families.

Mr. President, I was disappointed to learn that an agreement had been reached to continue the Whitewater investigation. Because I thought it was a poor use of the taxpayer's money, I voted against the original resolution and had the current resolution been brought to a rollcall vote, I would have voted to discontinue proceedings dealing with Whitewater.

The Whitewater investigation duplicates the ongoing independent counsel's investigation and wastes the limited time we have left in this session to pass important legislation. The independent counsel has full authority and budget to continue the investigation as long as he thinks is practicable. Calling an end to the Senate Whitewater

investigation only stops the duplication of investigations, neither of which have so far resulted in anything of substance.

The current resolution extends the committee's deadline until June 14 and will cost the taxpayer's an additional $480,000. I believe this investigation could have been completed by the original promised deadline of February 29.●

SAGINAW HIGH SCHOOL

●Mr. LEVIN. Mr. President, on March 28, 1996, I spoke about the inspiring victory of Saginaw High School in the Michigan Class A State Basketball Championship. However, I neglected to mention the names of the players and coaches. I submit the list of Saginaw's valiant victors for the RECORD.

Saginaw High School varsity basketball team and coaching staff. Players: Deon Anderson, Lawandzo Harris, Montell Lewis, Marcus McCray, Dwayne Nash, Jason Peoples, Deronnie Pitts, Andre Reed, Terrance Reed, Antoine Tatum, Armar Vansant, Terry Washington, Torrance Whitson, and Freeman Battle. Head coach: Marshall Thomas. Assistant coaches: Ronnie Bryant, Brian Humes, Larry Kelly, and Shevonne Weems.●

VOTE IN SUPPORT OF THE ANTI-TERRORISM BILL

●Mr. WELLSTONE. Mr. President, much has happened in the year since this bill left the Senate. Oklahoma City has begun the healing process from the senseless violence it suffered at the hands of a terrorist bomber. Prime Minister Yitzhak Rabin was killed by a terrorist. Terrorism in the Middle East, against subway riders in Tokyo and elsewhere have reminded us of the vulnerability of free societies to this kind of senseless violence. The unabomber's reign of terror has apparently been brought to an end by the FBI. And the antiterrorism bill that left this Senate has come back, in some ways, a better bill: It is less invasive of civil liberties when it comes to eavesdropping by Federal agents, and it prevents defendants from being deported based only on evidence they are not allowed to understand.

What happened to Rabin shows us all that terrorism is not going away. What may have been a success in stopping the unabomber shows that the Federal Government can fight back. I support this bill because I recognize that terrorism is a threat that puts all our lives at risk, and that we must bolster national antiterrorism efforts, including by providing to law enforcement and the courts new tools to combat cutting edge technologies of violence and increasingly bold villains, in order to stem the tide of destruction.

I have made it clear that I do not support everything in this bill. I voted against the Senate bill last year largely because of its broad habeas corpus provisions, which will limit Federal court review in death penalty cases. I am also opposed to this bill's provisions to weaken protections for refugees and asylees fleeing persecution in other countries which has nothing to do with antiterrorism efforts. While I am still profoundly opposed to these provisions, I have concluded that on balance this bill should pass.

There is much in this bill that is good, that will address concerns Minnesotans have expressed to me. This bill will make a real difference in the fight against terrorism. It includes many necessary changes to our Federal criminal laws. It will make it a Federal crime to plan or to carry out terrorist attacks in the United States. It will make it a Federal crime to plan terrorist attacks in the United States, even if the attacks are carried out overseas. It includes increased penalties for conspiracies involving explosives. It will make it easier to detect plastic explosives, and to track chemicals of which most bombs are composed. It will make it harder for terrorist groups to raise funds in the United States. It provides mandatory restitution for victims of terrorist acts. It will help prevent the sale of arms to terrorist states by third parties. And it expands the authority of government officials to deal with threats posed by chemical, biological, and nuclear technologies, involving deadly nuclear materials.

While I did not agree with every aspect of the 1994 crime bill I supported it because I concluded that, on balance, it contained many effective provisions to fight crime and violence. By the same token this is a bill that on balance can make an impact against terrorism.

I voted against provisions in this bill that I fiercely opposed, and supported many changes that were not agreed to. The President and Members of both parties on both sides of Capitol Hill have nearly unanimously come together in this statement against destruction and violence. Because this bill successfully addresses a threat that endangers all of us and because a unified effort makes a strong statement and therefore my voice can help make it stronger, I join my colleagues in its support.●

COL. JAMES C. BARBARA

● Mr. LEVIN. Mr. President, I rise today to honor Col. James C. Barbara on his retirement from the U.S. Army after 32 years of dedicated service. Colonel Barbara has had a far-reaching and successful career which has had a profound effect on the evolution of our Nation's armored vehicles.

Col. Jim Barbara was commissioned in armor through the Reserve Officer Training Corps and has served in Europe, Vietnam, and the United States. He has been the commander of five companies; adviser to Alabama, Mississippi, and Tennessee National Guard units; and the Secretary of the General Staff XVIII Airborne Corps.

From 1981–85, Colonel Barbara was the TRADOC systems manager and assistant manager for tanks, becoming responsible in 1986 for M1A1 initial production, follow-on evaluation, and live fire testing. From 1988–90, he led the common chassis advanced technology transition demonstrator, the largest, competitive weapons system program in the history of the Army.

In 1993, Colonel Barbara led a process action team focusing on ways to develop and implement reengineering techniques to support acquisition streamlining. In 1995, Jim became the deputy program executive officer for tactical wheeled vehicles, where he was responsible for organizing the tactical vehicle community's emergency efforts to design, test, produce, and field armor protection kits for use in Bosnia.

Jim holds bachelor's and master's degrees from Boston College and an MBA from Northwood University. Colonel Barbara's awards and decorations include the Legion of Merit, Bronze Star of Valor, Meritorious Service Medal, and Army Commendation Medal. He is married to the former Eleanor B. McMorrow of Worcester, MA.

I know that my Senate colleagues join me in congratulating Col. James C. Barbara on his 32 years of dedicated service to our Nation.●

THE BUDGET DEBATE

● Mr. ABRAHAM. Mr. President, as the Senate continues to debate our proper budget priorities, I have noted the presence of a number of inaccurate arguments. These arguments, in my opinion, are distracting us from the central question of how our taxing and spending policies affect middle-class Americans. Particularly worrisome to me are inaccurate views concerning the historical performance of tax cuts, and their impact on middle-class income in particular. Specifically, some are arguing that tax cuts in the 1980's produced lower incomes for our middle class, and saddled them with a larger percentage of total tax receipts.

In an attempt to focus debate more effectively on questions of what will and will not work for the American people, I would like to have inserted into the RECORD an article of mine, published recently in The World & I. In this article I set forth my view of the real effect of tax cuts in the 1980's. As published, the article is accompanied by spirited responses and defenses from several distinguished observers, including Gary Burtless of the Brookings Institution, Michael Meeropol of the Center for Popular Economics, Bruce Bartlett of the National Center for Policy Analysis, Norman B. Turé of the Institute for Research on the Economics of Taxation, and Paul M. Weyrich of the Free Congress Foundation.

I argue that the pro-growth and pro-family tax policies of the 1980's contributed significantly to the prosperity of America's middle-class families. In

addition, I point out that tax cuts produce lower, not higher, deficits and that tax cuts help the middle class and poor more than the rich. Not all the respondents agreed completely with my argument. But I believe the article can help all of us form more useful, coherent arguments as we face the budget challenges ahead.

The article follows:

THE REAL 1980'S

(By Spencer Abraham)

The debate over the budget is becoming a debate over the 1980s. Opponents of tax cuts and spending restraints are claiming that these policies wreaked havoc when tried before under Ronald Reagan. The policies of the 1980s, in this view, hurt American families and the American economy, and so should not be repeated.

To answer this criticism, one must explode three interrelated myths that are exercising undue influence over the budget debate today:

The progrowth and profamily tax policies of the 1980s actually hurt America's middleclass families.

Tax cuts necessarily increase the budget deficit.

Tax cuts disproportionately benefit the rich at the expense of the middle class and poor.

Using these myths, defenders of the status quo paint reformers as heartless friends of rich people and enemies of the poor and middle class. By exploding them, we can return the focus of our budget debate to the question of how best to reform tax and spending policies for the benefit of all Americans. But to do this, we must reestablish the truth about how our nation's middle class really fared under the low-tax, limited-government policies of the 1980s.

MYTH NO. 1

The claim that middle-class families suffered under conservative reforms is based on an inaccurate representation of the income data. For example, opponents of reform have said over and over that household income fell over a 15-year period, from $38,248 in 1979 to $36,959 in 1993, and that this decline was the direct result of the policies of Ronald Reagan and the Republicans. They wield a frightening graph, much like figure 1.

But the graph does not reflect reality. These 15 years did not constitute one monolithic era of Republican policy dominance. Rather, they included two periods characterized by overtaxation and overregulation (1979–81 and 1990–93) and one period (1982–89) during which Republican policies of lower taxes and less regulation were in place. An accurate portrayal of this overall period would look like figure 2.

In truth, this 15-year period consists of one era of middle-class prosperity under low-tax, limited-government policies and two eras of middle-class pain under policies of high taxes and increased regulation. Americans had 8 years of improvement in middle-class incomes from 1982 to 1989. Unfortunately for the middle class, the periods from 1979 to 1981 and 1990 to 1993 were dominated by overtaxation and overregulation, policies that resulted in declines in middle-class incomes.

Opponents of reform attempt to paint Ronald Reagan's low-tax, limited-government policies as harmful by treating the 1979–93 period as if all of it were in the Reagan era. They wrongly imply that Reagan was president and Republicans were in control throughout this period.

On closer inspection, it becomes clear that the first 3 of the 15 years were under high-tax and heavy regulatory policies. It is also clear that, during this first period, real median family income fell precipitously from over $38,000 to under $36,000, for a total loss of over $2,500, according to Census Bureau data. In fact, one of the sharpest declines in median family income on record occurred in the year 1980.

As anyone with a working knowledge of the calendar and even a passing interest in American politics Knows, Ronald Reagan was not president in 1979 or 1980. Jimmy Carter was. Further, Republicans controlled the Senate for only the first 6 years of Reagan's tenure.

What is more, Republicans did not control the House of Representatives at any time during this 15-year period. Democrats were in charge the entire time. And, in 1979 and 1980, they controlled both the legislature and the presidency.

Yet opponents of lower taxes and slower spending growth almost always include 1979 and 1980, the last years of the Carter era, in describing the impact of the Reagan administration's conservative tax and regulatory reforms. But no matter how much one opposes tax cutting and deregulation, it is difficult to argue that these policies, pursued under Ronald Reagan and the GOP in 1981 and beyond, were bad enough to cause income declines in the years before they were implemented.

Unlike the 1993 Clinton income tax increases, many of which were implemented retroactively, the 1981 Reagan economic policies did not take effect until the middle of 1982. And what happened after these policies went into effect in 1982? As anyone can see from figure 2, real, postinflation median family income in the United States rose between 1982 and 1990, from $35,419 to $39,086, for an increase of 10.4 percent.

COLD WATER ON THE ECONOMY

But in 1990, the Democratic majority in Congress began insisting that tax-revenue increases had to be part of any effort to reduce the budget deficit. The result was the budget summit deal of 1990.

After that, again shown in figure 2, we saw a different pattern. Between 1990 and 1993, median family income plummeted 5.4 percent, from $39,086 to $36,959. The most severe drop in middle-class income began in 1993, the year the Clinton retroactive tax increases took effect. In that year, there was a remarkable $709 (1.9 percent) plunge in real median family income.

So what conclusion should we reach? The answer seems clear: Republican economic and tax policies helped the middle class. Thus, to get middle-class incomes moving upward again, we should return to the low-tax, deregulatory policies of the 1980s. These policies produced one of the most dramatic increases in middle-class incomes in the last 30 years.

Nineteen million new jobs were created between 1982 and 1989—2.4 million in 1989 alone. And 82 percent of these jobs were in higher-paying occupations: technical, precision production, and managerial and professional. Clearly then, tax cuts helped the middle class in the best way possible, by producing economic opportunity and good jobs.

This brings us to a subset of the first myth: that the rich got richer and the poor got poorer during the 1980s. Once again, this claim is unsubstantiated by the facts. First, let us look at a graph (fig. 3) that surfaced during the economic policy debate.

According to this figure, the 15 years between 1979 and 1993 produced:

A 15 percent decline in real family income for the bottom 20 percent of America taxpayers.

A 7 percent drop in income for the second-lowest 20 percent of taxpayers.

A 3 percent drop in income for the middle 20 percent.

Meanwhile, this 15-year period saw:

A 5 percent increase in income for the fourth 20 percent.

An 18 percent increase in income for the richest 20 percent of taxpayers, which was most problematic of all for critics of taxcut policy.

Once again, however, the use of this 15-year conglomeration produces misleading figures. The data look bad for the poor and middle class on this graph because, once again, the figure lumps in the effects of Jimmy Carter's high-tax, high-regulation policies with those of low taxes and low regulation.

When we separate out the 1979–81 period (fig. 4) from the 1982–90 recovery years (fig. 5), we find that everyone got poorer under the high-tax, high-regulation policies of 1979–81—the poor much more so and much more devastatingly than the rich. From 1979 to 1981, the poorest fifth experienced a drop in income of 9 percent, the next fifth a drop of 6.8 percent, the middle fifth a drop of 5.4 percent, the following fifth a drop of 3.5 percent, and the top fifth a drop of 4.5 percent.

Meanwhile, when the government lowered taxes and regulations during the 1982–90 period, everyone got richer.

During the 1982–90 Reagan-Bush era, everyone was better off. The bottom fifth experienced an 11 percent increase in income, the next fifth experienced a 9.7 percent gain, the middle fifth a 10.3 percent increase, the next fifth an 11.8 percent rise, and the highest fifth a 17.9 percent increase.

After the 1990 budget deal, everyone again became worse off. And after President Clinton's retroactive tax hike took effect in 1993, average Americans were hit hard.

Perhaps some would complain that people with high incomes did even better than other Americans during the prosperous 1980s. But government's goal should not be to make all people the same. It should be to allow everyone to become better off. And policies of low taxes and fewer regulations did precisely this.

It really is very simple: Lower taxes and less regulation help the poor, along with everyone else, while higher taxes and more regulation hurt the poor, along with everyone else.

MYTH NO. 2

What about the notion that we cannot afford tax cuts and that the tax cuts of the 1980s produced the burdensome deficits our economy is staggering under today?

This myth, unfortunately, has led some in Congress to abandon their commitment to tax cuts in the name of common sense. They now argue that common sense demands that we delay, cut back, or abandon entirely any tax cuts, at least until we achieve a balanced budget.

In fact, tax cuts can help America achieve the goal of balancing the budget. Tax reductions—particularly those that strengthen incentives to work, save, and invest—increase the rate of economic growth and thereby produce higher tax revenues for the Treasury than would be the case under a high-tax regime.

It is a paradoxical truth—to paraphrase what President John F. Kennedy said in 1962—that tax rates are too high today and tax revenues are too low. And the soundest way to raise revenue in the long run is to cut the rates now.

Kennedy was right and for a simple if somewhat unexpected reason: Irrespective of the top marginal tax rate, the government will take in about the same amount as a percentage of gross domestic product (GDP).

Research by economist W. Kurt Hauser shows that government receipts as a proportion of GDP have continued to hover at 19.5

percent since 1960. In 1982, the tax share stood at 19.8 percent of GDP. By 1989, the tax share had declined slightly to 19.2 percent of GDP—much the same as it had been back in 1960.

In short, whether we have raised or lowered tax rates, the percentage of GDP in taxes has hovered at 19 percent. The issue, of course, is 19 percent of what? Is it 19 percent of a large and growing GDP, or of an anemic, stagnant one?

Here again, the real numbers destroy the myths and tell the true story. According to the federal Office of Management and Budget (OMB), in 1982, the year the tax cuts were implemented, tax receipts stood at $617.8 billion. By 1989, tax receipts had increased to $990.7 billion.

How did this come about? By lowering taxes, the government freed up capital and entrepreneurial spirit, creating jobs and wealth and expanding the size of the economic pie. From 1982 to 1989, GDP increased from $3.1 to $5.4 trillion. Therefore, while tax revenues as a share of GDP remained relatively constant at just over 19 percent, the dollar amount of tax revenues collected by the federal government rose dramatically, because the economy grew dramatically.

Tax cuts will increase economic growth and thereby reduce the deficit. The question is, by how much? Economist Bruce Bartlett, a former assistant secretary of the Treasury, notes that the OMB figures show that increases in real GDP significantly reduce the deficit. By the year 2000, the deficit would be diminished by more than $150 billion if the economy grew just 1 percent faster than currently projected over the next five years.

Of course, Bartlett says, there is no guarantee that the Republican tax cuts will achieve a 1 percent faster growth rate. But there is no doubt they will increase growth above what would otherwise have occurred. If growth is just 0.4 percent faster per year it would be enough to make the tax cut deficit-neutral, based on the OMB data.

Thus, a dispassionate review of the figures shatters the myth that the Reagan tax cuts increased the deficit. The problem was not our revenue stream, either in terms of the percentage of GDP paid in taxes, or in real tax dollars received. The problem was too much spending. From 1982 to 1989, government spending rose from $745 billion to $1.14 trillion, a 53 percent jump.

Tax cuts in the 1990s can help produce the same type of economic growth they generated in the 1980s. This growth in turn will help us reduce the deficit. All we must do is reduce the rate at which government spending grows. CBO figures show that, if we simply hold the rate at which federal spending grows to a little over 2 percent per year, we can cut taxes by $189 billion and balance the budget by the year 2002.

MYTH NO. 3

But this reference to tax cuts brings us face to face with another myth, namely, that tax cuts disproportionately benefit the rich at the expense of the poor.

The myth explodes, however, on contact with IRS data conclusively show that lower income-tax rates actually increase the percentage of the total tax bill paid by the rich while decreasing the tax burden on the poor.

There is an amazing historical correlation between decreases in the marginal tax rate and increases in the share of revenue paid by the top 1 percent of income earners. And, of course, along with this increase in taxes paid by the most wealthy went a decrease in the taxes paid by the lower 50 percent of income earners.

For example, by 1988, the share of income taxes paid by the bottom 50 percent of taxpayers assumed just 5.7 percent of the income tax burden. Also in 1988, the average tax payment of the top 1 percent of taxpayers amounted to 27.5 percent of the total.

On the other hand, after the budget summit deal of 1990, the top marginal tax rate was increased from 28 to 31 percent. This produced a 3.5 percent decrease in the revenue share paid by the top 1 percent—down to 24.6 percent of the total. That is, as marginal rates decreased, the rich paid more, and as marginal rates increased the rich paid less, leaving more for the middle class and poor to pay.

Clearly, then, if we want to help the middle class, the last thing we should do is increase marginal tax rates. Such an increase will lead to lower productivity, lower tax revenues from the rich, and an increased tax burden for those who are not rich.

The answer to our dilemma, then, is not to keep our current high taxes but to cut taxes while bringing spending under control.

By bringing together disparate kinds of tax cuts, from a $500-per-child tax credit to a reduction in the capital-gains tax rate that will strengthen small businesses and entrepreneurs, we can increase the well-being and productivity of America's middle-class families. These tax cuts would allow middle-class families to build a better future for their children.

The proposed $500-per-child tax credit directly benefits the middle class. The Joint Committee on Taxation has reported that three-quarters of the benefits from this tax cut will go to people with incomes less than $75,000.

A capital-gains tax cut will accrue to the middle class as well. IRS data show that 55 percent of taxpayers who report long-term capital gains earn $50,000 or less. And 75 percent of them earn $75,000 or less.

These tax cuts will bring real relief to America's middle class. They will help the economy and thereby help lower the deficit.

The 1980s teach us—if only we will examine their lessons properly—that a vibrant economy, spurred by low taxes and fewer regulations, will produce balanced budgets and economic well-being for the middle class. We need only trust Americans to spend and invest their own money as they see fit. We need only trust the people, rather than government, to make their own decisions about how to take care of their families and improve their lot in life.●

CONGRESSIONAL REVIEW TITLE OF H.R. 3136

● Mr. NICKLES. Mr. President, I will submit for the RECORD a statement which serves to provide a detailed explanation and a legislative history for the congressional review title of H.R. 3136, the Small Business Regulatory Enforcement Fairness Act of 1996. H.R. 3136 was passed by the Senate on March 28, 1996, and was signed by the President the next day. Ironically, the President signed the legislation on the first anniversary of the passage of S. 219, the forerunner to the congressional review title. Last year, S. 219, passed the Senate by a vote of 100 to 0 on March 29, 1995. Because title III of H.R. 3136 was the product of negotiation with the Senate and did not go through the committee process, no other expression of its legislative history exists other than the joint statement made by Senator REID and myself immediately before passage of H.R. 3136 on March 28. I am submitting a joint statement to be printed in the RECORD on behalf of myself, as the sponsor of the S. 219, Senator REID, the prime cosponsor of S. 219, and Senator STEVENS, the chairman of the Committee on Governmental Affairs. This joint statement is intended to provide guidance to the agencies, the courts, and other interested parties when interpreting the act's terms. The same statement has been submitted today in the House by the chairmen of the committees of jurisdiction over the congressional review legislation.

The joint statement follows:

STATEMENT FOR THE RECORD BY SENATORS NICKLES, REID, AND STEVENS

SUBTITLE E—CONGRESSIONAL REVIEW SUBTITLE

Subtitle E adds a new chapter to the Administrative Procedure Act (APA), ''Congressional Review of Agency Rulemaking,'' which is codified in the United States Code as chapter 8 of title 5. The congressional review chapter creates a special mechanism for Congress to review new rules issued by federal agencies (including modification, repeal, or reissuance of existing rules). During the review period, Congress may use expedited procedures to enact joint resolutions of disapproval to overrule the federal rulemaking actions. In the 104th Congress, four slightly different versions of this legislation passed the Senate and two different versions passed the House. Yet, no formal legislative history document was prepared to explain the legislation or the reasons for changes in the final language negotiated between the House and Senate. This joint statement of the authors on the congressional review subtitle is intended to cure this deficiency.

Background

As the number and complexity of federal statutory programs has increased over the last fifty years, Congress has come to depend more and more upon Executive Branch agencies to fill out the details of the programs it enacts. As complex as some statutory schemes passed by Congress are, the implementing regulations are often more complex by several orders of magnitude. As more and more of Congress' legislative functions have been delegated to federal regulatory agencies, many have complained that Congress has effectively abdicated its constitutional role as the national legislature in allowing federal agencies so much latitude in implementing and interpreting congressional enactments.

In many cases, this criticism is well founded. Our constitutional scheme creates a delicate balance between the appropriate roles of the Congress in enacting laws, and the Executive Branch in implementing those laws. This legislation will help to redress the balance, reclaiming for Congress some of its policymaking authority, without at the same time requiring Congress to become a super regulatory agency.

This legislation establishes a government-wide congressional review mechanism for most new rules. This allows Congress the opportunity to review a rule before it takes effect and to disapprove any rule to which Congress objects. Congress may find a rule to be too burdensome, excessive, inappropriate or duplicative. Subtitle E uses the mechanism of a joint resolution of disapproval which requires passage by both houses of Congress and the President (or veto by the President and a two-thirds' override by Congress) to be effective. In other words, enactment of a joint resolution of disapproval is the same as enactment of a law.

Congress has considered various proposals for reviewing rules before they take effect

for almost twenty years. Use of a simple (one-house), concurrent (two-house), or joint (two houses plus the President) resolution are among the options that have been debated and in some cases previously implemented on a limited basis. In *INS* v. *Chadha,* 462 U.S. 919 (1983), the Supreme Court struck down as unconstitutional any procedure where executive action could be overturned by less than the full process required under the Constitution to make laws—that is, approval by both houses of Congress and presentment to the President. That narrowed Congress' options to use a joint resolution of disapproval. The one-house or two-house legislative veto (as procedures involving simple and concurrent resolutions were previously called), was thus voided.

Because Congress often is unable to anticipate the numerous situations to which the laws it passes must apply, Executive Branch agencies sometimes develop regulatory schemes at odds with congressional expectations. Moreover, during the time lapse between passage of legislation and its implementation, the nature of the problem addressed, and its proper solution, can change. Rules can be surprisingly different from the expectations of Congress or the public. Congressional review gives the public the opportunity to call the attention of politically accountable, elected officials to concerns about new agency rules. If these concerns are sufficiently serious, Congress can stop the rule.

Brief procedural history of congressional review chapter

In the 104th Congress, the congressional review legislation originated as S. 348, the ''Regulatory Oversight Act,'' which was introduced on February 2, 1995. The text of S. 348 was offered by its sponsors, Senators Don Nickles and Harry Reid, as a substitute amendment to S. 219, the ''Regulatory Transition Act of 1995.'' As amended, S. 219 provided for a 45-day delay on the effectiveness of a major rule, and provided expedited procedures that Congress could use to pass resolutions disapproving of the rule. On March 29, 1995, the Senate passed the amended version of S. 219 by a vote of 100–0. The Senate later substituted the text of S. 219 for the text of H.R. 450, the House passed ''Regulatory Transition Act of 1995.'' Although the House did not agree to a conference on H.R. 450 and S. 219, both Houses continued to incorporate the congressional review provisions in other legislative packages. On May 25, the Senate Governmental Affairs Committee reported out S. 343, the ''Comprehensive Regulatory Reform Act of 1995,'' and S. 291, the ''Regulatory Reform Act of 1995,'' both with congressional review provisions. On May 26, 1995, the Senate Judiciary Committee reported out a different version of S. 343, the ''Comprehensive Regulatory Reform Act of 1995,'' which also included a congressional review provision. The congressional review provision in S. 343 that was debated by the Senate was quite similar to S. 219, except that the delay period in the effectiveness of a major rule was extended to 60 days and the legislation did not apply to rules issued prior to enactment. A filibuster of S. 343, unrelated to the congressional review provisions, led to the withdrawal of that bill.

The House next took up the congressional review legislation by attaching a version of it (as section 3006) to H.R. 2586, the first debt limit extension bill. The House made several changes in the legislation that was attached to H.R. 2586, including a provision that would allow the expedited procedures also to apply to resolutions disapproving of proposed rules, and provisions that would have extended the 60-day delay on the effectiveness of a major rule for any period when the House or Senate was in recess for more than three days. On November 9, 1995 both the House and Senate passed this version of the congressional review legislation as part of the first debt limit extension bill. President Clinton vetoed the bill a few days later, for reasons unrelated to the congressional review provision.

On February 29, 1996, a House version of the congressional review legislation was published in the Congressional Record as title III of H.R. 994, which was scheduled to be brought to the House floor in the coming weeks. The congressional review title was almost identical to the legislation approved by both Houses in H.R. 2586. On March 19, 1996, the Senate adopted a congressional review amendment by voice vote to S. 942, which bill passed the Senate 100–0. The congressional review legislation in S. 942 was similar to the original version of S. 219 that passed the Senate on March 29, 1995.

Soon after passage of S. 942, representatives of the relevant House and Senate committees and principal sponsors of the congressional review legislation met to craft a congressional review subtitle that was acceptable to both Houses and would be added to the debt limit bill that was scheduled to be taken up in Congress the week of March 24. The final compromise language was the result of these joint discussions and negotiations.

On March 28, 1996, the House and Senate passed title III, the ''Small Business Regulatory Enforcement Fairness Act of 1996,'' as part of the second debt limit bill, H.R. 3136. There was no separate vote in either body on the congressional review subtitle or on title III of H.R. 3136. However, title III received broad support in the House and the entire bill passed in the Senate by unanimous consent. The President signed H.R. 3136 into law on March 29, 1996, exactly one year after the first congressional review bill passed the Senate.

Submission of rules to Congress and to GAO

Pursuant to subsection 801(a)(1)(A), a federal agency promulgating a rule must submit a copy of the rule and a brief report about it to each House of Congress and to the Comptroller General before the rule can take effect. In addition to a copy of the rule, the report shall contain a concise general statement relating to the rule, including whether it is a major rule under the chapter, and the proposed effective date of the rule. Because most rules covered by the chapter must be published in the Federal Register before they can take effect, it is not expected that the submission of the rule and the report to Congress and the Comptroller General will lead to any additional delay.

Section 808 provides the only exception to the requirement that rules must be submitted to each House of Congress and the Comptroller General before they can take effect. Subsection 808(1) excepts specified rules relating to commercial, recreational, or subsistence hunting, fishing, and camping. Subsection 808(2) excepts certain rules that are not subject to notice-and-comment procedures. It provides that if the relevant agency finds ''for good cause . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest, [such rules] shall take effect at such time as the Federal agency promulgating the rule determines.'' Although rules described in section 808 shall take effect when the relevant Federal agency determines pursuant to other provisions of law, the federal agency still must submit such rules and the accompanying report to each House of Congress and to the Comptroller General as soon as practicable after promulgation. Thus, rules described in section 808 are subject to congressional review and the expedited procedures governing joint resolutions of disapproval. Moreover, the congressional review period will not begin to run until such rules and the accompanying reports are submitted to each House of Congress and the Comptroller General.

In accordance with current House and Senate rules, covered agency rules and the accompanying report must be separately addressed and transmitted to the Speaker of the House (the Capitol, Room H–209), the President of the Senate (the Capitol, Room S–212), and the Comptroller General (GAO Building, 441 G Street, N.W., Room 1139). Except for rules described in section 808, any covered rule not submitted to Congress and the Comptroller General will remain ineffective until it is submitted pursuant to subsection 801(a)(1)(A). In almost all cases, there will be sufficient time for an agency to submit notice-and-comment rules or other rules, that must be published to these legislative officers during normal office hours. There may be rare instance, however, when a federal agency must issue an emergency rule that is effective upon actual notice and does not meet one of the section 808 exceptions. In such a rare case, the federal agency may provide contemporaneous notice to the Speaker of the House, the President of the Senate, and the Comptroller General. These legislative officers have accommodated the receipt of similar, emergency communications in the past and will utilize the same means to receive emergency rules and reports during nonbusiness hours. If no other means of delivery is possible, delivery of the rule and related report by telefax to the Speaker of the House, the President of the Senate, and the Comptroller General shall satisfy the requirements of subsection 801(a)(1)(A).

Additional delay in the effectiveness of major rules

Subsection 553(d) of the APA requires publication or service of most substantive rules at least 30 days prior to their effective date. Pursuant to subsection 801(a)(3)(A), a major rule (as defined in subsection 804(2)) shall not take effect until at least 60 calendar days after the later of the date on which the rule and accompanying information is submitted to Congress or the date on which the rule is published in the Federal Register, if it is so published. If the Congress passes a joint resolution of disapproval and the President vetoes such resolution, the delay in the effectiveness of a major rule is extended by subsection 801(a)(3)(B) until the earlier date on which either House of Congress votes and fails to override the veto or 30 session days[1] after the date on which the Congress receives the veto and objections from the President. By necessary implication, if the Congress passes a joint resolution of disapproval within the 60 calendar days provided in subsection 801(a)(3)(A), the delay period in the effectiveness of a major rule must be extended at least until the President acts on the joint resolution or until the time expires for the President to act. Any other result would be inconsistent with subsection 801(a)(3)(B), which extends the delay in the effectiveness of a major rule for a period of time after the President vetoes a resolution.

Of course, if Congress fails to pass a joint resolution of disapproval within the 60-day period provided by subsection 801(a)(3)(A), subsection 801(a)(3)(B) would not apply and

[1] In the Senate, a ''session day'' is a calendar day in which the Senate is in session. In the House of Representatives, the same term is normally expressed as a ''legislative day.'' In the congressional review chapter, however, the term ''session day'' means both a ''session day'' of the Senate and a ''legislative day'' of the House of Representatives unless the context of the sentence or paragraph indicates otherwise.

would not further delay the effective date of the rule. Moreover, pursuant to subsection 801(a)(5), the effective date of a rule shall not be delayed by this chapter beyond the date on which either house of Congress votes to reject a joint resolution of disapproval.

Although it is not expressly provided in the congressional review chapter, it is the authors' intent that a rule may take effect if an adjournment of Congress prevents the President from returning his veto and objections within the meaning of the Constitution. Such will be the case if the President does not act on a joint resolution within 10 days (Sundays excepted) after it is presented to him, and ''the Congress by their Adjournment prevent its Return'' within the meaning of Article I, §7, cl. 2, or when the President affirmatively vetoes a resolution during such an adjournment. This is the logical result because Congress cannot act to override these vetoes. Congress would have to begin anew, pass a second resolution, and present it to the President in order for it to become law. It is also the authors' intent that a rule may take effect immediately if the President returns a veto and his objections to Congress but Congress adjourns its last session sine die before the expiration of time provided in subsection 801(a)(3)(B). Like the situations described immediately above, no subsequent Congress can act further on the veto, and the next Congress would have to begin anew, pass a second resolution of disapproval, and present it to the President in order for it to become law.

Purpose of and exceptions to the delay of major rules

The reason for the delay in the effectiveness of a major rule beyond that provided in APA subsection 553(d) is to try to provide Congress with an opportunity to act on resolutions of disapproval before regulated parties must invest the significant resources necessary to comply with a major rule. Congress may continue to use the expedited procedures to pass resolutions of disapproval for a period of time after a major rule takes effect, but it would be preferable for Congress to act during the delay period so that fewer resources would be wasted. To increase the likelihood that Congress would act before a major rule took effect, the authors agreed on an approximately 60-day delay period in the effective date of a major rule, rather than an approximately 45-day delay period in some earlier versions of the legislation.

There are four exceptions to the required delay in the effectiveness of a major rule in the congressional review chapter. The first is in subsection 801(c), which provides that a major rule is not subject to the delay period of subsection 801(a)(3) if the President determines in an executive order that one of four specified situations exist and notifies Congress of his determination. The second is in subsection 808(1), which excepts specified rules relating to commercial, recreational, or subsistence hunting, fishing, and camping from the initial delay specified in subsection 801(a)(1)(A) and from the delay in the effective date of a major rule provided in subsection 801(a)(3). The third is in subsection 808(2), which excepts certain rules from the initial delay specified in subsection 801(a)(1)(A) and from the delay in the effective date of a major rule provided in subsection 801(a)(3) if the relevant agency finds ''for good cause . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.'' This ''good cause'' exception in subsection 808(2) is taken from the APA and applies only to rules which are exempt from notice and comment under subsection 553(b)(B) or an analogous statute. The fourth exception is in subsection 804(2). Any rule promulgated under the Telecommunications Act of 1996 or any amendments made by that Act that otherwise could be classified as a ''major rule'' is exempt from that definition and from the 60-day delay in section 801(a)(3). However, such an issuance still would fall within the definition of ''rule'' and would be subject to the requirements of the legislation for non-major rules. A determination under subsection 801(c), subsection 804(2), or section 808 shall have no effect on the procedures to enact joint resolutions of disapproval.

A court may not stay or suspend the effectiveness of a rule beyond the period specified in section 801 simply because a resolution of disapproval is pending in Congress

The authors discussed the relationship between the period of time that a major rule is delayed and the period of time during which Congress could use the expedited procedures in section 802 to pass a resolution of disapproval. Although it would be best for Congress to act pursuant to this chapter before a major rule goes into effect, it was recognized that Congress could not often act immediately after a rule was issued because it may be issued during a recesses of Congress, shortly before such recesses, or during other periods when Congress cannot devote the time to complete prompt legislative action. Accordingly, the authors determined that the proper public policy was to give Congress an adequate opportunity to deliberate and act on joint resolutions of disapproval, while ensuring that major rules could go into effect without unreasonable delay. In short, the authors decided that major rules could take effect after an approximate 60-day delay, but the period governing the expedited procedures in section 802 for review of joint resolution of disapproval would extend for a period of time beyond that.

Accordingly, courts may not stay or suspend the effectiveness of any rule beyond the periods specified in section 801 simply because a joint resolution is pending before Congress. Such action would be contrary to the many express provisions governing when different types of rules may take effect. Such court action also would be contrary to the authors' intent because it would upset an important compromise on how long a delay there should be on the effectiveness of a major rule. The final delay period was selected as a compromise between the period specified in the version that passed the Senate on March 19, 1995, and the version that passed both Houses on November 9, 1995. It is also the authors' belief that such court action would be inconsistent with the principles of (and potentially violate) the Constitution, art. I, §7, cl. 2, in that courts may not give legal effect to legislative action unless it results in the enactment of law pursuant that Clause. See *INS* v. *Chadha*, 462 U.S. 919 (1983). Finally, the authors intend that a court may not predicate a stay on the basis of possible future congressional action because it would be improper for a court to rule that the movant had demonstrated a ''likelihood of success on the merits,'' unless and until a joint resolution is enacted into law. A judicial stay prior to that time would raise serious separation of powers concerns because it would be tantamount to the court making a prediction of what Congress is likely to do and then exercising its own power in furtherance of that prediction. Indeed, the authors intend that Congress may have been reluctant to pass congressional review legislation at all if its action or inaction pursuant to this chapter would be treated differently than its action or inaction regarding any other bill or resolution.

Time periods governing passage of joint resolutions of disapproval

Subsection 802(a) provides that a joint resolution disapproving of a particular rule may be introduced in either House beginning on the date of the rule and accompanying report are received by Congress until 60 calendar days thereafter (excluding days either House of Congress is adjourned for more than 3 days during a session of Congress). But if Congress did not have sufficient time in a previous session to introduce or consider a resolution of disapproval, as set forth in subsection 801(d), the rule and accompanying report will be treated as if it were first received by Congress on the 15th session day in the Senate, or 15th legislative day in the House, after the start of its next session. When a rule was submitted near the end of a Congress or prior to the start of the next Congress, a joint resolution of disapproval regarding that rule may be introduced in the next Congress beginning on the 15th session day in the Senate or the 15th legislative day in the House until 60 calendar days thereafter (excluding days either House of Congress is adjourned for more than 3 days during the session) regardless of whether such a resolution was introduced in the prior Congress. Of course, any joint resolution pending from the first session of a Congress, may be considered further in the nest session of the same Congress.

Subsections 802(c)–(d) specify special procedures that apply to the consideration of a joint resolution of disapproval in the Senate. Subsection 803(c) allows 30 Senators to petition for the discharge of resolution from a Senate committee after a specified period of time (the later of 20 calendar days after the rule is submitted to Congress or published in the Federal Register, if it is so published). Subsection 802(d) specifies procedures for the consideration of a resolution on the Senate floor. Such a resolution is highly privileged, points or order are waived, a motion to postpone consideration is not in order, the resolution is unamendable, and debate on the joint resolution and ''on all debatable motions and appeals in connection therewith'' (including a motion to proceed) is limited to no more than 10 hours.

Subsection 802(e) provides that the special Senate procedures specified in subsections 802(c)-(d) shall not apply to the consideration of any joint resolution of disapproval of a rule after 60 session days of the Senate beginning with the later date that rule is submitted to Congress or published, if it is so published. However, if a rule and accompanying report are submitted to Congress shortly before the end of a session or during an intersession recess as described in subsection 801(d)(1), the special Senate procedures specified in subsections 802(c)-(d) shall expire 60 session days after the 15th session day of the succeeding session of Congress—or on the 75th session day after the succeeding session of Congress first convenes. For purposes of subsection 802(e), the term ''session day'' refers only to a day the Senate is in session, rather than a day both Houses are in session. However, in computing the time specified in subsection 801(d)(1), that subsection specifies that there shall be an additional period of review in the next session if either House did not have an adequate opportunity to complete action on a joint resolution. Thus, if either House of Congress did not have adequate time to consider a joint resolution in a given session (60 session days in the Senate and 60 legislative days in the House), resolutions of disapproval may be introduced or reintroduced in both Houses in the next session, and the special Senate procedures specified in subsection 802(c)-(d) shall apply in the next session of the Senate.

If a joint resolution of disapproval is pending when the expedited Senate procedures specified in subsections 802(c)-(d) expire, the resolution shall not die in either House but shall simply be considered pursuant to the

normal rules of either House—with one exception. Subsection 802(f) sets forth one unique provision that does not expire in either House. Subsection 802(f) provides procedures for passage of a joint resolution of disapproval when one House passes a joint resolution and transmits it to the other House that has not yet completed action. In both Houses, the joint resolution of the first House to act shall not be referred to a committee but shall be held at the desk. In the Senate, a House-passed resolution may be considered directly only under normal Senate procedures, regardless of when it is received by the Senate. A resolution of disapproval that originated in the Senate may be considered under the expedited procedures only during the period specified in subsection 802(e). Regardless of the procedures used to consider a joint resolution in either House, the final vote of the second House shall be on the joint resolution of the first House (no matter when that vote takes place). If the second House passes the resolution, no conference is necessary and the joint resolution will be presented to the President for his signature. Subsection 802(f) is justified because subsection 802(a) sets forth the required language of a joint resolution in each House, and thus, permits little variance in the joint resolutions that could be introduced in each House.

Effect of enactment of a joint resolution of disapproval

Subsection 801(b)(1) provides that: ''A rule shall not take effect (or continue), if the Congress enacts a joint resolution of disapproval, described under section 802, of the rule.'' Subsection 801(b)(2) provides that such a disapproved rule ''may not be reissued in substantially the same form, and a new rule that is substantially the same as such a rule may not be issued, unless the reissued or new rule is specifically authorized by a law enacted after the date of the joint resolution disapproving the original rule.'' Subsection 801(b)(2) is necessary to prevent circumvention of a resolution disapproval. Nevertheless, it may have a different impact on the issuing agencies depending on the nature of the underlying law that authorized the rule.

If the law that authorized the disapproved rule provides broad discretion to the issuing agency regarding the substance of such rule, the agency may exercise its broad discretion to issue a substantially different rule. If the law that authorized the disapproved rule did not mandate the promulgation of any rule, the issuing agency may exercise its discretion not to issue any new rule. Depending on the law that authorized the rule, an issuing agency may have both options. But if an agency is mandated to promulgate a particular rule and its discretion in issuing the rule is narrowly circumscribed, the enactment of a resolution of disapproval for that rule may work to prohibit the reissuance of any rule. The authors intend the debate on any resolution of disapproval to focus on the law that authorized the rule and make the congressional intent clear regarding the agency's options or lack thereof after enactment of a joint resolution of disapproval. It will be the agency's responsibility in the first instance when promulgating the rule to determine the range of discretion afforded under the original law and whether the law authorizes the agency to issue a substantially different rule. Then, the agency must give effect to the resolution of disapproval.

Limitation on judicial review of congressional or administrative actions

Section 805 provides that a court may not review any congressional or administrative ''determination, finding, action, or omission under this chapter.'' Thus, the major rule determinations made by the Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget are not subject to judicial review. Nor may a court review whether Congress complied with the congressional review procedures in this chapter. This latter limitation on the scope of judicial review was drafted in recognition of the constitutional right of each House of Congress to ''determine the Rules of its Proceedings,'' U.S. Const., art. I, §5, cl. 2, which includes being the final arbiter of compliance with such Rules.

The limitation on a court's review of subsidiary determination or compliance with congressional procedures, however, does not bar a court from giving effect to a resolution of disapproval that was enacted into law. A court with proper jurisdiction may treat the congressional enactment of a joint resolution of disapproval as it would treat the enactment of any other federal law. Thus, a court with proper jurisdiction may review the resolution of disapproval and the law that authorized the disapproved rule to determine whether the issuing agency has the legal authority to issue a substantially different rule. The language of subsection 801(g) is also instructive. Subsection 801(g) prohibits a court or agency from inferring any intent of the Congress only when ''Congress does not enact a joint resolution of disapproval,'' or by implication, when it has not yet done so. In deciding cases or controversies properly before it, a court or agency must give effect to the intent of the Congress when such a resolution is enacted and becomes the law of the land. The limitation on judicial review in no way prohibits a court from determining whether a rule is in effect. For example, the authors expect that a court might recognize that a rule has no legal effect due to the operation of subsections 801(a)(1)(A) or 801(a)(3).

Enactment of a joint resolution of disapproval for a rule that was already in effect

Subsection 801(f) provides that: ''Any rule that takes effect and later is made of no force or effect by enactment of a joint resolution under section 802 shall be treated as though such rule had never taken effect.'' Application of this subsection should be consistent with existing judicial precedents on rules that are deemed never to have taken effect.

Agency information required to be submitted to GAO

Pursuant to subsection 801(a)(1)(B), the federal agency promulgating the rule shall submit to the Comptroller General (and make available to each House) (i) a complete copy of the cost-benefit analysis of the rule, if any, (ii) the agency's actions related to the Regulatory Flexibility Act, (iii) the agency's actions related to the Unfunded Mandates Reform Act, and (iv) ''any other relevant information or requirements under any other Act and any relevant Executive Orders.'' Pursuant to subsection 801(a)(1)(B), this information must be submitted to the Comptroller General on the day the agency submits the rule to Congress and to GAO.

The authors intend information supplied in conformity with subsection 801(a)(1)(B)(iv) to encompass both agency-specific statutes and government-wide statutes and executive orders that impose requirements relevant to each rule. Examples of agency-specific statutes include information regarding compliance with the law that authorized the rule and any agency-specific procedural requirements, such as section 9 of the Consumer Product Safety Act, as amended, 15 U.S.C. §2054 (procedures for consumer product safety rules); section 6 of the Occupational Safety and Health Act of 1970, as amended, 29 U.S.C. §655 (promulgation of standards); section 307(d) of the Clean Air Act, as amended, 42 U.S.C. §7607(d) (promulgation of rules); and section 501 of the Department of Energy Organization Act, 42 U.S.C. §7191 (procedure for issuance of rules, regulations, and orders). Examples of government-wide statutes include other chapters of the Administrative Procedure Act, 5 U.S.C. §§551–559 and 701–706; and the Paperwork Reduction Act, as amended, 44 U.S.C. §§3501–3520.

Examples of relevant executive orders include E.O. No. 12866 (Sept. 30, 1993) (Regulatory Planning and Review); E.O. No. 12606 (Sept. 2, 1987) (Family Considerations in Policy Formulation and Implementation); E.O. No. 12612 (Oct. 26, 1987) (Federalism Considerations in Policy Formulation and Implementation); E.O. No. 12630 (Mar. 15, 1988) (Government Actions and Interference with Constitutionally Protected Property Rights); E.O. No. 23875 (Oct. 26, 1993) (Enhancing the Intergovernmental Partnership); E.O. No. 12778 (Oct. 23, 1991) (Civil Justice Reform); E.O. No. 12988 (Feb. 5, 1996) (Civil Justice Reform) (effective May 5, 1996).

GAO reports on major rules

Fifteen days after the federal agency submits a copy of a major rule and report to each House of Congress and the Comptroller General, the Comptroller General shall prepare and provide a report on the major rule to the committee of jurisdiction in each House. Subsection 801(a)(2)(B) requires agencies to cooperate with the Comptroller General in providing information relevant to the Comptroller General's reports on major rules. Given the 15-day deadline for these reports, it is essential that the agencies' initial submission to the General Accounting Office (GAO) contain all of the information necessary for GAO to conduct its analysis. At a minimum, the agency's submission must include the information required of all rules pursuant to 801(a)(1)(B). Whenever possible, OMB should work with GAO to alert GAO when a major rule is likely to be issued and to provide as much advance information to GAO as possible on such proposed major rule. In particular, OMB should attempt to provide the complete cost-benefit analysis on a major rule, if any, well in advance of the final rule's promulgation.

It also is essential for the agencies to present this information in a format that will facilitate the GAO's analysis. The authors expect that GAO and OMB will work together to develop, to the greatest extent practicable, standard formats for agency submissions. OMB also should ensure that agencies follow such formats. The authors also expect that agencies will provide expeditiously any additional information that GAO may require for a thorough report. The authors do not intend the Comptroller General's reports to be delayed beyond the 15-day deadline due to lack of information or resources unless the committees of jurisdiction indicate a different preference. Of course, the Comptroller General may supplement his initial report at any time with any additional information, on its own, or at the request of the relevant committees or jurisdiction.

Covered agencies and entities in the executive branch

The authors intend this chapter to be comprehensive in the agencies and entities that are subject to it. The term ''Federal agency'' in subsection 804(1) was taken from 5 U.S.C. §551(1). That definition includes ''each authority of the Government'' that is not expressly excluded by subsection 551(1)(A)–(H). With those few exceptions, the objective was to cover each and every government entity, whether it is a department, independent agency, independent establishment, or government corporation. This is because Congress is enacting the congressional review

chapter, in large part, as an exercise of its oversight and legislative responsibility. Regardless of the justification for excluding or granting independence to some entities from the coverage of other laws, that justification does not apply to this chapter, where Congress has an interest in exercising its constitutional oversight and legislative responsibility as broadly as possible over all agencies and entities within its legislative jurisdiction.

In some instances, federal entities and agencies issue rules that are not subject to the traditional 5 U.S.C. §553(c) rulemaking process. However, the authors intend the congressional review chapter to cover every agency, authority, or entity covered by subsection 551(1) that establishes policies affecting any segment of the general public. Where it was necessary, a few special exceptions were provided, such as the exclusion for the monetary policy activities of the Board of Governors of the Federal Reserve System, rules of particular applicability, and rules of agency management and personnel. Where it was not necessary, no exemption was provided and no exemption should be inferred from other law. This is made clear by the provision of section 806 which states that the Act applies notwithstanding any other provision of law.

Definition of a ''major rule''

The definition of a ''major rule'' in subsection 804(2) is taken from President Reagan's Executive Order 12291. Although President Clinton's Executive Order 12866 contains a definition of a ''significant regulatory action'' that is seemingly as broad, several of the Administration's significant rule determinations under Executive Order 12866 have been called into question. The authors intend the term ''major rule'' in this chapter to be broadly construed, including the non-numerical factors contained in the subsections 804(2)(B) and (C).

Pursuant to subsection 804(2), the Administrator of the Office of Information and Regulatory Affairs in the Office of Management and Budget (the Administrator) must make the major rule determination. The authors intend that centralizing this function in the Administrator will lead to consistency across agency lines. Moreover, from 1981–93 OIRA staff interpreted and applied the same major rule definition under E.O. 12291. Thus, the Administrator should rely on guidance documents prepared by OIRA during that time and previous major rule determinations from that Office as a guide in applying the statutory definition to new rules.

Certain covered agencies, including many ''independent agencies,'' include their proposed rules in the Unified Regulatory Agenda published by OMB but do not normally submit their final rules to OMB for review. Moreover, interpretative rules and general statements of policy are not normally submitted to OMB for review. Nevertheless, it is the Administrator that must make the major rule determination under this chapter whenever a new rule is issued. The Administrator may request the recommendation of any agency covered by this chapter on whether a proposed rule is a major rule within the meaning of subsection 804(2), but the Administrator is responsible for the ultimate determination. Thus, all agencies or entities covered by this chapter will have to coordinate their rulemaking activity with OIRA so that the Administrator may make the final, major rule determination.

Scope of rules covered

The authors intend this chapter to be interpreted broadly with regard to the type and scope of rules that are subject to congressional review. The term ''rule'' in subsection 804(3) begins with the definition of a ''rule'' in subsection 551(4) and excludes three subsets of rules that are modeled on APA sections 551 and 553. This definition of a rule does not turn on whether a given agency must normally comply with the notice-and-comment provisions of the APA, or whether the rule at issue is subject to any other notice-and-comment procedures. The definition of ''rule'' in subsection 551(4) covers a wide spectrum of activities. First, there is formal rulemaking under section 553 that must adhere to procedures of sections 556 and 557 of title 5. Second, there is informal rulemaking, which must comply with the notice-and-comment requirements of subsection 553(c). Third, there are rules subject to the requirements of subsection 552(a)(1) and (2). This third category of rules normally either must be published in the Federal Register before they can adversely affect a person, or must be indexed and made available for inspection and copying or purchase before they can be used as precedent by an agency against a non-agency party. Documents covered by subsection 552(a) include statements of general policy, interpretations of general applicability, and administrative staff manuals and instructions to staff that affect a member of the public. Fourth, there is a body of materials that fall within the APA definition of ''rule'' and are the product of agency process, but that meet none of the procedural specifications of the first three classes. These include guidance documents and the like. For purposes of this section, the term rule also includes any rule, rule change, or rule interpretation by a self regulatory organization that is approved by a Federal agency. Accordingly, all ''rules'' are covered under this chapter, whether issued at the agency's initiative or in response to a petition, unless they are expressly excluded by subsections 804(3)(A)–(C). The authors are concerned that some agencies have attempted to circumvent notice-and-comment requirements by trying to give legal effect to general statements of policy, ''guidelines,'' and agency policy and procedure manuals. The authors admonish the agencies that the APA's broad definition of ''rule'' was adopted by the authors of this legislation to discourage circumvention of the requirements of chapter 8.

The definition of a rule in subsection 551(4) covers most agency statements of general applicability and future effect. Subsection 804(3)(A) excludes ''any rule of particular applicability, including a rule that approves or prescribes rates, wages, prices, services, or allowances therefore, corporate and financial structures, reorganizations, mergers, or acquisitions thereof, or accounting practices or disclosures bearing on any of the foregoing'' from the definition of a rule. Many agencies, including the Treasury, Justice, and Commerce Departments, issue letter rulings or other opinion letters to individuals who request a specific ruling on the facts of their situation. These letter rulings are sometimes published and relied upon by other people in similar situations, but the agency is not bound by the earlier rulings even on facts that are analogous. Thus, such letter rulings or opinion letters do not fall within the definition of a rule within the meaning of subsection 804(3).

The different types of rules issued pursuant to the internal revenue laws of the United States are good examples of the distinction between rules of general and particular applicability. IRS private letter rulings and Customs Service letter rulings are classic examples of rules of particular applicability, notwithstanding that they may be cited as authority in transactions involving the same circumstances. Examples of substantive and interpretative rules of general applicability will include most temporary and final Treasury regulations issued pursuant to notice-and-comment rulemaking procedures, and most revenue rulings, revenue procedures, IRS notices, and IRS announcements. It does not matter that these later types of rules are issued without notice-and-comments rulemaking procedures or that they are accorded less deference by the courts than notice-and-comment rules. In fact, revenue rulings have been described by the courts as the ''classic example of an interpretative rul[e]'' within the meaning of the APA. See *Wing* v. *Commissioner*, 81 T.C. 17, 26 (1983). The test is whether such rules announce a general statement of policy or an interpretation of law of general applicability.

Most rules or other agency actions that grant an approval, license, registration, or similar authority to a particular person or particular entities, or grant or recognize an exemption or relieve a restriction for a particular person or particular entities, or permit new or improved applications of technology for a particular person or particular entities, or allow the manufacture, distribution, sale, or use of a substance or product are exempted under subsection 804(3)(A) from the definition of a rule. This is probably the largest category of agency actions excluded from the definition of a rule. Examples include import and export licenses, individual rate and tariff approvals, wetlands permits, grazing permits, plant licenses or permits, drug and medical device approvals, new source review permits, hunting and fishing take limits, incidental take permits and habitat conservation plans, broadcast licenses, and product approvals, including approvals that set forth the conditions under which a product may be distributed.

Subsection 804(3)(B) excludes ''any rule relating to agency management or personnel'' from the definition of a rule. Pursuant to subsection 804(3)(C), however, a ''rule of agency organization, procedure, or practice,'' is only excluded if it ''does not substantially affect the rights or obligations of non-agency parties.'' The authors' intent in these subsections is to exclude matters of purely internal agency management and organization, but to include matters that substantially affect the rights or obligations of outside parties. The essential focus of this inquiry is not on the type of rule but on its effect on the rights or obligations of non-agency parties.●

10TH ANNIVERSARY OF CHERNOBYL

● Mr. LEVIN. Mr. President, on April 26, 1986, reactor number 4 at the V.I. Lenin Atomic Power Plant in Chernobyl near Kiev, Ukraine exploded. The explosion released a cloud of radioactive steam into the atmosphere reported to contain about 200 times more radio activity than was released at Hiroshima and Nagasaki.

The explosion took an enormous toll on the people directly exposed to the radiation emitted from the plant. Shortly after the explosion, Soviet officials admitted to 31 deaths among reactor operators and the team attempting to contain the damage. Thousands of workers were eventually exposed at the site.

However, children have been the first among the general population to suffer from the effects of the explosion at Chernobyl. Children are most susceptible to the radioactive iodine emitted from Chernobyl because of their active

thyroid glands. Researchers in the region have seen a dramatic increase in thyroid cancer among children. However, this is only the earliest problem to make itself known and one of the few to be studied. The problem with estimating the toll on human life in the region is that 10 years is a short period of time to see all of the impacts. Radioactive fallout is only beginning to show its damaging effects on the population.

At the time of the explosion, the prevailing winds carried much of the radiation north into Belarus and points beyond. Excessive levels of radiation were recorded in Scandinavia, Great Britain, the Mediterranean, and Alaska in the first weeks after the explosion. About 1000 acres of pine forest in the path of the first plume of the Chernobyl explosion died immediately as a result of direct fallout. A permanent 30-kilometer dead zone was established around the power station where human habitation is still forbidden today because of the high level of contamination. The Chernobyl area, known as the Polissia region, was once famous for its old-growth forests rich with mushrooms, berries and medicinal herbs. The community's well-being revolved around the health of the forest. Their dependency on the forest resulted in a very unique spirituality and culture in the region. After the accident, residents were forced to leave their homes and move to completely different environments. The inability to return to the land they once knew and worries about possible exposure to radiation now cause great stress among the population. Two of Chernobyl's four units remain functional today. Ukraine says it wants to completely close Chernobyl, but cannot function without the energy it provides and cannot afford to properly close the plant, even though radioactive material is now threatening water tables in the area. The American people should specifically lend their support to the efforts to make the area around Chernobyl as safe as possible. We should also work to improve the health, economic and environmental well-being of areas affected by the Chernobyl disaster. The Chernobyl explosion has been a devastating event for the entire world. Ukrainian-Americans have worked strenuously to lend support to their homeland. In my home State, the Michigan Committee—Chernobyl Challenge 1996 will be holding events to commemorate the 10-year anniversary of the explosion. On April 28, 1996, a commemorative program will be held at St. Josaphat Ukrainian Catholic Church in Warren, MI. The guest speaker will be Ukraine's Ambassador to the United Nations, Anatoly Zlenko. There will also be blood drives held at the Ukrainian Cultural Center and at St. Michael Ukrainian Catholic Church in cooperation with the American Red Cross, where volunteers will bring to the public's attention the ongoing tragedy in Ukraine. I salute their efforts to help Ukraine recover from the tragedy that occurred a decade ago at Chernobyl.●

SUBMITTING CHANGES TO THE BUDGET RESOLUTION DISCRETIONARY SPENDING LIMITS, APPROPRIATE BUDGETARY AGGREGATES, AND APPROPRIATIONS COMMITTEE ALLOCATION

● Mr. DOMENICI. Mr. President, section 103(c) of Public Law 104–121, the Contract With America Advancement Act, requires the chairman of the Senate Budget Committee to adjust the discretionary spending limits, the appropriate budgetary aggregates and the Appropriations Committee's allocation contained in the most recently adopted Budget Resolution—in this case, House Concurrent Resolution 67—to reflect additional new budget authority and outlays for continuing disability reviews—CDR's, as defined in section 201(g)(1)(A) of the Social Security Act.

I hereby submit revisions to the nondefense discretionary spending limits for fiscal year 1996 contained in sec. 201 of House Concurrent Resolution 67 in the following amounts:

	1996
Budget authority:	
Current nondefense discretionary spending limit	$219,668,000,000
Adjustment	15,000,000
Revised nondefense discretionary spending limit	219,683,000,000
Outlays:	
Current nondefense discretionary spending limit	267,725,000,000
Adjustment	60,000,000
Revised nondefense discretionary spending limit	267,785,000,000

I hereby submit revisions to the budget authority, outlays and deficit aggregates for fiscal year 1996 contained in sec. 101 of House Concurrent Resolution 67 in the following amounts:

	1996
Budget authority:	
Current aggregate	$1,285,500,000,000
Adjustment	15,000,000
Revised aggregate	1,285,515,000,000
Outlays:	
Current aggregate	1,288,100,000,000
Adjustment	60,000,000
Revised aggregate	1,288,160,000,000
Deficit:	
Current aggregate	245,600,000,000
Adjustment	60,000,000
Revised aggregate	245,660,000,000

I hereby submit revisions to the 1996 Senate Appropriations Committee budget authority and outlay allocations, pursuant to sec. 302 of the Congressional Budget Act, in the following amounts:

	1996
Budge authority:	
Current Appropriations Committee allocation	$772,349,000,000
Adjustment	15,000,000
Revised Appropriations Committee allocation	772,364,000,000
Outlays:	
Current Appropriations Committee allocation	$807,374,000,000
Adjustment	60,000,000
Revised Appropriations Committee allocation	807,434,000,000

Public Law 104–121 also requires me to adjust discretionary spending limits for any future fiscal year—1997–2002—when the Committee on Appropriations reports an appropriations measure specifying an amount in excess of a 1995 base level amount for continuing disability reviews. The allowable adjustment to the outlay cap amounts to $2.7 billion over the period 1996 to 2002. CBO estimates that the additional CDR's flowing from the increased appropriations would result in savings in the Social Security, SSI Medicare and Medicaid programs of roughly $3.5 billion over the 7-year time frame.●

TRIBUTE TO PRINCE GEORGES COUNTY

● Mr. SARBANES. Mr. President, I rise to join the people of Maryland in celebrating the tricentennial anniversary of the founding of Prince Georges County on April 23, 1696. Over the centuries the residents and leadership of Prince Georges County have demonstrated a remarkable commitment to preserving their rich historic legacy, while encouraging economic growth and cultural enrichment.

While evidence suggests that the first human settlements in the area later to be called Prince Georges County existed over 10,000 years ago, the first documented visit to the region occurred in 1608 when Captain John Smith sailed up the Potomac River to map the Chesapeake Bay region and search for food for the fledgling Jamestown Colony. Captain Smith paid only a brief visit to this region which, less than a century later, would be home to about 1,700 Marylanders. This rich land extending from Mattawoman Creek in the south all the way to the Pennsylvania border was proclaimed a self-governing county by the colonial Governor in 1696, and was named Prince Georges County in honor of Prince George of Denmark, husband of Princess Anne, heir to the throne of England.

Due to the abundance of fertile farm land, agriculture dominated the local economy in colonial times, contributing to the livelihood of almost every Prince Georges County inhabitant. Preservation of this important aspect of colonial life has remained a priority to the residents of Prince Georges County who, through groups such as the Accokeek Foundation, work to maintain the National Colonial Farm, displaying to all a continuum of American farm life from the 1600's through the 18th century.

Evidence of the importance of the agricultural economy in southern Maryland remains in many aspects of Prince Georges County life, including the Maryland higher education system. In 1856, in order to educate the sons of colonial farmers and to foster the exchange of new ideas, the Maryland Agricultural College—the first of its kind in the Nation—was established in Prince Georges County. Today we know the Maryland Agricultural College as the University of Maryland College Park, the flagship institution of the University of Maryland system.

While agriculture was the predominant force in the Prince Georges County economy, the push for western expansion in Maryland led to the growth of thriving commercial and trading centers such as Upper Marlboro, Laurel and Bladensburg. Cotton mills, steamboats, and railroads resulted in increased commercial development, strengthening the county's ties with Europe and other American colonies and leading to increased economic development.

This early entrepreneurial spirit continues to flourish and thrive today. Prince Georges County is now home to over 13,600 businesses which employ over 223,700 workers. Major employers including Giant Food, United Parcel Service, and Dimensions Health Corporation serve to make Prince Georges County a prime example of a large and prospering business community, while the Prince Georges County Economic Development Corporation has been nationally recognized for its programs to assist individual entrepreneurs and small minority-owned businesses.

The county's close proximity to the District of Columbia has been another factor in its evolution and maturation. Over the years towns and cities have sprung up to meet the needs of a growing community of Federal employees who increasingly choose to live outside the Federal city in suburban Maryland. Towns such as Takoma Park, New Carrollton, Greenbelt, and District Heights are home to the over 87,000 Federal employees who work both in the District and at the many Federal installations which are located in modern Prince Georges County.

Prince Georges County is today one of the Nation's largest and most vibrant subdivisions, winning widespread acclaim and national recognition for its success in promoting diversity and opening up the doors of opportunity for all of its citizens. This well-deserved reputation as a national model is due to a strong sense of community and cooperation among its residents and to enlightened and visionary leadership. In the forefront of these efforts have been our respected Governor and former Prince Georges County Executive Parris Glendening, two of my distinguished colleagues in the Congress, Representatives STENY HOYER and ALBERT WYNN, and the present dynamic County Executive Wayne Curry.

Such citizens and leaders throughout history have guided Prince Georges County from a region of frontier wilderness and rural plantations to today's modern urban communities and advanced agricultural centers. Prince Georges County has adapted to meet the changes wrought by the centuries, while preserving the evidence of 300 years of growth and progress. This tricentennial celebration pays tribute to the rich legacy of our Maryland ancestors and bears testament to the limitless promise and potential of Prince Georges County.●

A FOND FAREWELL TO AN HISTORIC AIRCRAFT

❨ Mr. KEMPTHORNE. Mr. President, on April 20, 1996, the last of the Idaho Air National Guard's F–4G ''Wild Weasels'' will be retired.

As we bid farewell to this reliable workhorse that has served this Nation well for nearly three decades, let me recognize the historic accomplishments of the Wild Weasel and the superb men and women of the 124th Fighter Group stationed at Gowen Field in Boise, ID, who have flown and maintained this remarkable aircraft.

Since June 1991, the 124th has flown the F–4G Wild Weasel. It is a two-seat, twin engine jet that can travel at more than twice the speed of sound. Armed with radar and heat seeking missiles as well as conventional bombs, the Wild Weasel is often the first aircraft to enter combat and the last to leave. Its mission is to find and attack enemy radar and missile sites—clearing the path in a hostile environment for friendly fighters and bombers to enter enemy airspace.

When the Wild Weasels first arrived at Gowen Field, the 124th converted to the new mission and was combat ready in record time.

Six months later, these men and women were called on to leave their homes, families and jobs to serve their Nation. Without a Presidential call-up, these troops volunteered for service and became the first Air National Guard unit activated for a combat mission during peace time when they were deployed to Saudi Arabia as part of Operation Southern Watch.

The Group was fully integrated into the Air Force Wing deployed to the region. They were given day to day mission responsibilities for patrolling southern Iraq and escorting coalition aircraft into enemy airspace that had proven over time to be a hostile environment.

As I visited the men and women of the Idaho Guard stationed in Saudi Arabia, I saw how effectively the active duty and National Guard forces were working together to defend our Nation's interest. I also heard British and French pilots state they would not fly over Iraq unless they knew the Wild Weasels were also in the sky to protect them against surface to air missiles.

Maj. Gen. Darrell V. Manning praised his men and women for their critical role in this international enforcement effort. He said, ''They were the only trained organization in place that could perform this mission and we had the trained and motivated people required to succeed in this critical role.''

But this success required the support of hundreds of personnel who performed their duties to near perfection. The mechanics, refuellers, weapons handlers, and every other member of this team—and I mean team—contributed to the effectiveness of the 124th Fighter Group.

The 124th was again called to service in Operation Provide Comfort—this time to Turkey where they enforced the northern Iraq no-fly zone as part of combat-ready patrol along with other United States, British, French and Turkish coalition forces.

In the fall of 1995, the Idaho Air National Guard made Air Force history by flying the 50,000th aerial mission in support of Operation Provide Comfort II.

I had the privilege of visiting the 124th Fighter Group in Turkey in early October, 1995. Once again I saw a well trained and well disciplined group of men and women serving our Nation's interests. I also saw the pride that these men and women from Idaho had in their venerable aircraft, the Wild Weasel. And while there, I let them know their State and country were proud of the 124th's dedication and commitment to peace in that troubled region.

Mr. President, it is clear the men and women of the 124th Fighter Group have established themselves as one of the premier Guard units in the country. And while I have some parochial pride in making that statement, that distinction was hard-earned and well-deserved.

Based on the Wild Weasel's performance in Saudi Arabia, the Secretary of the Air Force came to Boise, ID in December 1993 to honor the 124th Fighter Group. Secretary Sheila Widnall and Maj. Gen. Philip G. Killey, Director of the Air National Guard, presented the men and women of the 124th Fighter Group with the Air Force's Outstanding Unit Award for their role as the leading edge of force projection during peacetime, and the first to assume this new and difficult role for Air Reserve forces.

Mr. President, we all knew the time would come for the Wild Weasel to be retired, and with the downsizing of active and reserve units that has taken place, there were concerns over future missions for Gowen Field.

As we looked for a new mission for Gowen Field, it was clear the men and women of the Idaho Air National Guard had already presented their case. The performance of the Wild Weasel was well-documented. The dependability of the Idaho Air Guard was second to none. Together, they had earned not one, but two new missions to replace the Wild Weasels—the A–10's and the C–130's.

And while we say goodbye to this trusted airframe, we know the tradition of the Wild Weasel will live on with the men and women of the Idaho Air National Guard where the motto is ''First Class or Not At All.''●

● Mr. MOYNIHAN. Mr. President, the Dole/Roth amendment adopted earlier today includes a provision designed to address the problem of renunciation of U.S. citizenship by Americans who move abroad in order to avoid U.S. taxation. On April 6, 1995, shortly after this issue first came to light, I introduced S. 700, a bill to close the loophole in the Tax Code that permits expatriates, as they have come to be called,

from evading U.S. taxation. I said here on the floor that the Senate would act expeditiously to end this abuse, and would act in a careful and judicious manner to do so. The amendment before us today, which includes a modification of S. 700, would do just that.

Although expatriation to avoid taxes occurs infrequently, it is a genuine abuse. The Tax Code currently contains provisions, dating back to 1966, intended to prevent tax-motivated relinquishment of citizenship, but these provisions have proven difficult to enforce and are easily evaded. One international tax expert described avoiding them as ''child's play.'' Individuals with substantial wealth can, by renouncing U.S. citizenship, avoid paying taxes on gains that accrued during the period that they acquired their wealth—and while they were afforded the many benefits and advantages of U.S. citizenship. Moreover, even after renunciation, these individuals are permitted to keep residences and reside in the United States for up to 120 days per year without incurring U.S. tax obligations. Indeed, certain wealthy individuals have renounced their U.S. citizenship and avoided their tax obligations while still maintaining their families and homes in the United States. They need only take care to avoid being in the United States for more than 120 days each year.

Meanwhile, ordinary Americans who remain citizens continue to pay taxes on their gains when assets are sold or when estate taxes become due at death.

I regret to say that the expatriation issue has been the subject of more controversy than it probably deserves, so in the interest of setting the record straight, I will briefly review the history of its consideration in the Congress. On February 6, 1995, the President announced a proposal to address expatriation in his fiscal year 1996 budget submission. Three weeks later, on March 15, 1995, during Finance Committee consideration of legislation to restore the health insurance deduction for the self-employed, I offered a modified version of the administration's expatriation tax provision as an amendment to the bill. My amendment would have substituted the expatriation proposal for the repeal of minority broadcast tax preferences as a funding source for the bill. The amendment failed in the face of united opposition by members of the majority on the Committee. The vote against the amendment was 11–9.

Subsequently, Senator BRADLEY offered the expatriation provision as a free-standing amendment, with the revenues it raised to be dedicated to deficit reduction. Senator BRADLEY's amendment passed by voice vote. That is how the expatriation tax provision was added to the bill that came before the Senate.

After the Finance Committee reported the bill, but before full Senate action and before our conference with the House, the Finance Committee held a hearing to review further the issues raised by expatriation. At our hearing, we heard criticisms of some technical aspects of the provision, as well as testimony raising the issue of whether the provision comported with Article 12 of the International Covenant on Civil and Political Rights, which the United States ratified in 1992. Section 2 of Article 12 states: ''Everyone shall be free to leave any country, including his own.''

Robert F. Turner, a professor of international law at the U.S. Naval War College, testified that the expatriation provision was problematic under the Covenant because it constituted a legal barrier to the right of citizens to leave the United States. The State Department's legal experts disagreed, as did two other outside experts who provided written opinions to the Committee: Professor Paul B. Stephan III, a specialist in both international law and tax law at the University of Virginia School of Law; and Mr. Stephen E. Shay, who served as International Tax Counsel at the Department of the Treasury in the Reagan administration.

Given this division in authority, it seemed clear that the Senate should not act improvidently on the matter. Genuine questions of human rights under international law, and the solemn obligations of the United States under treaties, had been raised. We therefore sought the views of other experts. Opinions concluding that the expatriation provision did not violate international law were received from Professor Detlev Vagts of Harvard Law School and Professor Andreas F. Lowenfeld of New York University School of Law. The State Department issued a lengthier analysis supporting the legality of the provision, and the American Law Division of the Congressional Research Service reached a like conclusion. However, there were dissenting views, most notably the powerful opinion of Professor Hurst Hannum of the Fletcher School of Law and Diplomacy at Tufts University, who first wrote to me on March 24, 1995.

This is where things stood when the House-Senate conference met on March 28, 1995. Although the weight of authority appeared to support the validity of the provision under international law, very real questions remained. Yet the underlying bill had to move at great speed. As my colleagues well know, the legislation restoring the health insurance deduction for the self-employed for calendar year 1994 needed to be passed and signed into law well in advance of the April 17, 1995 tax filing deadline, so that self-employed persons would have time to prepare and file their 1994 tax returns. The conference committee had to decide immediately whether to retain the expatriation provision; there was no time for further inquiry into its validity under international law. We accordingly chose not to risk making the wrong decision with respect to international law and human rights, and so the expatriation provision was not included in the conference report. The conferees instead adopted a provision directing the Joint Committee on Taxation to study the matter and report back.

This decision, which was the only prudent one at the time, met with some not very pleasant criticism in the Senate. This was surprising, since I believed it was axiomatic that government should proceed with great care when dealing with human rights—particularly the rights of persons who are despised. The persons affected by the expatriation proposal—millionaires who renounce their citizenship for money—certainly fall into that category.

Since that time, a general consensus has developed that the provision does not conflict with the obligations of the United States under international law. Professor Hannum, after receiving additional and more specific information about the expatriation tax, wrote a second letter of March 31, 1995 stating that he was now ''convinced that neither its intention nor its effect would violate present U.S. obligations under international law.''

In the interim, there has been time to consider other approaches to the problem. On June 1, 1995, the Joint Committee on Taxation published its report on the tax treatment of expatriation. Shortly thereafter, on June 9, 1995, Chairman ARCHER introduced an expatriation bill that adopted a different approach than S. 700, the bill introduced by the Senator from New York. The Archer bill, rather than impose a tax on accrued gains, would build on the current law approach of taxing only a portion of the income of an expatriate received during the 10-year period following expatriation. A version very similar to the Archer bill was included in House-passed version of the Balanced Budget Act of 1995.

We held a second Finance Committee hearing on expatriation on July 11, 1995 to consider the two competing approaches. Soon thereafter, the Senate in the Senate-passed version of the Balanced Budget Act of 1995 adopted the accrued gains approach from my bill, rather than the House alternative, as the superior response to the problem.

During the conference on the Balanced Budget Act of 1995, the conferees opted for the House approach. This was, I believe, a serious error. Fortunately, that version did not become law because the President vetoed the conference agreement. The conferees on the pending bill will be faced with the same choice. The House version of the expatriation provision is included in the House-passed companion to the Kassebaum-Kennedy bill. We ought not repeat the mistake made in the Balanced Budget Act.

I am convinced that the House approach has serious defects and would fail to eliminate the very substantial tax advantages that currently accrue

to those willing to give up their citizenship. Under the House proposal, several categories of taxpayers would continue to owe no tax at all should the IRS be unable to prove a tax avoidance motive for expatriating. As under current law, taxpayers who are patient would avoid all tax on accrued gains by simply holding their assets for 10 years. A wealthy expatriate in need of funds during the 10-year period could simply borrow money using his or her assets as security. Since the income from foreign assets generally would remain exempt as under current law, clever tax practitioners would continue to find ways to convert U.S. assets into foreign assets in order to avoid tax on the income earned during the 10-year period.

The House approach also would be destined to fail because it relies on the voluntary payment of taxes by people who have moved beyond the reach of U.S. courts. In contrast, the Senate version would collect tax while the individual is still subject to the taxing power of the United States, which is surely a more administrable approach.

A separate objection to the House bill is that it would unilaterally override existing tax treaties. In its report on expatriation, the Joint Tax Committee staff stated that the House version may ultimately require that as many as 41 of our 45 existing tax treaties be renegotiated and that it might be necessary for the United States to forego benefits to accomplish renegotiation. This is a serious matter.

Article VI of our Constitution states:

> . . . [A]ll Treaties made, or which shall be made, under the authority of the United States, shall be the supreme Law of the Land.

Further, our treaties come into being through a singular exacting sequence. Treaties are entered into by the United States with other nations either directly or through adherence to a common document. They are signed by a member of the executive branch. Thereafter, the Senate of the United States must by resolution, two-thirds of the Senators present concurring therein, give its advice and consent to ratification. This advice and consent having been given—by an extraordinary majority—the President then ratifies and confirms the treaty in an instrument of ratification. Only at that point shall the said treaty become ''the supreme Law of the Land.'' Matters that survive this singularly exacting process should not be abrogated lightly.

One final point, of utmost importance. During the time we have taken to write this law carefully and well, billionaires have not been slipping through the loophole and escaping tax by renouncing their citizenship. The President announced the original proposal on February 6, 1995 and made it effective for taxpayers who initiate a renunciation of citizenship on or after that date. This was an entirely appropriate way to put an end to an abusive practice under current law. Likewise all the proposals considered by the Senate, including my bill S. 700, used February 6, 1995 as their effective date. The House conferees on the self-employed bill had proposed moving the effective date forward to March 15, 1995, the date of Senate Finance Committee action on the provision. But the two chairmen of the tax-writing committees ultimately—and wisely—resisted that overture, and issued a joint statement giving notice that February 6, 1995 would be the effective date of any legislation affecting the tax treatment of those who relinquish citizenship.

Now that the Senate has had adequate opportunity to fully explore the best way to address the expatriation problem, it is time to act. As the first Senator to have introduced legislation to end tax avoidance by so-called expatriates, and as one who urged that it be acted upon by the Senate expeditiously, I am pleased that the Dole/Roth amendment incorporates the expatriation changes I have favored. I hope that the conferees will retain the superior Senate expatriation provision, and that it will be enacted as soon as possible.●

AMENDING THE INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT

Mr. ABRAHAM. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 3034 just received from the House.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

> A bill (H.R. 3034) to amend the Indian Self-Determination and Education Assistance Act to extend for two months the authority for promulgating regulations under the Act.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

Mr. ABRAHAM. Mr. President, I ask unanimous consent that the bill be deemed read a third time and passed, that the motion to reconsider be laid upon the table, and that any statements relating to the bill appear at the appropriate place in the RECORD.

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

The bill (H.R. 3034) was deemed read the third time and passed.

ORDERS FOR FRIDAY, APRIL 19, 1996

Mr. ABRAHAM. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until the hour of 10 a.m., on Friday, April 19; further, that immediately following the prayer, the Journal of proceedings be deemed approved to date, no resolutions come over under the rule, the call of the calendar be dispensed with, the morning hour deemed to have expired, and the time for the two leaders reserved for their use later in the day; that there then be a period for morning business until the hour of 12 noon, with Senators permitted to speak therein for up to 5 minutes each, with the first 75 minutes under the control of Senator COVERDELL, or his designee, and the last 45 minutes under the control of Senator DASCHLE, or his designee, with 10 minutes of that time reserved for Senator MURRAY; further, that at the hour of 12 noon the Senate begin consideration of Calendar No. 201, S.J. Res. 21, regarding a constitutional amendment to limit congressional terms.

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

PROGRAM

Mr. ABRAHAM. Mr. President, for the information of all Senators, the Senate will convene at 10 a.m. Shortly after convening, the Senate will consider a sense-of-the-Senate resolution regarding the anniversary of the Oklahoma City bombing. The Senators are asked to be on the floor promptly at 10 a.m., as there will be a brief period of silence to remember the tragedy.

Following morning business, the Senate will then begin consideration of the term limits legislation. No rollcall votes will occur during Friday's session.

When the Senate completes debate Friday, it will resume consideration of the term limits legislation on Monday. No rollcall votes will occur during Monday's session. However, Senators are encouraged to debate the legislation and offer any amendments during Friday's and Monday's sessions of the Senate. The Senate may also be asked to turn to any other legislative items that can be cleared for action.

ORDER FOR ADJOURNMENT

Mr. ABRAHAM. Mr. President, if there is no further business to come before the Senate, I now ask that the Senate stand in adjournment under the previous order following the remarks of Senator LAUTENBERG.

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

Mr. LAUTENBERG addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

TOXIC WASTE CLEANUP

Mr. LAUTENBERG. Mr. President, at this moment, though the hour is late, and I apologize to those who are inconvenienced while I make my remarks, this is a topic of great importance to me and my home State of New Jersey, and a number of communities across the country—that is, the cleanup of toxic waste.

Mr. President, 73 million Americans live near toxic waste sites. That is

about one of every four of our citizens. Many people think of hazardous waste as a problem of ugly dump sites that harm a community's appearance and property values. But it is far more than that, Mr. President. Toxic waste is a huge threat to public health. By contaminating our drinking water, our air and our soil, dangerous waste contributes to a wide range of health problems, and these include cancer, birth defects, cardiovascular problems, immune disorders, and even something as simple and obvious as dermatitis.

Now, Mr. President, it is difficult to say how many people are harmed because of exposure to toxic waste. But the number is considerable. Unfortunately, New Jersey, where there are more Superfund sites than any other State, is being hit especially hard. Recent studies found that in all but one of New Jersey's 21 counties, cancer rates and areas around hazardous waste sites exceeded the national average.

Studies from other parts of the country also suggest that those living near toxic waste sites have suffered disproportionately from serious health problems. Beyond the public health problems associated with toxic waste, these sites also have serious economic effects on local communities. They discourage investment and occupy otherwise valuable real estate that could be used for productive economic activity. If we do not clean up these sites, we are depriving communities of good jobs and local tax revenues.

Mr. President, Congress created the Superfund Program in 1980, largely to respond to health problems, to save lives and protect and restore the environment. The program was designed to ensure that toxic waste sites were cleaned up promptly and that polluters took responsibility for cleaning them up.

Unfortunately, as many know, the Superfund Program got off to a very slow start for a variety of reasons, including a lack of Presidential commitment. Many cleanups were delayed. However, in recent years, the program has turned around. Under the Clinton administration, toxic waste cleanups have been 20 percent faster, 25 percent cheaper, and there is real progress in cleaning up sites. Although we have a long way to go, many more sites are being cleaned up, and delays have been reduced significantly.

Like any program, Mr. President, Superfund has its share of problems and critics. And there are many legitimate concerns that must be addressed. We do need to speed cleanups, reduce unnecessary litigation, and make the program work more efficiently.

Still, Mr. President, there has been tremendous progress. And President Clinton and EPA Administrator Carol Browner deserve real credit for that.

Unfortunately, just as the program has picked up steam, the Congress has permitted its funding mechanism to expire. This funding source simply must be reestablished, or the whole program could be threatened.

It is important, in my view, to pass a Superfund reform bill. Many of us in the Congress have been working long and hard, and in a bipartisan way, to develop reform legislation, and to make needed improvements in the program.

As ranking minority member of the Senate's Superfund Subcommittee, I have worked with many of my colleagues on this issue for several years now, especially my distinguished colleague from Montana, Senator BAUCUS, the ranking member of the Environment and Public Works Committee.

Last congress, after a long and arduous process involving all affected parties, we developed a bill that would have made comprehensive changes in the Superfund program.

Our bill would have made Superfund fairer, more efficient, and less costly. It addressed every major issue raised by those affected by Superfund, and provided relief on every front.

It would have fostered greater and earlier community involvement in cleanup decisions. It speeded up cleanups and made them more efficient. It would have slashed private litigation costs in half, and established a mechanism to efficiently resolve disputes involving polluters, their insurers, and the Government.

It allowed qualified States to play a greater role in remedy selection and cleanup of sites, including federally-owned facilities. It promoted the voluntary cleanup and economic redevelopment of contaminated properties. And it provided much-needed relief to lenders, small businesses, municipalities and others who have been caught up in the liability scheme.

Unfortunately, despite very broad support from environmentalists, industry, small businesses, State and local governments, communities, lenders, and others involved in Superfund, this reform bill was killed in the waning days of the 103d Congress. And so, last year, a new effort began to reauthorize the Superfund Program.

Senator SMITH, our new chairman of the Superfund Subcommittee, introduced a proposal last October.

And for the past few months, Senator CHAFEE, chairman of the Committee, and Senators BAUCUS, SMITH, and myself have spent countless hours trying to resolve our differences and produce a bill that can enjoy broad, bipartisan support. Representatives from the Clinton administration have worked with us virtually every day to support this effort.

Last month, Senators CHAFEE and SMITH introduced another measure that proposed a new liability scheme and made some other changes.

Mr. President, I remain hopeful that we can reach an agreement on comprehensive reform, and note that the latest bill introduced by Senators CHAFEE and SMITH—apart from the provisions on liability—include improvements over the earlier draft.

For example, the new measure would require that Superfund cleanups continue to meet Federal and State cleanups standards, and would allow States to impose their own liability and cleanup requirements. I am pleased by this progress and hope that it continues. Of course I would like to see it continue.

At the same time, I remain deeply concerned about provisions in the chairmen's latest proposal that would dramatically reduce the responsibility of polluters to clean up their own waste.

Before I go further, Mr. President, let me emphasize that Senators CHAFEE, SMITH, BAUCUS and I share many goals. And I know every one of these senators is genuinely committed to making progress. We all want to reduce unnecessary litigation, and make Superfund more fair. Yet, I believe the approach embodied in their legislation has serious flaws.

Their legislation essentially would eliminate polluters' liability for all actions causing pollution that took place before 1980.

By letting so many polluters off the hook entirely, the proposal would fundamentally alter a basic principle of the Superfund Program: the principle that, in general, polluters—not taxpayers—should pay for cleaning up their own toxic waste.

Mr. President, abandoning this principle would have serious consequences. It would lead to fewer cleanups. It would impose huge new burdens on State and local governments, which would be left holding the bag for cleaning up hundreds, if not thousands, of sites. And it would mean, in the end, that many fewer toxic waste sites will get cleaned up.

Mr. President, Senator BAUCUS and I, along with the administration, have developed a different approach to reforming Superfund liability. I ask unanimous consent that an outline of our proposal be printed in the RECORD. I hope my colleagues will take a close look at it.

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

LIABILITY COUNTERPROPOSAL TO S. 1285

I. RELIEF FOR SMALL BUSINESS

A. Exempt all businesses which are liable solely under CERCLA sections 107(a)(3) or (a)(4) as generators or transporters for activities occurring wholly before 1/1/96, where the party seeking the benefit of the exemption demonstrates that the business (including its parents, subsidiaries and other affiliates):

1. had annual gross revenues of no more than $2 million as reported to the Internal Revenue Service for each of the preceding three years;

2. has 25 or fewer employees;

3. provides full cooperation, assistance and facility access in connection with the implementation of response actions at the facility; and

4. is not affiliated with any other party liable for response costs at the facility (through any direct or indirect family relationship, or any contractual, corporate, or financial relationship other than a contract for the treatment or disposal of hazardous substances)

unless the President determines:

1. that the party seeking the exemption has not complied with all requests made under authority of CERCLA section 104(e); or

2. that the materials containing hazardous substances generated or transported by the business have contributed significantly or could contribute significantly to the costs of the response or to natural resource damages.

B. Funding. Shares of responsibility attributed by an allocator to the exempt small businesses that do not also qualify for the de micromis exemptions in III.A and IV. shall be included in the orphan share, subject to the provisions of section VI.

C. Recognition of Limited Ability to Pay of Businesses with Fewer than 100 Employees: For parties not exempt under I.A. above, EPA will implement expedited ability to pay settlements for those small businesses with fewer than 100 employees, including small business owner or operators that demonstrate a limited ability to pay.

II. RELIEF FOR MUNICIPAL OWNERS AND OPERATORS

A. Liability Cap:

1. For a municipality with a population of greater than 100,000 that is or was an owner or operator of a landfill listed on the NPL that contains predominantly municipal solid waste (MSW) or municipal sewage sludge (MSS), its response costs liability at the facility shall not exceed the cost of closing the facility under RCRA Subtitle D.

2. For a municipality with a population of fewer than 100,000 that is or was an owner or operator of a landfill listed on the NPL that contains predominantly municipal solid waste (MSW) or municipal sewage sludge (MSS), its response costs liability at the facility shall not exceed the lesser of the cost of closing the facility under RCRA Subtitle D or 10% of the total response costs for remediation of the site;

unless the President determines that the municipal owner or operator seeking the liability limitation does not meet the following criteria:

1. the municipality has complied with all requests made under authority of CERCLA section 104(e);

2. the municipality provides full cooperation, assistance and facility access in connection with the implementation of response actions at the facility;

3. the municipality, during its period of ownership or operation, accepted predominantly MSW or MSS, and any materials, other than MSW or MSS, containing hazardous substances accepted at the site do not contribute significantly to the costs of the response or to natural resource damages; and

4. for activities occurring after 1/1/96, the municipality had a qualified household hazardous waste collection program in effect, and accepted for disposal only materials that it was permitted to accept by law.

B. Funding: Shares of responsibility attributed to municipal owners or operators in excess of the amount specified under II.A. above shall be included in the orphan share, subject to the provisions of para. VA below.

C. Recognition of Municipalities' Limited Ability to Pay: EPA will implement expedited ability to pay settlements for all municipalities which demonstrate a limited ability to pay.

III. EXEMPT GENERATORS AND TRANSPORTERS OF MUNICIPAL SOLID WASTE

A. Small MSW contributors: Exempt all generators and transporters of MSW or MSS that are businesses with fewer than 100 employees, residential homeowners, and small non-profit organizations who:

1. are liable solely under CERCLA sections 107 (a)(3) or (a)(4) as generators or transporters;

2. contributed only MSW or MSS;

3. have complied with all requests made under authority of CERCLA section 104(e); and

4. provides full cooperation, assistance and facility access in connection with the implementation of response actions at the facility.

B. Other MSW contributors: Exempt all other generators and transporters of MSW or MSS (including federal government entities) at NPL sites for activities occurring wholly prior to 1/1/96. The party seeking the exemption must demonstrate that:

1. it is liable solely under CERCLA sections 107 (a)(3) or (a)(4) for activities occurring prior to 1/1/96;

2. a) it contributed only MSW or MSS; or

b) it contributed predominantly MSW or MSS—in which case the exemption under this paragraph shall apply only to the portion of its waste that is demonstrated by the generator or transporter to be solely MSW or MSS, and the generator or transporter shall become an allocation party, or an expedited settlement party, and shall pay its allocated share for the waste that is not demonstrated to be MSW or MSS;

3. it has complied with all requests under authority of CERCLA section 104(e); and

4. it provides full cooperation, assistance and facility access in connection with the implementation of response actions at the facility.

For activities occurring after 1/1/96, no generator or transporter that otherwise demonstrates that it satisfies criteria (1)–(4) above shall be liable for more than 10 percent of total response costs at a facility listed on the NPL, provided its waste was disposed of pursuant to a qualified household hazardous waste collection program. Where more than one generator or transporter qualifies under this paragraph, the 10% limitation shall apply to the aggregate liability for response costs of all such generators and transporters.

C. Funding: The allocator shall not assign a share of responsibility to the parties exempt under paragraph III.A. above. Shares of responsibility attributed to parties exempted under paragraph III.B. above shall be included in the allocation and shall be attributed to the orphan share, subject to the provisions of para. VI below.

IV. EXEMPT DE MICROMIS CONTRIBUTORS OF HAZARDOUS WASTE

A. Exempt all generators and transporters (including federal government entities) who contributed to a site 110 gallons or less of liquid materials containing hazardous substances or 200 pounds or less of solid materials containing hazardous substances wholly before 1/1/96, provided that:

1. the party has complied with all requests made under authority of CERCLA section 104(e); and

2. the party provides full cooperation, assistance and facility access in connection with the implementation of response actions at the facility,

unless the President has determined that the waste contributed significantly or could contribute significantly to the costs of response or natural resource restoration.

B. Funding: The allocator shall not assign a share of responsibility to exempt de micromis parties.

V. EXPEDITED DE MINIMIS SETTLEMENTS

The government will provide expedited settlements to any small volume (de minimis) waste contributors (including federal government entities). A ''small volume'' is presumed where the President estimates the volume to be 1% or less of the total waste at the site. The President may determine that site specific conditions indicate that another amount constitutes a small volume. To provide finality for these settling parties, such settlements shall include premia that cover the risks of, among other things, cost overruns. Recovery from these settlements will be used to reduce the liability of other settling responsible parties.

VI. FULL FUNDING—MAINTAINING THE PACE OF CLEANUP

A. Orphan share includes shares of responsibility for response costs specifically attributable to:

1. identified but insolvent or defunct allocation parties who are not affiliated with any other person liable for response costs at the facility, through any direct or indirect familial relationship, or any contractual, corporate, or financial relationship;

2. the ability to pay settlement ''delta'';

3. small businesses that are exempt under section I.A. and that do not also qualify for the exemptions described in sections III.A. IV.;

4. municipal owners and operators for whom liability is limited under section II.A., to the extent that their shares of responsibility exceed this liability limitation; and

5. the shares of responsibility attributable to parties exempt under section III.B.

B. Responsibility for hazardous substances that the allocator cannot attribute to any identified party shall be distributed among the allocation parties, including the orphan share.

C. The bill shall authorize up to $450 million per year for orphan share payments funded under para. A.

D. The amount of funding available for orphan share payments in any fiscal year:

1. shall not exceed the amounts that have been specifically appropriated by Congress for that purpose in the fiscal year in which the claim for payment is presented; and

2. must be in excess of the President's budget request for Superfund (excluding those amounts identified in section VI.A.) or the budget for the Superfund program as established in a Budget Reconciliation Act signed by the President (excluding those amounts identified in section VI.A.).

Shortfall: If claims for such payments exceed available funds, any deficit shall be allocated pro rata among the parties presenting the claim in that fiscal year. If funds appropriated for this purpose are not fully obligated in the fiscal year appropriated, the funds shall be carried over and made available for claims in subsequent years.

VII. OTHER ISSUES

A. NPL Listing Cap: Delete the cap in NPL listings.

B. Burden of proof: For each liability exemption or limitation described in this document, the party claiming the benefit of the exemption or limitation or seeking to establish the availability of an orphan share payment shall demonstrate the applicability of that exemption or limitation.

C. Related allocation issues: Establish an allocation process to enable PRPs to reach settlement with the United States based on their allocated shares and to provide a mechanism for determining the Trust Fund payments provided for above. The allocation process would have the following key features:

1. Allocations shall be required for sites with 2 or more potentially responsible parties, for which

a. a remedial action is selected after enactment; and

b. a remedial action was selected prior to enactment, if requested by the parties performing the remedial action.

2. The Administrator shall have discretion to provide allocations at other sites.

3. Allocations shall not be required for sites where there has been a previous adjudication or settlement determining liability

of all parties or the allocated shares of all parties, or at sites where all parties are liable under sections 107(a)(1) and (2).

4. Allocations under 1.b. and 2. shall not be construed to require the payment of orphan shares, to confer reimbursement rights, or to permit the reopening of a settlement.

D. *Additional exemptions, limitations and clarifications:* Liability exemptions, limitations and clarifications should be provided, as appropriate, for the following additional parties: lenders; fiduciaries; bona fide prospective purchasers; inheritors of real property; federal, state and local governments who own rights-of-way or issue business licenses; federal agencies providing disaster relief; contiguous landowners; religious, charitable, scientific or educational organizations who receive property as gifts; owners of railroad spurs; and recyclers.

E. *Settlements:* any settlement or judgment signed or entered prior to date of enactment shall not be affected by any exemption or limitation set forth above.

F. *Fee Shifting:* Any party who seeks to bring a non-liable party or a party who has fully resolved its liability to the United States into the allocation system will be responsible for paying the attorney fees and other costs of the nominated party for participating in the allocation system. Any party who sues another party during the allocation moratorium or who sues a party who has fully settled its liability to the United States will be responsible for paying that party's attorney fees and other litigation costs.

G. *Small business ombudsman:* The Administrator shall establish a small business assistance section within EPA's small business ombudsman office, to act as a clearinghouse of information for small businesses regarding CERCLA. The office will also provide general advice and assistance to small businesses regarding the allocation and settlement process, but will not give legal advice or participate in the allocation process.

Mr. LAUTENBERG. Mr. President, we think our proposal addresses many of the concerns that have been raised about Superfund's liability system. It would increase fairness, increase efficiency, and reduce transaction costs. At the same time, it would protect both the pace and protectiveness of cleanups.

It would provide greater fairness and efficiency by establishing an allocation system under which those responsible for pollution pay only their fair share. Under this system, they would be able to do this quickly and without litigation.

Second, the proposal increases fairness and efficiency, and cuts down on lawsuits, by pulling out of the process people who never should have been pulled in. This is accomplished through a series of exemptions and limitations on liability for small businesses, contributors of small amounts of waste, municipalities, charities, lenders, and other parties.

The proposal would exempt as many as 30,000 small businesses from Superfund liability. It would limit the liability of up to 525 municipal owners and operators of municipal landfills. It would exempt countless individuals, businesses, and small nonprofit organizations that otherwise would be liable as a generator or transporter of municipal solid waste.

It would exempt cities whose involvement is due solely to household trash created by its citizens. And it would exempt approximately 10,000 contributors of small amounts of waste.

This means that parties like the Girl Scouts, local taxpayers, pizza parlors, and churches will be protected from frivolous lawsuits—suits brought by polluters who have tried to force innocent parties to bear cleanup costs, simply because they have sent ordinary household garbage to Superfund sites.

At the same time, Mr. President, our proposal would reaffirm the principle that polluters should pay. It would ensure the availability of funding for more cleanups. And it would ensure that those responsible for pollution are held accountable for cleaning up the mess they have made.

It is important to provide relief to many who have been swept into the Superfund system unfairly. But it is equally critical that toxic waste sites not be left untended as a result, or passed off as a burden to local taxpayers.

Mr. President, I remain committed and hopeful about the possibility of enacting a Superfund bill in this Congress. I also want to express my appreciation to Senators SMITH and CHAFEE for their acknowledgment that the only way to get Superfund reform this year is through a bipartisan effort.

That kind of cooperation is part of a long tradition at the Environment and Public Works Committee, and it has resulted in landmark legislation protecting our citizens and environment. It will also be necessary if President Clinton is to sign a reform proposal into law.

Chairman CHAFEE has scheduled hearings next week on Superfund, and I hope we will have an opportunity to discuss this proposal, among others.

We have shared this proposal with our Republican colleagues, and we hope they will view it favorably. If we work together, we believe there is still time left in this session of Congress for the full Senate to consider a bill and work with our colleagues in the House of Representatives to approve a bipartisan, consensus bill the President can sign.

We believe our proposal is a serious effort to address concerns raised by our Republican colleagues. It also has the strong endorsement of the Administrator of the Environmental Protection Agency, Carol Browner, and the White House.

Mr. President, I believe that this proposal represents the best hope of securing a bipartisan Superfund bill this year that not only will be approved by the Senate, but which will be signed into law. And I remain committed to working hard with my colleagues to reach an agreement.

Mr. President, we can have a Superfund program that is both more fair and more efficient at protecting public health and the environment. To accomplish this goal, we need to continue working together in a cooperative fashion.

Seventy-three million Americans in every State of the country are counting on us to get the job done. I hope we will not let them down.

With that I conclude my remarks. I yield the floor.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands in adjournment until 10 a.m. Friday, April 19, 1996.

Thereupon, the Senate, at 11:15 p.m., adjourned until Friday, April 19, 1996, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate April 18, 1996:

THE JUDICIARY

ARTHUR GAJARSA, OF MARYLAND, TO BE U.S. CIRCUIT JUDGE FOR THE FEDERAL CIRCUIT, VICE HELEN WILSON NIES, RETIRED.

LAWRENCE E. KAHN, OF NEW YORK, TO BE U.S. DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF NEW YORK, VICE NEAL P. MCCURN, RETIRED.

WALKER D. MILLER, OF COLORADO, TO BE U.S. DISTRICT JUDGE FOR THE DISTRICT OF COLORADO, VICE JIM R. CARRIGAN, RETIRED.