United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 105th CONGRESS, SECOND SESSION

Vol. 144 WASHINGTON, FRIDAY, JULY 24, 1998 No. 101

House of Representatives

The House met at 9 a.m.

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

When all is said and done, O God, we are aware and appreciative of all Your gifts to us and to all people. We have been blessed in ways that have been greater than our deserving. Your grace has touched our lives with love and compassion and mercy. O gracious God, from whom all blessings flow, we ask Your benediction on us and those about us that in all things Your hand will sustain us and Your mercy will be without end. This is our earnest prayer. Amen.

THE JOURNAL

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

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

PLEDGE OF ALLEGIANCE

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

Mr. SOLOMON led the Pledge of Allegiance as follows:

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

MESSAGE FROM THE SENATE

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

H.R. 39. An act to reauthorize the African Elephant Conservation Act.

H. Con. Res. 298. concurrent resolution expressing deepest condolences to the State and people of Florida for the losses suffered as a result of the wild land fires occurring in June and July 1998, expressing support to the State and people of Florida as they overcome the effects of the fires, and commending the heroic efforts of firefighters from across the Nation in battling the fires.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain one-minutes after legislative business.

PATIENT PROTECTION ACT OF 1998

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 509 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 509

Resolved, That upon the adoption of this resolution it shall be in order to consider in the House the bill (H.R. 4250) to provide new patient protections under group health plans. The bill shall be considered as read for amendment. The amendments printed in the report of the Committee on Rules accompanying this resolution shall be considered as adopted. The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage without intervening motion except: (1) one hour of debate on the bill, as amended, equally divided and controlled by Representative Hastert of Illinois and a Member opposed to the bill; (2) the further amendment printed in the Congressional Record and numbered 2 pursuant to clause 6 of rule XXIII, which shall be in order without intervention of any point of order or demand for division of the question, shall be considered as read, and shall be separately debatable for one hour equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Florida (Mr. GOSS) is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, I am going to depart from normal custom and yield the first minute of this to the distinguished gentleman from New York (Mr. LAZIO) for a matter of colleague comity.

(Mr. LAZIO of New York asked and was given permission to speak out of order.)

HONORING THE HONORABLE ROB PORTMAN

Mr. LAZIO of New York. I want to thank the gentleman from Florida (Mr. GOSS) and the gentleman from New York (Mr. SOLOMON) for their courtesy.

Mr. Speaker, I rise to honor my pal and colleague, the gentleman from Ohio, Mr. ROB PORTMAN. He is one of the most accomplished people in this Congress. He stood up for America's taxpayers and was the driving force behind the landmark IRS reform bill signed into law this week. He authored the National Underground Railroad Act signed into law this week. By preserving underground railroad sites, America celebrates the journey of slaves from bondage to freedom.

The gentleman from Ohio is the congressional leader in the war against drugs. His Drug-Free Communities Act, signed into law, will give us peace of mind when our children are away from home. His pro-business mandates legislation is the law of this House and his pro-environment tropical rain forest legislation should be signed into law next week.

In an era when bipartisanship is essential for legislative success, Rob Portman is the even-headed leader we need. He is balanced and principled, substantive, competent, intelligent. He is a man of integrity, of modesty and of great character.

The gentleman form Ohio, Mr. ROB PORTMAN, gets the job done for families in Cincinnati, in Ohio, and throughout America.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would like to announce that the rules do not allow Members to wear badges when they are addressing the

Printed on recycled paper.

House. The Chair will enforce this rule throughout the debate today.

Mr. GOSS. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. FROST), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, this is a structured rule that allows timely consideration of this very, very important legislation on health care. In yesterday's Rules meeting, which actually went on for quite a while, the minority requested that the Dingell substitute be made in order and we indeed have obliged them in this rule. It provides for 1 hour of debate on the Patient Protection Act to be equally divided between the gentleman from Illinois (Mr. HASTERT) and an opponent, and 1 hour of debate on the Dingell substitute. These are two very different approaches to providing better health care for more Americans and I am sure that we will have quite a vigorous debate on the merits of each today. Finally, the rule provides for one motion to recommit with or without instructions. In effect, giving the minority two bites at the apple. I certainly feel this is a fair rule.

Mr. Speaker, today we will move to restore true patient power. The Patient Protection Act is the only bill that restores commonsense patient protections to Americans while also extending affordable coverage to the 41 million Americans who currently lack it and cannot get health care coverage. One clear difference between the two approaches is the fact that the Kennedy-Dingell Patients' Bill of Rights makes no effort to secure affordable health insurance for the 40-plus million Americans who have none currently. In fact, when asked what the Kennedy-Dingell bill does for uninsured Americans, the minority leader in the other body reportedly summed it up in two words, and I quote, ''Not much.'' Instead of turning our backs on the uninsured, our bill attacks their problem head-on. We know that over 75 percent of uninsured Americans are in a family where the primary caregiver works for a small business. This is especially true in southwest Florida, which I represent, where mom and pop shops cannot afford to provide their employees with health insurance. The Patient Protection Act allows small businesses to pool their resources and the achieve economies of scale needed to offer quality, affordable health insurance to their employees. If it is good enough for the Microsofts and the IBMs and the GMs of the world, should it not be good enough for the little guys, too? We take care of that.

As with any major proposal, there comes a certain level of misinformation and this effort is no exception. Many of my friends on the other side of the aisle have confused a patient's bill of rights with a trial lawyer's right to bill. Under our bill, patients would still have the right to sue their HMO for malpractice and that includes punitive damages. I wonder how many times I am going to be saying that in the next few months. Under our bill, patients would still have the right to sue their HMO for malpractice, and that includes punitive damages. I think we are going to be hearing some debate on that subject today. If the HMO runs the wrong tests on you or they happen to cut off the wrong foot, you will have recourse through the courts, of course. That is essential and that is protected. But as we studied the problem and talked to people, the folks who were being denied care in what we call coverage disputes, we thought we could do better than settling for, or encouraging even more litigation. I do not know many people who have gotten much good medical attention in a courtroom. We came to the conclusion that we have an innovative solution that assures patients get the care they need, up front, when they need it, at a place they need it, from a doctor, from a real medical person. Our expedited internal and external appeals process means that if your HMO denies your experimental treatment, or your treatment, you will be able to have a doctor, independent of the HMO, review that decision. Of course if you are unsatisfied at the end of that process, you can take the offending HMO to court. However, unlike the current law, the judge will have the flexibility to serve a fine up to $250,000 against the HMO plan. This is not available under current law and it is a healthy and reasonable constraint on HMO abuse. I know it has already got their attention.

We have provided commonsense patient protections in this package. Women will have direct access to their OB-GYN. Kids will get to see a pediatrician without any red tape or having to get permission from a government official. And, most importantly, doctors will have no restrictions on the recommendations they give their patients. No gag rule. These are positive steps to improve the doctor-patient relationship, not a retreat into more nonsensical and, I would say, very expensive bureaucracy that other approaches take.

Mr. Speaker, as a member of Chairman HASTERT's working group, I can assure you that we have worked hard and I think we have come up with a pretty good package that provides real protections without returning us to the days of double-digit inflation. I encourage my friends on both sides of the aisle to ignore the demagogues and focus on the pro-patient, pro-small business, pro-family provisions in our health care bill. I believe they will find it is worth reading.

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

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

Mr. Speaker, there is no doubt that the American public wants managed care reform. Today we have the opportunity to respond. At long last after months and months of denying that a problem exists, the Republican majority has agreed to let the House vote on a bill that seeks to provide a response to the concerns of millions of Americans. While what we have before us today is two bills, one written behind closed doors by the Republican leadership and supported by the insurance industry, there really is only one bill which meets the critical test of addressing the concerns of our constituents. That bill is a bipartisan proposal supported by doctors, nurses and consumers.

Mr. Speaker, there are two bills before us today, but if we listen carefully to what our constituents have been saying, there is little doubt how we should vote. Only the bipartisan bill sponsored by the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) really offers working families what they have been asking for. The bipartisan Ganske-Dingell Patients' Bill of Rights assures working families access to necessary medical care and will return health care decision-making to patients and their doctors. The bipartisan bill will give patients real remedies for real problems. The Ganske-Dingell Patients' Bill of Rights will reform a system that is badly in need of repair.

My Republican colleagues will say today that the bipartisan bill is nothing more than big government. They will say the bipartisan bill is nothing more than a lawyers full employment act. Well, if that is the case, Mr. Speaker, why then is the Ganske-Dingell substitute supported by the American Medical Association, an organization not normally known to support big government or trial lawyers? Why then is it supported by the American Nurses Association, an organization representing those health care givers closest to the patient? Why then, Mr. Speaker, is it supported by consumer groups and opposed by insurance companies? The arguments my Republican colleagues will make against the Ganske-Dingell bill are just plain bogus and no one should be fooled. Ganske-Dingell offers real reform, not just election year posturing.

That we are even able to consider and debate Ganske-Dingell today is testimony to the power of the call of the American people. For far too long, my Republican colleagues have denied that there is a problem, but the voices of working families who have been demanding that the Congress respond to their real concerns has been heard.

□ 0915

In their efforts to deny the House the opportunity to respond to those concerns, the Republican leadership had us guessing until 12:30 a.m. this morning whether they were even going to give the bipartisan substitute a place at the table. I suspect that only after it became clear that the rule might not pass without the Ganske-Dingell

amendment made in order that the Republican leadership relented and agreed to make the substitute in order.

Mr. Speaker, every Member in this House needs to recognize that the bipartisan substitute offers American working families something more than election year rhetoric. Ganske-Dingell is a good bill and deserves the support of every Member of this body. To do less is to do disservice to our constituents. I urge Members to do the right thing and to support Ganske-Dingell.

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

Mr. GOSS. Mr. Speaker, I yield as much time as he may consume to the distinguished gentleman from Glens Falls, New York (Mr. SOLOMON), chairman of the Committee on Rules.

Mr. SOLOMON. Mr. Speaker, I was not going to speak this morning. We spoke enough yesterday and last night into the wee hours. But I just want to make sure that all the Members on both sides of the aisle know, as the gentleman from Florida (Mr. GOSS) has just outlined, that this is a negotiated fair rule that was approved by the Democrat minority.

The Dingell substitute is made in order with ample time for debate so that this House has its choice, and that is the way that it should be. I just want to point out that we are going to be somewhat repetitive here, because what is going to be said now in this next hour on the rule could have not been wasted if we had had unanimous consent.

The gentleman from Michigan (Mr. DINGELL) last night agreed to unanimous consent to bring this bill on the floor without taking this extra hour of time on the rule. That means that Members could have gone back home. It is difficult in these last 3 or 4 weeks now before we recess for the August break, and taking up the rule today is going to add another hour and a half. It is too bad that the Democratic minority objected to us offering a unanimous consent to bring this bill on the floor, and I just wanted Members to know that.

But I hope that they will come over and vote for the rule, vote for the bill, and we will at least will have made some great progress in patients' rights.

Mr. FROST. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, the gentleman from New York was bemoaning the fact that we could not bring this measure up under unanimous consent but, rather, that we would have an hour's debate on the rule. This may be the most important piece of legislation we will consider this year. Certainly it is reasonable to have an hour debate on the rule on this matter.

The other side was so anxious to bring this up quickly early this morning and out of the line of fire without public attention. It is clearly appropriate to have an hour's debate on the rule.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

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

Mr. GREEN. Mr. Speaker, I thank my colleague and friend, the gentleman from Texas, and a Member of the Committee on Rules for allowing me to speak this morning.

I rise, not in opposition to the rule, but in opposition to the process where we have gotten to today, Mr. Speaker. Managed care reform is not about politics; it is about people.

We have a responsibility to guarantee the American people top quality health care. We have a responsibility to protect our children from negligent medical decisions made by insurance companies.

The Republican proposal that we will be debating today is simply profit over people. The only people in our country who are guaranteed immunity from their decisions are foreign diplomats and HMO officials.

We cannot really have a Patients' Bill of Rights without access to specialists, a timely internal and external appeals process, point of service options, choice for our patients, accountability of that decision matter, and open communication between the patient and a provider; in other words, no gag rule.

Can we honestly say that the system will protect patients without an enforcement mechanism, without an accountability? There is no responsibility.

The Republican bill that will be voted on today never enjoyed a public hearing. It was drafted behind closed doors. In fact, I serve on the committee that would have been helping draft this bill, and we did have hearings over the last few months, but this bill never had a public hearing.

We did not see it until late last night. Do my colleagues know why? Because, one, it does not end gag rules. It does not define severe pain as a reason a constituent of mine can go to the emergency room. It also does not actually provide for the point of service option that we want, the choice for that patient. That is easily bypassed by the HMO decision makers.

The Republican bill also will decide what medically necessary is. My concern is we are not giving the patient and that physician or that provider the decision making that the Democratic bill provides; and that is why, later on today, we hopefully will pass the Dingell-Ganske bill.

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

ISSUES OF CONCERN IN THE HASTERT TASK FORCE BILL

Does not end gag rules

While the bill claims to end gag rules, the statutory language creates a loophole that guts the protection. Under the Balanced Budget Act, Medicare and Medicaid plans cannot ''prohibit or otherwise restrict'' medical communications. The GOP bill only refers to prohibitions. So a plan could ''allow'' medical communications, but only after the doctor first complies with certain restrictions (such as calling the plan first and delivering the advice in pig latin). The deletion of the words ''or restrict'' render this protection hollow. This also creates the possibility for lawsuits over whether something is a restriction or a prohibition.

Does not define/include ''severe pain'' as a reason to get ''emergency medical care

The access to emergency care language in Medicare and Medicaid contains a specific definition of what a prudent layperson would think required immediate treatment: ''a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.''

By contrast, the GOP bill does not include ''severe pain'' as a condition that health plans must cover in the emergency room. The deletion is significant. For example, the American Heart Association advises that anyone experiencing crushing chest pain should go to the ER immediately, as that is a warning sign of a possible heart attack.

Under H.R. 4250, a health plan can refuse to pay the ER bills of a man who went to the emergency room with crushing chest pain but whose EKG came out negative. That might be only a temporary result; he might have a heart attack when the plan gives him a bill for the ER services!

Allows the plan to decide what is ''medically necessary''

At its heart, the debate over HMO reform is really about ensuring that health care decisions are made by doctors and patients, not by HMO business executives. H.R. 4250, however, does not fulfill that promise. Under the disclosure section, plans must inform participants of whether care may be excluded because ''of a failure to meet the plan's requirements for medical appropriateness. . . .'' In other words, it is not the doctor and patient who decide what is medically necessary; it is the plan which retains that capability.

During Commerce Committee testimony two years ago, Dr. Linda Penno, a former HMO medical reviewer, described this as a plan's 'smart-bomb' capability. By retaining the power to define what is and what is not medically necessary, the plan is able to take control of health care decisionmaking.

This is also relevant to the external appeals provisions of the Hastert Task Force Bill. The review is limited to whether the plan followed its own definition of medical necessity or whether or not a treatment is experimental.

Point of service provision is easily by-passed

The most powerful argument in the health care debate is the right to choose your own doctor. The GOP bill attempts to respond to this by including a point of service provision for closed panel HMOs (allowing patients to see providers outside the network). H.R. 4250, however, contains loopholes that effectively gut the provision. Employers would not have to offer employees point of service coverage if they could prove that this will cause premiums to rise just 1%—even if all of the added costs would be borne by employees who chose this option! And this ''proof'' could be prospective—meaning a company would not have to offer a single employee a POS option to determine its actual effect on premiums.

I am concerned that it will be easy for employers to ''prove'' that premiums will increase 1%. For example, one study by opponents of this legislation suggested that managed care reform legislation would increase premiums between 3 and 90%. While CBO's very low estimate of 4% should put those wild allegations to bed, they show how easy it is to prospectively make a doom and gloom forecast with a straight face. Combine that with the fact that insurance premiums are expected to take a big jump this year, and it is not hard to see how health plans will be able to use the 1% threshold to avoid offering their employees a choice of health care providers.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Speaker, I want to thank the Committee on Rules for bringing a fair rule to the floor. I intend to support it. I encourage all my colleagues to support the rule.

Mr. Speaker, think about how far we have come in the last 6 months. Six months ago, we would have never had this debate on the abuses in managed care. Today we are going to have that debate.

Let me briefly outline some of the arguments you will hear today so you can evaluate the competing proposals. Here is a sample of key protections which are not included in the Hastert task force bill, but are included in the substitute plan that I will offer:

The Ganske-Dingell substitute provides patients with access to clinical trials. The Hastert bill does not.

The Ganske-Dingell substitute allows doctors to override drug formularies when medically necessary. The Hastert bill does not.

The Ganske substitute provides for ongoing access to specialists for chronic conditions. The Hastert bill does not.

The Ganske substitute prevents plans from giving doctors financial incentives to deny care. The Hastert bill does not.

The Ganske substitute has hospital stay protection for mastectomy patients. The Hastert bill does not.

The Ganske substitute provides choice for doctors within the plan. The Hastert bill does not.

The Ganske substitute has a provision for guaranteeing continuity of care when providers leave the network. The Hastert bill does not.

The Ganske substitute requires plans to collect quality data or to maintain quality improvement programs. The Hastert plan does not.

There are other significant provisions in the Hastert bill that are of significant concern. The Hastert bill allows a plan to decide what is medically necessary. The Hastert bill requires enrollees to spend their own money to secure an independent review.

Finally, I would draw your attention to the HealthMart and MEWA, Multiply Employee Working Association, provisions which could make it more difficult for States to fund high-risk pools and other programs to help keep health insurance affordable. I am glad to support the rule. I look forward to the debate today.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, I thank the gentleman for yielding to me. I am going to oppose this bill today and I am going to oppose the rule here today, because we are going to have 2 hours, basically, to debate this bill.

I think it shows the insensitivity of this rule, insensitivity to basic rights that every American demands, and insensitivity to a basic understanding to health care in this Nation.

We as parents, we all know the world stops when a child falls ill. As sons and daughters, we want the best for our parents when they need health care. As husbands and wives and brothers and sisters, when a family member is stricken, we insist that nothing comes between that patient and their health care. We want the best possible treatment. Unfortunately, the Hastert bill does not provide it.

That is what health insurance is supposed to be about. We pay for it, we have it, and we want it when we need it. The doctors, the nurses, the hospitals, the emergency room, the medicine, we want whatever it takes to get our child, our parents back healthy again. That is how it used to be.

But in the last years, millions of Americans have moved into managed care plans, and something got in the way. Priorities were shifted from patients to profits. Emergency room crises were compromised by boardroom considerations. Professionals in white lab coats start taking orders, not from doctors, but insurance bureaucrats. The delivery of top-notch health care became less important; and the bottom line, profit.

When we take a look at the bill today, we will see that the Democratic bill, the Ganske-Dingell bill is the only one that will get the job done for us when we pay for health care and we demand quality care.

The Democratic bill is designed to provide medical coverage. Medical professions will be back in control of medical decisions. Emergency care in an emergency, no questions asked, underneath the Democratic plan. Expedited appeals process to approve the care we deserve before it is too late. Access to a specialist when you need it.

I hope we will defeat this rule and put some time into the Democratic plan.

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

Mr. Speaker, I would note to the gentleman who just spoke that we have tried very hard to accommodate all the schedules. It is a busy time of year. But surely our plan is more sensitive for the debate of this important issue than the discharge petition that they have provided for.

Mr. Speaker, I am very pleased to yield such time as he may consume to the distinguished gentleman from Illinois (Mr. HASTERT), the leader of the Speaker's task force on health care.

Mr. HASTERT. Mr. Speaker, today is an important day for American families. Today we will take a step forward to strengthen the Nation's health care system. Today we will debate and vote upon the House Republican-sponsored Patient Protection Act.

Our legislation is the only proposal on the table that truly protects patients and guarantees choices without the heavy hand of big government. Specifically, our bill guarantees patients have increased access to affordable health care they need when they need it most by holding insurance companies accountable.

How? Our proposal guarantees the unprecedented expedited review process internally and externally. We want patients to receive the care they need first rather than be thrown into a long, drawn-out legal process controlled by lawyers after harm or death has occurred. Patients should be treated in hospital rooms, not courtrooms.

Besides true accountability, our plan has another major advantage over other proposals in this Congress. The Patient Protection Act is the only bill which will help cover the 42 million uninsured working Americans.

We create new initiatives to guarantee more access to affordable health care choices. Association Health Care Plans, HealthMarts, Community Health Organizations, and Expanded Medical Savings Account help employees and employers work together to provide the coverage that best meet their need.

As a matter of fact, just this week at a news conference, the Senate minority leader TOM DASCHLE was asked, ''What does the Democrat plan do for the uninsured?'' His response, ''Not much.'' At least he was truthful.

I hope my colleagues on the other side of the aisle today are just as forthright and resist the temptation to distort the facts about what is in the House Republican plan. We truly believe that high quality health care depends upon the patient-doctor relationship.

Personally, I believe that doctors owe their patients the benefit of their education, the benefit of their experience, and the benefit of their good judgment. Medical decisions should be decided by doctors, not by insurance company bureaucrats.

We prevent health plans from gagging doctors for explaining the full range of treatment options available no matter what the cost, no matter if the other options are covered by the plan or not. We also ensure patients have ready access to emergency room care and prohibit their health plan from arbitrarily refusing to pay for it. We guarantee that women and children have direct access to their doctors without having first going to the insurance company gatekeeper.

Our proposal will also empower patients and doctors through information. It creates new access to plan coverage information while also protecting individual patient records from abuse through new confidentiality requirements.

□ 0930

Access to affordable health care is a fundamental patient protection. Without affordability, you cannot have accessibility, nor, for that matter, health care coverage at all. As you can see, we are protecting patients and guaranteeing choices, without the heavy hand of big government.

Mr. Speaker, we must have a comprehensive approach to meeting America's health care needs. Our Patient Protection Act is the only proposal before Congress that increases accessibility, affordability and accountability in our health care system. I urge my colleagues to support this rule so we can deliver the health care reform that Americans need.

Mr. FROST. Mr. Speaker, I yield three minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I do want to first thank the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE) and the members of the Democratic Health Care Task Force and all those who worked very hard to make sure that this substitute came up today. The discharge petition effort, which I think has over 190 Members, and other efforts to appear before the Committee on Rules finally brought fruit, I think, and made it possible for us to bring the substitute up today, and that hard work, I believe, paid off.

In my view, there is nothing more important in the managed care debate than giving patients the right to hold their HMO accountable when they are denied the care they need. Any legislation that fails to give patients that renders the protections within it absolutely meaningless. The Patient's Bill of Rights includes an enforcement mechanism which ensures patients will finally get that right. Our bill repeals the ERISA exemption, the 1974 law which shields HMOs from being sued if they deny people needed care.

The other bill we are considering today, the Republican bill, does nothing to hold HMOs accountable for their actions. If not only leaves ERISA essentially intact, it actually exacerbates the problem. Its external appeals process only applies to people whose insurance comes under ERISA. Individuals in the private insurance market are left without any external recourse when they are denied care. What is even worse is that those who are fortunate enough to be covered by ERISA are subject to the HMO's definition of ''medical necessity.''

The Republican bill allows HMOs, and not doctors and patients, to define ''medical necessity.'' This provision, of course, flies in the face of the whole idea of managed care debate, that medical necessity should be the determinant of whether or not a patient needs care and not cost considerations. It all but guarantees that insurance company bureaucrats will continue to make medical decisions and people will continue to be denied care because of it.

I also want to dispel a myth that my Republican colleagues have been working overtime to spread. The Patients' Bill of Rights does not create any new Federal legislation. Repealing the ERISA exemption would simply allow patients to go back to their states, where individuals would normally bring suit. In other words, the Patients' Bill of Rights does not create a new Federal remedy. Its approach is essentially states' rights by repealing a Federal preemption.

Another piece of propaganda the Republicans have been actively spreading is the charge that the Patients' Bill of Rights provides for employers to be sued for medical malpractice. This is patently false. In fact, the Patients' Bill of Rights specifically excludes employers from liability. Any employer can only be held liable if they intervene in a medical decision that leads to injury or death.

Mr. Speaker, President Clinton recently said that ''a right without a remedy is not a right,'' referring to HMOs. If you want good patient protections, and, just as importantly, enforcement of those protections, vote ''yes'' on the Patients' Bill of Rights and vote ''no'' on the Republican bill.

Mr. GOSS. Mr. Speaker, I yield two minutes to the distinguished gentleman from Kentucky (Mr. BUNNING).

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

Mr. BUNNING. Mr. Speaker, I rise in strong support of the rule and the Patient Protection Act. This bill is a well-crafted piece of legislation which addresses many of the problems facing our Nation's rapidly changing health care system.

What the bill does makes it worth supporting. It strengthens health care plan accountability by providing a system of reviews and appeals, to make sure that Americans who have health insurance get the care they need when they need it; it guarantees patients' choice by ensuring a point of service option, so that patients have the freedom to see the provider of their choice; it expands the availability and affordability of health insurance for millions of Americans through the creation of HealthMarts and Association Health Plans, by creating Community Health Center networks, and by expanding Medical Savings Accounts; it guarantees the right of patients to emergency room service; it guarantees the right of women to have direct access to their OB-GYN; it guarantees parents the right to direct access to pediatricians for their children.

These are much-needed improvements, and they are the one big reason to support the Patient Protection Act, the things it does.

But there is another reason to support the Patient Protection Act, and that is what it does not do. It does not load down the health care system with a new layer of bureaucracy; it does not guarantee an explosion of unnecessary costs and costly litigation, it puts people into care, and not into courtrooms; and it would not increase the cost of health care dramatically, like the Patients' Bill of Rights would do.

Mr. Speaker, it is a very good piece of legislation because of what it does, and even because of what it does not do.

I urge my colleagues to support the Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield two minutes to the gentlewoman from the Virgin Islands (Ms. CHRISTIAN-GREEN).

Ms. CHRISTIAN-GREEN. Mr. Speaker, I thank my colleague for yielding me time.

Mr. Speaker, I rise in support of the Ganske-Dingell bill. As a physician who has practiced medicine for more than 20 years, I know well many of the troubling aspects of the industry, particularly as they affect minorities. That is why I rise today to support the Ganske-Dingell bill and to bring to this body's attention and to the attention of the American people an issue which might not be discussed today, the discrimination of African-American physicians and patients by managed care plans.

Because minority physicians often serve poorer, sicker and are often solo practitioners and not a part of a group that makes a tidy profit each year, we do not make attractive candidates for inclusion into managed care plans.

Similarly, because minority patients are often uninsured and receive medical assistance from programs such as Medicare and Medicaid, they are also not attractive sources of revenue to such plans as well. As we seek to reform the managed care industry, we must not forget the concerns of minorities in this effort and their struggle to have their health care needs addressed.

My friends in the majority must stop playing politics with the lives of the American public and pass the Patients' Bill of Rights. The people who put us here and depend on us have asked us for and deserve a better health care delivery system. The Ganske-Dingell bill does that. I urge its passage. Let us put the ''care'' back in health care.

Mr. FROST. Mr. Speaker, I yield three minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, before coming to this Congress, I worked each day in a much different place, in a courtroom, as a judge on the highest court in Texas. I was called a justice, as were my colleagues, and asked to do justice. And yet, time after time, I found my hands and those of my colleagues tied by a Federal law.

We saw victims of injustice, who had suffered not only some grievous loss in

terms of an illness or an injury, but the same families who suffered abuse at the hands of insurance companies, and, because of a law that was passed in this National capital, we were powerless to do anything about it.

Recently the State of Texas became the first state to pass a new law to try to hold these managed care companies accountable for what they were doing. And, wouldn't you know it, the same insurance companies that used to come into my court went into another court to try to block this new state accountability law.

Today that same group of health care companies finds willing allies over here from the Republican leadership to help them continue to do the very same thing. They are folks who would deny help to the infirm. What is happening here is much like a firefighter, who sometimes builds a small fire in order to stop a much larger fire. There is a fire of outrage burning across this country, as one family after another suffers abuse and limitation of care at the hands of managed care companies.

So the Republican leadership has come forward today in a very contrived fashion. They tried to provide the least amount of reform possible and still call it ''patients rights,'' while doing essentially nothing to untie the hands of judges all across this country to provide a remedy.

Mr. Speaker, they say that what they are about is providing help to patients and not getting lawyers in the process. But, you know, that is false under their whole procedure. They keep lawyers involved in the process. They keep them involved only for the insurance company, not for the victim of the insurance company's abuse. They say that it is okay to have the lawyers that write the loopholes, that counsel the insurance companies to interfere with some clerk, who never had any health care experience, in the best recommendations of a physician or other health care provider to help that physician's patient get well. But Republicans would deny any enforcement, any accountability, for that insurance company.

They say they are opposed to getting juries involved in this process, and that is also false. They simply leave the only jury as not a jury of one's peers, but an insurance company, that acts as judge, jury and, in too many cases, executioner when it comes to providing health care. We would remedy that through the Dingell proposal, not through some election year sop.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, I rise in support of the Ganske-Dingell bill and truly relish this debate. I truly wish we had more time for it.

Today we are going to vote on a Republican sham HMO reform bill which actually leaves patients with less rights than they have under current law.

Let me give you an example. The GOP bill will repeal state laws that keep HMOs from giving out your private medical records. Under this Republican proposal, your employer could call for your medical records and your HMO could release your personal medical records without your permission.

But the worst thing about this political charade is that the Republican bill does not address the one problem that millions of Americans have asked us to fix, that doctors and patients should make medical decisions, not insurance company bean counters.

Under the GOP bill, HMOs will continue to define what is medical necessity and accountants will continue to decide what medical care Americans ought to receive. And if some HMO bureaucrat with no medical training makes a mistake that injures or kills you or a member of your family, you have no legal recourse. The GOP bill says, too bad, and tough luck.

This is a sham bill, and that is why the American Medical Association and dozens of other medical groups oppose it, and why the HMO companies support it. It has no protections and no enforcement mechanism. That is why the President has said he will veto it.

Let us pass real reform for the American people in this country. That is what they want, that is what they need. Pass the Democratic Patients' Bill of Rights. It is the way that we need to address the serious issue of getting back the decisionmaking between doctors and patients, and out of the hands of the HMOs.

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

Mr. Speaker, regrettably, the last speaker has been victimized by misinformation in the paper, in the Washington Post this morning, as have other Members. When we get to the debate we will explain that much of what was presented was incorrect.

Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Missouri (Mr. TALENT), a member of the special task force.

□ 0945

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

I am very pleased to rise in strong support of the Patient Protection Act because it is the only bill on the House floor today that will provide health care coverage to millions of people, hard-working Americans who currently do not have it. It is the only bill that will ensure that Americans who have health care coverage get the coverage their physician recommends when they need it, before they get sick, and it is the only bill that does what it does without big government and big bureaucracy.

First, access to the uninsured. Mr. Speaker, there are 42 million Americans today who do not have health care coverage. Most of them work for small employers who, because of the high administrative costs and the low buying power with small pools, cannot afford to provide them health insurance. If they worked for IBM, they would have access to a variety of different options.

So what our bill does is allows those small employers to pool together and get the buying power of a pool. It will cover millions of people with good, private sector health insurance and provide many more choices to millions of those who currently only have one choice or two.

What does the Dingell bill do? What does it do for the uninsured? Well, according to a cosponsor from the other body, not much. In fact, the ''not-much'' plan is worse than not much, because according to the CBO, it will drive costs up to the point that 1.6 million people who now have health insurance will be thrown off the health insurance rolls.

Our bill also ensures that people will get the care they need when they need it, and does it without big government. It provides swift, certain, low-cost access for somebody whose physician has recommended care whose plan has turned it down to get that decision reversed. First internal review has to be before a physician, not a health care professional, not a nurse. That is a difference from the Dingell bill.

Second, automatic appeal has a right to an external review before physicians. The Dingell bill does not have that. We get people in the treatment rooms, not waste billions of dollars that should be spent on health care in the courtrooms.

Mr. Speaker, all of us who have dealt with this issue have dealt with the stories about people who have needed coverage and have had it denied by their managed care plans. Those are not just horror stories, they are horrible stories. Tales of human misery, of pain, of loss of babies, loss of limbs; that should not happen. Under our bill and only under our bill those stories would not have happened and will not happen in the future.

That is what this debate today is about, that is what this bill is about. It should not be about politics, it should not be about an issue for November; it should be about helping the people to get the care that they need when their physician recommends it. That is why I rise in strong support of the Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas, (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, it is ironic that I stand here and know so well that every taxpaying American has paid for much of the research that persons now are denied the result of.

I wish this was not such a partisan area, because we are dealing with the most basic need and right of the American people, and that is health care. No insurance company has the right to only insure young, healthy people.

I have heard all kinds of rhetoric about the bureaucracy. The bureaucracy rests with the insurance companies who are doing everything they can to deny care so that health care premiums can be used as cash cows. That is most unfortunate. Can we imagine someone who goes to an emergency room, very ill, very confused and frightened, and then be told they have to wait to get permission to take care of them. That is where we are today.

I do not understand, frankly, how we can become so committed to an industry, the insurance industry, that we forget that we are here to protect people.

Mr. Speaker, I rise against this rule because I do not want it to continue to gag physicians who have been educated and trained to take care of patients. I do not want to support a system that only makes money for the insurance companies. It has been never intended that health care services be cash cows for insurance companies.

This is a terrible rule. I hope we all understand that the people are crying out for help. They do not mean help the insurance companies. They want help themselves.

We owe it to the American people to offer them this protection. We have failed to do it with this Republican plan, and I rise against this rule and ask everyone to vote against it until we can produce a decent plan.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume to say to the gentlewoman that I hope she will be relieved to find when she reads our bill that we have, in fact, removed the gag order.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. PAUL).

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

I rise in support of the rule. Under the circumstances, the rule is very fair. It offers an opportunity for our side to vote for the Patient Protection Act as well as a vote for the opposition. I think that is quite fair, so I strongly support the rule.

I would like to call to the attention of my colleagues one particular part of our bill that I think is very important and addresses a problem I see as being very serious.

In 1996, the Kennedy-Kassebaum bill allowed for a national identifier and a national data bank to control all our medical records at a national level. This is very dangerous. In a bill that is called the Patient Protection Act, obviously the best thing we can do is protect patient privacy. If we do not, we interfere with the doctor-patient relationship, and this is a disaster.

This whole concept of a national identifier—the administration is already working to establish this—is dangerous and we must do whatever is possible to stop it.

I compliment the authors of this bill to prohibit this national medical data bank.

Mr. FROST. Mr. Speaker, I would inquire about the time remaining.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Texas has 11 minutes remaining and the gentleman from Florida has 10 minutes remaining.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. TRAFICANT).

Mr. TRAFICANT. Mr. Speaker, I support the rule; I also support the Democrat substitute, and if it fails, I will support the Republican bill. Both bills are better than the current system, and the need for reform is greater than Democrat and Republican posturing.

Doctors should make decisions on our health care, not businessmen. Patients should be able to choose the doctor they want. Insurance companies and business managers without medical degrees should not be delivering our health care system.

Mr. Speaker, I say to my colleagues, this current system is not managed care; this system in America is managed cost. Dollars are all they see, not pain, not disease, not people, not children, not cancer, not cures; they see dollars.

The Congress of the United States is appropriately making necessary changes today, and these business people have to understand that the American people want a doctor, not an accountant, when they have a gall bladder problem, I say to my colleagues. And hospitals should not be throwing them out because of dollar concerns; it should be predicated on sound medical practice.

It is a shame when Congress has to intervene, but America has gone from the Hippocratic oath to hypocrisy in a managed cost health care system.

I will support whatever survives; it is better than the animal that still lives.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Kentucky (Mrs. NORTHUP).

Mrs. NORTHUP. Mr. Speaker, I am glad to be a part of this debate. In my previous life I was part of the Kentucky General Assembly, and while they were altruistic legislators that created the disaster that we had in Kentucky, the fact is that that is exactly what they created, a terrible disaster.

We had what would be proposed today by the Democrats in the term of health care reform, and what it created were enormously escalating prices, prices that escalated so fast that we tried to intervene by capping the prices of our insurance premiums. What did that do? It chased 45 out of 47 of the insurance companies that were selling insurance in Kentucky right out of the State.

So what did our consumers in Kentucky get left with? They got left with higher prices for insurance, they got left with higher copayments, and they got left with fewer choices.

I am so proud to be here today, to be part of an effort to give the American people what they really want. What do they want? They want essential medical services. They want them to be affordable, both the insurance and the copayments, and they want more choices. We are taking a giant step in that direction today.

What we are doing is helping make sure that medical money stays in medicine. The American people resent the fact that they pay for their insurance, that their employer contributes to their insurance, and they make copayments, and a tremendous amount of that money gets diverted to lawyers, to court costs, to liability costs and to administrative costs.

We need to make sure that all the money we spend in medicine, understanding that there is a finite amount of money that gets spent on good health delivery, for patients when they need it.

We need to make sure that we do not create a bill that has so many mandates in it that we begin to say to the American people, you are going to pay more and more because we know what you need and want, not you. I thank the task force for creating this opportunity.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, I thank my friend from Texas for yielding me this time.

Mr. Speaker, this is one of the most important issues that we are going to deal with in this Congress, how we provide patients protection in the health care system of this country. I am outraged, and I hope my colleagues are outraged, by the process that we are using in considering this legislation.

There have been no hearings on the Republican bill. It did not go through any of the committees of jurisdiction for the purpose of markup or to try to get the drafting done correctly, and no wonder that this bill is drafted so poorly. My Republican colleagues did not get it right. It is not going to do what they are advertising.

Let me just give one example. H.R. 815, which I introduced many, many months ago, deals with access to emergency care. We have 240 cosponsors of that legislation that adopts the prudent layperson standard so that an HMO has to reimburse a patient who should go to an emergency room. We passed it last year for Medicare and Medicaid, and yet the Republican bill does not get it right. It does not include pain. So if one has severe pain and reasonably should go to an emergency room, one's HMO can deny coverage. That is wrong. Even the HMOs acknowledge that pain is a reason to go to an emergency room. But my Republican colleagues did not put it in their bill and they did not allow a correction to be made. That is wrong.

Let me give another example. My Republican colleagues brag about an external appeal process, that they are giving the patients the right to take an

appeal, but what they are not saying is they did not get that right. The decision is not binding on the HMO. It is not independent. The HMO gets to select the people that serve on the panel. My Republican colleagues did not get it right.

There is legislation that has been filed that deals with external appeal, but my Republican colleagues did not bother taking it through the committees so that we could have that debate.

I urge my colleagues to adopt the bipartisan bill, which is our only chance today to provide meaningful patient protection.

Mr. GOSS. Mr. Speaker, I thank the distinguished gentleman from Maryland (Mr. CARDIN), my friend, who is indeed my close friend. I did not get it exactly right in describing our bill as the debate will show, but that is why we have the debate.

Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BOEHNER).

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

□ 1000

Mr. BOEHNER. Mr. Speaker, in just 3 years this Congress has delivered the first balanced budget in a generation, the first tax cuts from Washington in 16 years, and real reforms that are improving the lives of many who are on welfare today as they are able to move from welfare to work.

Today we are going to move in a bipartisan fashion to continue to add to our record of success and an opportunity to help the American people.

As I travel around my district, I have had many conversations with my constituents who are concerned about access to good-quality health care. As much as they want access, they are also concerned about making sure that it is affordable.

As I look at the two pieces of legislation that we are going to debate today, it is clear to me that the bill brought to us by the task force, headed by the gentleman from Illinois (Mr. DENNIS HASTERT), is a bill that does that. It empowers consumers, not lawyers. It makes sure that health care continues to be affordable and accessible for all Americans.

I think, in the end, that is what people want. They do not want to go to court. They want to be able to go to the doctor. They want to be able to get the treatments they need. And I think the empowerment that we see in our piece of legislation is exactly that.

The other bill that we will be debating, the proposal by the gentleman from Michigan, in fact creates an awful lot of big government, an awful lot of access to lawsuits and to lawyers and to courts, driving up the cost of health care. My greatest concern about the proposal from the gentleman from Michigan is that, by opening up employers to the lawsuit abuse that could occur, many employers in America are going to say we are not going to be providing health care coverage to our employees anymore.

I know myself, as a small employer, I would not continue to offer health care to my employees if I am subject to being sued by doctors, who may be on solid ground, maybe not. I am going to give them a voucher and let them go fight for their own.

I do not think that is what the American people want. They want reasonable access, reasonable cost to good-quality care.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from North Carolina (Mrs. CLAYTON).

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

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

When a child has a disease that can be cured, should the decision of whether to provide needed treatment be made by a doctor and the child's parents or by bureaucrats who are counting dollars and cents?

When a wife or mother has had a mastectomy and the procedure has not yet worn off, should she be forced to leave the hospital because of a rigid routine for saving dollars rather than saving lives?

When a husband and a father is unable to get prior approval from the insurance who he is paying for an emergency, should he be required to pay that medical bill himself?

When a grandfather is stricken with a life-threatening stroke, should the person transporting him be required to pass a hospital that is closest to him to go to one that is further away because a narrow-thinking person is more interested in saving dollars than, again, in saving lives?

H.R. 3605, which is the Patients' Bill of Rights, the Democrat substitute, indeed speaks to a number of basic rights that all of these patients that I just described should have and not have to suffer. The Republican bill, H.R. 4250, does not.

Many of the patient rights that we are talking about indeed does mean that a patient should have a right to sue. A patient should have a right to indeed hold us accountable for our liabilities and our rights. The patient should have a right to choose their doctor. A patient should have a right to choose other professionals that they desire.

H.R. 3605 does provide open communication. Although those on the other side say the gag clause is in there, I cannot find it. So I urge my colleagues to support the Patients' Bill of Rights, the Democratic substitute.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. WELDON), my colleague.

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding me this time.

As a physician who still practices medicine, I rise in strong support of this rule. I have worked in managed-care settings and I have worked in fee-for-service settings. The important issue here is can we, in Washington, pass legislation that will help restore the doctor-patient relationship and, importantly, help restore quality health care within managed-care networks?

Now, my good friends on the Democrat side of the aisle have their bill; we have our bill. We are going to have a very interesting debate here this morning. I think the important issue, which speaks of how much better our Republican bill is, is the fact our bill is the bill that is not going to drive up costs, where the Democrat bill will; and, importantly, our bill is going to enable people who are uninsured to have access to health care and help them to more easily afford health care.

I would encourage all my colleagues to support this rule. Listen to the debate during general debate and the debate on the amendments and, in the end, I believe our bill is going to pass. Our bill is the better bill for restoring quality, for restoring the doctor-patient relationship, for reducing cost and giving the uninsured better access to health care.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. TURNER).

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

Mr. TURNER. Mr. Speaker, it has been suggested that the Republican bill is better, a better protection for patients. I submit to my colleagues that the Republican bill is worse protection for patients than exists in current law in most of our States.

I come from Texas. The Texas legislature passed patient protection legislation in 1977, fully intending that all HMOs be covered by the protections of State law.

The Republicans submit a bill today that would control patient protections at the Federal level. It would set out a set of rules that are far inferior to those in the Democratic alternative.

On the Republican bill, if the HMO denied coverage, the only remedy would be to go, if an individual is in a self-insured plan, to Federal Court. And when that individual gets there, they will not have a remedy.

In 1971, Phyllis Cannon was diagnosed with leukemia. She appealed to her HMO for a bone marrow transplant. The HMO refused. For over 40 days the HMO refused coverage. About a month after that, she died.

The court ruled that, under ERISA, she had no recovery. Under the Republican bill today, she would be entitled, her estate, to $20,000, a small price for a life, the denial of treatment. Under the Republican bill, the penalty is $500 a day. A much cheaper alternative for an HMO than providing the treatment that should have been provided to Phyllis Cannon.

I submit to my colleagues that every Member of this House needs to look at

what their State has done to protect patients, because a vote for the Republican bill is rolling back the protections that most of our States have already provided for patients under the law. In every place in this country, protecting patients enrolled in HMOs has been a bipartisan effort. Only in Washington is patient protection partisan.

Mr. GOSS. Mr. Speaker, may I ask for an accounting of the times again?

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Florida (Mr. GOSS) has 6 minutes remaining and the gentleman from Texas (Mr. FROST) has 3 minutes remaining.

Mr. GOSS. Mr. Speaker, I yield 3 minutes to the gentlewoman from Ohio (Ms. PRYCE), who is also a member of the task force as well as a member of leadership.

Ms. PRYCE of Ohio. Mr. Speaker, I thank my friend for yielding me this time, and I rise in strong support of this rule. And as a member of the working group on health care quality, I first want to thank our chairman, the gentleman from Illinois (Mr. DENNY HASTERT), for his patience and expertise and many hours of hard work that got us here today.

Mr. Speaker, the Patient Protection Act is the only managed care reform bill that goes beyond patient protection to address the issues of access and affordability of health care. Not only does this bill ban gag rules, provide emergency room access, and guaranty a choice of provider, it increases the number of people with insurance. It does that by helping small employers purchase affordable health benefits for their employees.

Now, it is nice to talk about quality. We all want the best health care we can get. But A-plus care does not help if we cannot afford to buy it. The Democrat proposal would price many, many people out of the market. We all know that more requirements, regulations, and government is not going to make insurance any cheaper. Rest assured, more government largess is just what we will get with the Democrat health bill.

Now, liability has become the rallying cry for the opponents of the Patient Protection Act. And the health care working group discussed this issue at length and came to some very rational conclusions. As a former judge, I think the solution we provide meets every legitimate goal of liability reform. The bottom line is that Americans pay a pretty sum for their health insurance and they expect it to cover the health care that they need when they need it. That is the crux of this debate.

Patients do not want bureaucrats denying their access to care; and when a claim is denied, patients want a quick remedy that relies on the opinion of a medical professional. But my Democratic colleagues would tell these dissatisfied patients that they must hire a lawyer and they send them off to court.

Mr. Speaker, what the Democrats fail to understand is that patients do not want a lawyer, a court date and expensive litigation. They want a doctor, a diagnosis, and treatment their doctor tells them that they need.

The Republican bill will get them that care by guaranteeing patient access to expedited review by independent medical experts. The Republican plan keeps patients out of court and in the health care system, and it requires the health plans to provide the coverage that they are promised.

The expedited appeals process in the Patient Protection Act gives patients the leverage they need to quickly get the care they deserve without going to court and waiting through years and years of litigation. I urge my colleagues to support patients, not lawyers' paychecks, and vote for this rule and the Republican Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, this is the real face of health care in America: A young boy who had a difficult birth and developed cerebral palsy. And at age 14 months the bureaucrats from the HMOs, the ones who are there just to ensure that those who need care do not get care, denied this young boy speech therapy and other kinds of therapies that he needed to have a better life.

Americans know the real deal. They understand what it means as they travel around this summer on vacation and something tragic happens and they go to an emergency room away from their State and that emergency room, because the HMO says they cannot come in, sends them away. They understand when a little one falls from a tree playing in the back yard and has pain; and the emergency room, because of the HMO, says no because all they have is pain as evidence of their injury and the HMO says pain is not enough.

I would say to my colleagues, Mr. Speaker, the real Bill of Rights is that of the Democrats, and that is what we need to support today. It is bipartisan, it is for real, it will the right health care coverage and the American people know the real thing.

Mr. FROST. Mr. Speaker, I yield the balance of my time to the gentleman from Maryland (Mr. HOYER).

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

Mr. HOYER. Mr. Speaker, the gentlewoman from Ohio (Ms. PRYCE) said what the Democrats know. Let me tell my colleagues what the Democrats know. When people commit wrongs, they do not want to be held accountable, and the Republicans are making sure that is true.

I rise today in opposition to H.R. 4250, the bill that my friends on the other side of the aisle claim reforms managed care. The previous speaker, the chairman of their conference, said what the Republican Congress had brought as it pertains to a balanced budget. We will argue that some other time. The fact is, this Congress has not brought hardly anything to the American public.

□ 1015

It is the do-nothing Congress.

This bill is on the floor today because a discharge petition was signed by the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) and about 190 others of us, and says, we want a health care reform bill on this floor. That is the reason it is here and the only reason we are here today.

I rise in strong support of the substitute offered by the gentleman from Iowa (Mr. GANSKE), a Republican and a doctor, and the gentleman from Michigan (Mr. DINGELL), the former Chairman of the Committee on Commerce, now Ranking Member, and the next Chairman of the Committee on Commerce.

The Republicans have chosen to support H.R. 4250, the so-called ''Patient Protection Act.'' They bring this bill to the floor today with no hearings, no mark-ups, and no CBO estimate. In other words, they were so panicked by the discharge petition, that they brought it to the floor without the regular process.

Mr. Speaker, the American public wants access to health care. The American public wants decisions made by their doctors and by themselves, not by, as all of us have said, insurance companies. They are right. But the American public will not be fooled as to which alternative gives them protection, as to which bill gives them access, and as to which bill allows them to hold accountable those who undercut their health care protection.

My colleagues, I ask you to support the Democratic substitute, the Republican substitute, supported by Members on the other side of the aisle, the Ganske-Dingell substitute, supported by Members on the other side of the aisle, which does in fact do what everybody says they want to do.

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

Mr. Speaker, this debate has been on the rule. Very clearly, we have not heard much concern about the rule, with some question about sensitivity by one speaker. But I do believe we have got a better process here than a discharge petition. And I think we will have a fair, longer, more extensive, complete, and deliberative debate at a result of this rule. And I do urge that everybody support it. I honestly do not think it is controversial in any way.

What we are doing today is responding to the call of all American people for improvements in our health care system but particularly for those who have no health care insurance. We are

not responding to the interests of any special groups or any special parties. And there are plenty of those who are asking for special attention. I think we have responded to America, to the people of America, who need health care.

We are doing this in the same spirit that we resolved the job lock and portability problems, the preexisting condition problems. We are doing this in same way that made the trust fund whole in Medicare. We are addressing the problems in our country in health care and we are doing it responsibly.

There has been a lot said and there will be a lot more said, and there clearly is much misinformation. I even read some misinformation in the Washington Post this morning, which has obviously misled some of the speakers who have addressed this during this rule.

It is very clear that we have made a good bill, and it is very clear that not everybody understands it yet. It is also very clear that the Patient Protection Act does not have any big brother in it. There is no big brother in our bill. In fact, we put a halt to the big brother ID system that has been recently discussed and that so many Americans find extremely distasteful and an invasion of their privacy.

I think that many portions of the legislation that we have, as virtually everybody knows that is tuned into this, have already been through appropriate committees and they have been I think well put together and much debated.

I think the critical point probably is that what we have done in this bill is cut into the 42 million Americans, that big pool of people who do not have health care insurance, and given them the opportunity to get it.

The bill on the other side, the Dingell-Kennedy bill, adds, according to CBO, to the pool of Americans who will not have health care insurance. That is simply unacceptable. Accessibility to health care insurance is critical.

I want to close on a note that many will recognize. My wife and I experienced something this year that every parent dreads, a seriously sick youngster coming in and asking for health care and the plan that that child was under could not perform. I personally got involved with why and what went wrong.

So when I speak to my colleagues to say that I think we have a fix in the patient protection care, I speak to them as a parent, not as a legislator. I assure my colleagues, I would not be supporting this legislation if I did not think my sick youngster would be better off under this plan.

I urge support of this rule.

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

The previous question was ordered.

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

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

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

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

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 279, nays 143, not voting 12, as follows:

[Roll No. 335]

YEAS—279

Aderholt
Archer
Armey
Bachus
Baesler
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bono
Boswell
Boyd
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Chabot
Chambliss
Christensen
Clayton
Clement
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Cramer
Crane
Crapo
Cubin
Cummings
Cunningham
Danner
Davis (VA)
Deal
DeGette
Delahunt
DeLay
Diaz-Balart
Dickey
Dingell
Doyle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Etheridge
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Fox
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Greenwood
Gutknecht
Hall (TX)
Hamilton
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Hefner
Hill
Hilleary
Hobson
Hoekstra
Holden
Hooley
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Jackson-Lee (TX)
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kanjorski
Kasich
Kelly
Kennedy (MA)
Kennelly
Kildee
Kilpatrick
Kim
Kind (WI)
King (NY)
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Lucas
Manton
Manzullo
Mascara
McCarthy (MO)
McCarthy (NY)
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McIntyre
McKeon
Metcalf
Mica
Millender-McDonald
Miller (FL)
Mollohan
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Obey
Ortiz
Oxley
Packard
Pallone
Pappas
Parker
Pascrell
Pastor
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Redmond
Regula
Riggs
Riley
Rivers
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Royce
Ryun
Salmon
Sanford
Sawyer
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherman
Shimkus
Shuster
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Adam
Smith, Linda
Snowbarger
Snyder
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Traficant
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Wexler
Weygand
White
Whitfield
Wicker
Wilson
Wise
Wolf

NAYS—143

Abercrombie
Ackerman
Allen
Andrews
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bishop
Blagojevich
Bonior
Borski
Boucher
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Carson
Castle
Clay
Clyburn
Condit
Conyers
Costello
Coyne
Davis (FL)
Davis (IL)
DeFazio
DeLauro
Deutsch
Dicks
Dixon
Doggett
Dooley
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Filner
Forbes
Frank (MA)
Furse
Gejdenson
Gephardt
Green
Hall (OH)
Harman
Hastings (FL)
Hilliard
Hinchey
Hinojosa
Hoyer
Istook
Jackson (IL)
John
Johnson (WI)
Johnson, E.B.
Kaptur
Kennedy (RI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Lee
Levin
Lewis (GA)
Lowey
Luther
Maloney (CT)
Maloney (NY)
Martinez
Matsui
McDermott
McGovern
McHale
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Miller (CA)
Minge
Mink
Moakley
Nadler
Neal
Oberstar
Olver
Owens
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rangel
Reyes
Rodriguez
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Schumer
Scott
Serrano
Sisisky
Skaggs
Slaughter
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Thompson
Thurman
Tierney
Towns
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Woolsey
Wynn

NOT VOTING—12

Chenoweth
Doolittle
Ford
Gonzalez
Gutierrez
Herger
Jefferson
Markey
Torres
Yates
Young (AK)
Young (FL)

☐ 1040

Mr. RANGEL and Mr. MENENDEZ changed their vote from ''yea'' to ''nay.''

Ms. LOFGREN, Mrs. MCCARTHY of New York, Mr. BILIRAKIS and Mr. CRAMER changed their vote from ''nay'' to ''yea.''

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. HASTERT. Mr. Speaker, pursuant to House Resolution 509, I call up the bill (H.R. 4250) to provide new patient protections under group health plans, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. KOLBE). The bill is considered read for amendment.

The text of H.R. 4250 is as follows:

H.R. 4250

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—The Act may be cited as the ''Patient Protection Act of 1998''.

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

Sec. 1. Short title and table of contents.

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

Subtitle A—Patient Protections.

Sec. 1001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 1101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 1102. Effective date.

Subtitle C—New Procedures and Access to Courts for Grievances Arising under Group Health Plans

Sec. 1201. Special rules for group health plans.

Sec. 1202. Effective date.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

Sec. 1301. Short title of subtitle.

Sec. 1302. Rules governing association health plans.

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.

''Sec. 802. Certification of association health plans.

''Sec. 803. Requirements relating to sponsors and boards of trustees.

''Sec. 804. Participation and coverage requirements.

''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

''Sec. 807. Requirements for application and related requirements.

''Sec. 808. Notice requirements for voluntary termination.

''Sec. 809. Corrective actions and mandatory termination.

''Sec. 810. Trusteeship by the secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

''Sec. 811. State assessment authority.

''Sec. 812. Special rules for church plans.

''Sec. 813. Definitions and rules of construction.

Sec. 1303. Clarification of treatment of single employer arrangements.

Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.

Sec. 1305. Enforcement provisions relating to association health plans.

Sec. 1306. Cooperation between Federal and State authorities.

Sec. 1307. Effective date and transitional and other rules.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

Subtitle B—Patient Access to Information

Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 2102. Reporting on fraud and abuse enforcement activities.

Sec. 2103. Effective date.

Subtitle C—HealthMarts

Sec. 2201. Short title of subtitle.

Sec. 2202. Expansion of consumer choice through HealthMarts.

''TITLE XXVIII—HEALTHMARTS

''Sec. 2801. Definition of HealthMart.

''Sec. 2802. Application of certain laws and requirements.

''Sec. 2803. Administration.

''Sec. 2804. Definitions.

SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

Sec. 2301. Promotion of provision of insurance by community health organizations.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 3002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 3102. Reporting on fraud and abuse enforcement activities.

Sec. 3103. Effective date.

Subtitle C—Medical Savings Accounts

Sec. 3201. Expansion of availability of medical savings accounts.

Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 4001. Federal reform of health care liability actions.

Sec. 4002. Definitions.

Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 4011. Statute of limitations.

Sec. 4012. Calculation and payment of damages.

Sec. 4013. Alternative dispute resolution.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

Sec. 5001. Confidentiality of protected health information.

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''Sec. 1181. Inspection and copying of protected health information.

''Sec. 1182. Supplementation of protected health information.

''Sec. 1183. Notice of confidentiality practices.

''Sec. 1184. Establishment of safeguards.

''Sec. 1185. Availability of protected health information for purposes of health care operations.

''Sec. 1186. Relationship to other laws.

''Sec. 1187. Civil penalties.

''Sec. 1188. Definitions.

Sec. 5002. Study and report on effect of State law on health-related research.

Sec. 5003. Study and report on State law on protected health information.

Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

Sec. 6001. Medical savings accounts for Federal employees.

Sec. 6002. Effective date.

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

Subtitle A—Patient Protections

SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, AND PEDIATRIC CARE.

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

''SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

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

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

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

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)), except for items or services specifically excluded—

''(A) the plan or issuer shall provide benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I).

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

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

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

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

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

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

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

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

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

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

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

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

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

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

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

''Sec. 713. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.''.

SEC. 1002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 713 of the Employee Retirement Income Security Act of 1974 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

(d) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, section 2101, and subtitle A of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(e) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers religious nonmedical providers,

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers,

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers,

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers, or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider, or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

Subtitle B—Patient Access to Information

SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

''DISCLOSURE BY GROUP HEALTH PLANS

''SEC. 111. (a) DISCLOSURE REQUIREMENT.—

''(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

''(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b), including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any

health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.

''(h) DEFINITIONS.—For purposes of this section—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 503(b)(6).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by striking ''section 733(a)(1)'' each place it appears and inserting ''section 503(b)(6)''; and

(B) by inserting before the period at the end the following: ''; and, in the case of a group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a)''.

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

''Sec. 111. Disclosure by group health plans.
''Sec. 112. Repeal and effective date.''.

SEC. 1102. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, subtitle B of title II, and subtitle B of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

Subtitle C—New Procedures and Access to Courts for Grievances Arising Under Group Health Plans

SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.'';

(2) by inserting ''(other than a group health plan)'' after ''employee benefit plan''; and

(3) by adding at the end the following new subsection:

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

''(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the participant,

''(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision,

''(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named fiduciary who did not make the initial decision, and

''(D) meet the additional requirements of this subsection.

''(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

''(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

''(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (9)(J) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT AND EMERGENCY MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

''(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including

issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

''(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

''(i) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

''(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

''(I) does not meet the plan's requirements for medical appropriateness or necessity, or

''(II) would constitute experimental treatment or technology.

''(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

''(i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or

''(ii) $25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (C)(iii) is to reverse or modify the coverage decision.

''(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

''(i) one or more independent medical experts will be selected in accordance with subparagraph (E) to review the coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title,

''(ii) the record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record,

''(iii) such expert or experts will report in writing to the plan their recommendation, based on the determination made under clause (i), as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the recommendation, and

''(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

''(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

''(E) INDEPENDENT MEDICAL EXPERTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

''(I) who is a physician or, if appropriate, another medical professional,

''(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

''(III) who was not involved in the initial decision or any earlier review thereof, and

''(IV) who is selected in accordance with clause (ii) and meets the requirements of clause (iii).

''(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

''(I) the expert is selected by an intermediary which itself meets the requirements of clause (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert,

''(II) the expert is selected, by an appropriately credentialed panel of physicians meeting the requirements of clause (iii) established by a fully accredited teaching hospital meeting such requirements,

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of clause (iii),

''(IV) the expert is selected by an external review organization which meets the requirements of clause (iii) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary, or

''(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (iii).

''(iii) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in clause (ii) meets the independence requirements of this clause if—

''(I) the expert or entity is not affiliated with any related party,

''(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity,

''(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review, and

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

''(iv) RELATED PARTY.—For purposes of clause (ii)(I), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(III) the institution at which the medical care involved in the coverage decision is provided,

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

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

''(v) AFFILIATED.—For purposes of clause (iii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(F) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED

FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to review under this paragraph, unless such determination is found in such decision to be based solely on the fact that the item or service—

''(i) does not meet the plan's requirements for medical appropriateness or necessity, or

''(ii) would constitute experimental treatment or technology (as defined under the plan).

''(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

''(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

''(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries, or

''(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of any alternative dispute resolution procedure,

''(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure,

''(iii) any applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures), is incorporated in such alternative dispute resolution procedure, and

''(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

''(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

''(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

''(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations, and

''(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

''(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.— In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term 'specialist' means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

''(8) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

''(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

''(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

''(9) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after such medical care has been provided.

''(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

''(C) ADVANCE DETERMINATION OF COVERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

''(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before such medical care is provided.

''(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

''(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either—

''(i) the imminent death of the participant or beneficiary, or

''(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant or beneficiary.

''(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

''(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

''(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(II) serious impairment to bodily functions, or

''(III) serious dysfunction of any bodily organ or part,

or

''(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

''(J) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(K) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(L) URGENT DECISION PERIOD.—The term 'urgent decision period' means a period of 10 days, or such longer period as may be prescribed in regulations of the Secretary.

''(M) EMERGENCY DECISION PERIOD.—The term 'emergency decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(N) SPECIALTY DECISION PERIOD.—The term 'specialty decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(O) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

''(i) in the case of a decision involving urgent medical care, such term means the urgent decision period, and

''(ii) in the case of a decision involving emergency medical care, such term means the emergency decision period.

''(P) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in

such other reasonable form as may be specified by the plan) to make an initial coverage decision.

''(Q) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

''(R) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

''(S) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

''(T) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

''(U) WRITTEN OR IN WRITING.—

''(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

''(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.''.

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A)(i) In any case in which—

''(I) a benefit under a group health plan (as defined in section 503(b)(8)) is not timely provided to a participant or beneficiary pursuant to a final decision of the plan which was not in accordance with the terms of the plan or this title, and

''(II) such final decision of the plan is contrary to a recommendation described in section 503(b)(4)(C)(iii),

any person acting in the capacity of a fiduciary of such plan so as to cause such failure may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

''(ii) Such civil penalty shall be in the amount of up to $250 a day from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed $100,000.

''(B) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan (as defined in section 503(b)(8)) in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act, and

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

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

''(C)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fidicuary of one or more group health plans (as defined in section 503(b)(8)) for—

''(I) any pattern or practice of repeated adverse coverage decisions in violation of the terms of the plan or plans or this title, or

''(II) any pattern or practice of repeated violations of the requirements of section 503 with respect to such plan or plans.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

''(ii) Such penalty shall be in an amount not to exceed the lesser of—

''(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice, or

''(II) $100,000.

''(iii) Any person acting in the capacity of a fiduciary of a group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, and may be precluded from returning to any such position or involvement for a period determined by the court.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking ''(6)'' and inserting ''(7)''.

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking ''or'' at the end;

(2) in subsection (a)(9), by striking the period and inserting ''; or'';

(3) by adding at the end of subsection (a) the following new paragraph:

''(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).''.

(4) by adding at the end of subsection (b) the following new paragraph:

''(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.''.

(d) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(e) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking ''under subsection (a)(1)(B) of this section'' and inserting ''under subsection (a)(1)(A) for relief under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)''; and

(2) in the last sentence, by striking ''of actions under paragraphs (1)(B) and (7) of subsection (a) of this section'' and inserting ''of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)''.

SEC. 1202. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

SEC. 1301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Small Business Affordable Health Coverage Act of 1998''.

SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

''(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

''(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for

periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

''(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the applicable authority shall certify an association health plan as meeting the requirements of this part only if the applicable authority is satisfied that—

''(1) such certification—

''(A) is administratively feasible,

''(B) is not adverse to the interests of the individuals covered under the plan, and

''(C) is protective of the rights and benefits of the individuals covered under the plan, and

''(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part, including requirements relating to commencement of new benefit options by plans which do not consist of health insurance coverage.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

''(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

''(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(B) LIMITATION.—

''(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

''(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

''(2) the requirements of section 804(a)(1) shall be deemed met.

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

''(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

''(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

''(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

''(C) the requirements of section 804 shall be deemed met.

''(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

''(A) the plan is a multiemployer plan, or

''(B) the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

''(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—

''(1) IN GENERAL.—Subject to paragraph (2), the requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer, unless—

''(A) the affiliated member was an affiliated member on the date of certification under this part, or

''(B) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(2) LIMITATION.—The requirements of this subsection shall apply only in the case of plans which were in existence on the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating

employer, unless participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer,

''(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

''(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from

''(i) setting contribution rates based on the claims experience of the plan, or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market,

subject to the requirements of section 702(b) relating to contribution rates.

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority may prescribe by regulation as necessary to carry out the purposes of this part.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

''SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage, or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions,

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

''(iii) a reserve sufficient for any other obligations of the plan, and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan,

and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than $200,000). The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to $2,000,000, reduced in accordance with a scale, prescribed in regulations of the applicable authority to an amount not less than $500,000, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

''(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

''(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS STOP/LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is,

or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2), or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means , in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

''(1) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination),

''(2) which is guaranteed renewable and noncancellable for any reason (except as may be provided in regulations of the applicable authority), and

''(3) which allows for payment of premiums by any third party on behalf of the insured plan.

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as may be prescribed in regulations of the applicable authority.

''(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED RULEMAKING.—The regulations under this section shall be prescribed under negotiated rulemaking in accordance with subchapter III of chapter 5 of title 5, United States Code, except that, in establishing the negotiated rulemaking committee for purposes of such rulemaking, the applicable authority shall include among persons invited to membership on the committee at least one of each of the following:

''(1) a representative of the National Association of Insurance Commissioners,

''(2) a representative of the American Academy of Actuaries,

''(3) a representative of the State governments, or their interests,

''(4) a representative of existing self-insured arrangements, or their interests,

''(5) a representative of associations of the type referred to in section 801(b)(1), or their interests, and

''(6) a representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the applicable authority, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor, and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the applicable authority as necessary to carry out the purposes of this part.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the applicable authority. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority).

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association

health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

''(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the applicable authority.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

''(7) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

''(8) to terminate the plan (or provide for its termination accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship,

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options, and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator,

''(2) each participant,

''(3) each participating employer, and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations of the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the

date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals,

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

''(3) such tax is otherwise nondiscriminatory, and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

''SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

''(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

''(b) EFFECT OF ELECTION.—

''(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

''(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

''(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) STATE LAW.—The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

''(B) STATE.—The term 'State' includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

''(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

''(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

''(A) for the exclusive purpose of:

''(i) providing benefits to participants and their beneficiaries; and

''(ii) defraying reasonable expenses of administering the plan;

''(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

''(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

''(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

''(A) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

''(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

''(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

''(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

''(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

''(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

''(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

''(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

''(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

''(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

''(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

''(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

''SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

''(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan, or

''(ii) if there if no State referred to in clause (i), the Secretary.

''(B) EXCEPTIONS.—

''(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

''(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i),

section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section (3)(6)) includes any partner in relation to the partnership, and

''(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

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

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Patient Protection Act of 1998 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''Sec. 807. Requirements for application and related requirements.
''Sec. 808. Notice requirements for voluntary termination.

''Sec. 809. Corrective actions and mandatory termination.
''Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
''Sec. 811. State assessment authority.
''Sec. 812. Special rules for church plans.
''Sec. 813. Definitions and rules of construction.''.

SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement;'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

''(ii)(I) the plan or arrangement is a multiemployer plan; and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998, or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

''(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8,

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8, or

''(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

''(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 1302, 1305, and 1306 shall take effect on January 1, 2000. The amendments made by sections 1303 and 1304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act before January 1, 2000.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 1302) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on April 1, 1997, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act,

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement,

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote, and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement,

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement,

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan,'' ''medical care,'' and ''participating employer'' shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

(d) PILOT PROGRAM FOR SELF-INSURED ASSOCIATION HEALTH PLANS.—

(1) IN GENERAL.—During the pilot program period, association health plans which offer benefit options which do not consist of health insurance coverage may be certified under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 only if such plans consist of the following:

(A) plans which offered such coverage on the date of the enactment of this Act,

(B) plans under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(C) plans whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plans in accordance with regulations which the Secretary shall prescribe, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

(2) PILOT PROGRAM PERIOD.—For purposes of this subsection, the term ''pilot program period'' means the 5-year period beginning on January 1, 1999.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

''SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

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

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

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

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan or issuer shall provide benefits, without requiring preauthorization, for

appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

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

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

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

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

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

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

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

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

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

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

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

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

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

(c) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall first issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(2) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this paragraph, any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

''SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

''(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

''(1) is a health maintenance organization (as defined in section 2791(b)(3)), and

''(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

''(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

''(c) EXCEPTIONS.—

''(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

''(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

''(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

''(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization, and

''(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently that once every two years.

''(4) INCREASED COSTS.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the

class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently that once every two years. This paragraph shall be applied on an average per enrollee or similar basis.

''(5) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

''(d) DEFINITIONS.—For purposes of this section:

''(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' has the meaning given such term in section 2706(a)(2).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage offered on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subtitle B—Patient Access to Information

SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

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

''SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage for the relevant coverage terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted in connection with such coverage pursuant to section 503(b) of the Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications, and

''(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or

programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

SEC. 2102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys–with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to such guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on Commerce of the House of Representatives not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 2103. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

Subtitle C—HealthMarts

SEC. 2201. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Health Care Consumer Empowerment Act of 1998''.

SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—HEALTHMARTS

''SEC. 2801. DEFINITION OF HEALTHMART.

''(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

''(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of representatives of not fewer than 2 and in equal numbers from each of the following:

''(A) Small employers.

''(B) Employees of small employers.

''(C) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

''(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

''(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

''(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

''(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

''(3) GEOGRAPHIC AREAS.—

''(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

''(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

''(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this

title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

''(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

''(6) FILING INFORMATION.—The HealthMart—

''(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

''(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health insurance coverage pursuant to section 330B(a)),

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b), and

''(iii) offers the coverage under a contract with the HealthMart;

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

''(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

''(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

''(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

''(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

''(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

''(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

''(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

''(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

''(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

''(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

''(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

''(A) Coverage through a health maintenance organization.

''(B) Coverage in connection with a preferred provider organization.

''(C) Coverage in connection with a licensed provider-sponsored organization.

''(D) Indemnity coverage through an insurance company.

''(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

''(F) Coverage that includes a point-of-service option.

''(G) Coverage offered by a community health organization (as defined in section 330B(e)).

''(H) Any combination of such types of coverage.

''(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

''(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) PURCHASERS.—

''(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

''(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

''(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

''(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

''(2) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

''(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

''(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

''(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

''(3) HEALTH INSURANCE ISSUERS.—

''(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a

member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

''(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

''(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

''(d) PREVENTION OF CONFLICTS OF INTEREST.—

''(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

''(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

''(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

''(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

''(B) CONSTRUCTION.—For purposes of subparagraph (A), the term ''affiliated'' does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

''(e) CONSTRUCTION.—

''(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

''(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

''(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

''(i) a change of employers through which the coverage is provided, or

''(ii) a change in place of employment to an area not served by the previous HealthMart.

''(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

''(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

''SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

''(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

''(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

''(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

''(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

''(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

''(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

''(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

''(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

''(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

''(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

''(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

''(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

''(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

''(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

''(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

''(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

''SEC. 2803. ADMINISTRATION.

''(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

''(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

''(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title.

''(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

''(A) oversight of the operations of HealthMarts under this title; and

''(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

''(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the

rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

"SEC. 2804. DEFINITIONS.

''For purposes of this title:

''(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services.

''(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

''(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

''(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term group health insurance coverage in section 2791(b)(4).

''(5) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

''(7) HEALTHMART.—The term 'HealthMart' is defined in section 2801(a).

''(8) MEMBER.—The term 'member'' means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

''(9) PURCHASER.—The term 'purchaser' means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

''(10) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term for purposes of title XXVII.''.

Subtitle D—Community Health Organizations

SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public Health Service Act is amended by adding at the end the following new section:

''WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

''SEC. 330B. (a) WAIVER AUTHORIZED.—

''(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

''(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the 'Secretary') by not later than November 1, 2003, and

''(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (A), (B), or (C) of paragraph (2) has been met.

''(2) GROUNDS FOR APPROVAL OF WAIVER.—

''(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

''(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

''(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

''(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

''(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

''(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in paragraph (5).

''(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

''(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

''(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

''(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

''(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

''(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2003.

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization;

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

''(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

''(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

''(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

''(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

''(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

''(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

''(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

''(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

''(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 1999.

''(e) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH ORGANIZATION.—The term 'community health organization ' means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

''(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 2791(b)(1).

''(4) CONTROL.—The term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.''.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

''SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

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

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

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

''(1) IN GENERAL.—To the extent that the group health plan provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan shall provide benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in clause (i) of section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan—

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

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

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

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

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

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

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

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

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

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

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

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

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.''

SEC. 3002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON PENALTY FOR CERTAIN FAILURES.—No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs before the date of issuance of regulations issued in connection with such requirement if the plan has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 9813 of

the Internal Revenue Code of 1986 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

"SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.

''(a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 of Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) contains the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any health insurance issuer offering health insurance coverage in connection with such plan provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the requirements under section 4980B.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b) of Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or a health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any

preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9814. Disclosure by group health plans.''

SEC. 3102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys–with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to that guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on the Judiciary and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 3103. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of the Treasury or the Secretary's delegate shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking ''and such employer is a small employer''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the taxpayer's coverage under the high deductible health plan.''

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (5) of section 220(b) of such Code is amended to read as follows:

''(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999'', and

(B) by striking ''1997'' and inserting ''1998''.

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS ACCOUNTS.—Paragraph (1) of section 220(c) of such Code (defining eligible individual), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULES FOR INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

''(i) IN GENERAL.—Subparagraph (A)(iii) and subsection (b)(4) shall not apply for any month to an individual—

''(I) who, as of the 1st day of such month, is enrolled in a high deductible health plan under chapter 89 of title 5, United States Code, and

''(II) who is entitled to receive for such month any amount by reason of being an annuitant (as defined in section 8901(3) of such title 5).

''(ii) SPECIAL RULE FOR SPOUSE OF ANNUITANT.—In the case of the spouse of an individual described in clause (i) who is not also described in clause (i), subsection (b)(4) shall not apply to such spouse if such individual and spouse have family coverage under the same plan described in clause (i)(I).''

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN CASE OF MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 220(d)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) INSURANCE OFFERED BY COMMUNITY HEALTH CENTERS.—

''(I) IN GENERAL.—Subject to clauses (II) and (III), clause (i) shall not apply to any expense for coverage under insurance offered by a health center (as defined in section 330(a)(1) of the Public Health Service Act) if the coverage consists solely of coverage for required primary health benefits (as defined

in section 330(b)(1)(A) of such Act) provided on a capitated basis.

''(II) INCOME LIMITATION.—Subclause (I) shall only apply to expenses for coverage of an individual who, in the taxable year involved, has income that is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(III) LIMITATION ON NUMBER OF CONTRACTS.—For a taxable year ending in a calendar year, subclause (I) shall apply only to expenses for coverage for the first 15,000 individuals enrolled in insurance described in such subclause in the year.''.

(b) REPORTS ON ENROLLMENT.—Section 330(j)(3) of the Public Health Service Act (42 U.S.C. 254c(j)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (K),

(2) by striking the period at the end of subparagraph (L) and inserting ''; and'', and

(3) by inserting after subparagraph (L) the following new subparagraph:

''(M) if the center offers insurance coverage to an individual with a medical savings account under subclause (I) of section 220(d)(2)(B)(iii), the center shall provide such reports in such time and manner as may be required by the Secretary and the Secretary of the Treasury in order to carry out subclause (III) of such section.''.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4002. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against—

(A) a health care provider,

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter

such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 4003. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court, and

(2) any health care liability claim subject to an alternative dispute resolution system,

that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 4011. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 4012(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(3) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

''SEC. 1181. (a) IN GENERAL.—Subject to the succeeding provisions of this section, upon the request of an individual who is the subject of protected health information, a person who is a health care provider, health plan, employer, health or life insurer, or educational institution shall make available to the individual (or, in the discretion of the person, to a health care provider designated by the individual), for inspection and copying, protected health information concerning the individual that the person maintains, including records created under section 1182.

''(b) ACCESS THROUGH ORIGINATING PROVIDER.—Protected health information that is created by an originating provider, and subsequently received by another health care provider or a health plan as part of treatment or payment activities, shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

''(c) INVESTIGATIONAL INFORMATION.—With respect to protected health information that

was created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established to review health research with respect to potential risks to human subjects pursuant to Federal regulations adopted under section 1802(b) of the Public Health Service Act (42 U.S.C. 300v–1(b)) and the notice (informally referred to as the 'Common Rule') promulgated in the Federal Register at 56 Fed. Reg. 28003), a request under subsection (a) shall be granted only to the extent and in a manner consistent with such regulations.

''(d) OTHER EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, a person to whom a request under subsection (a) is made is not required to grant the request, if—

''(1) the person determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of, or cause substantial harm to, any individual; or

''(2) the information is compiled principally—

''(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

''(B) for use in such action or proceeding.

''(e) DENIAL OF REQUEST FOR INSPECTION OR COPYING.—If a person to whom a request under subsection (a) is made denies a request for inspection or copying pursuant to this section, the person shall inform the individual making the request, in writing, of—

''(1) the reasons for the denial of the request;

''(2) the availability of procedures for further review of the denial; and

''(3) the individual's right to file with the person a concise statement setting forth the request.

''(f) STATEMENT REGARDING REQUEST.—If an individual has filed with a person a statement under subsection (e)(3) with respect to protected health information, the person, in any subsequent disclosure of the information—

''(1) shall include a notation concerning the individual's statement; and

''(2) may include a concise statement of the reasons for denying the request for inspection or copying.

''(g) PROCEDURES.—A person providing access to protected health information for inspection or copying under this section may set forth appropriate procedures to be followed for such inspection or copying and may require an individual to pay reasonable costs associated with such inspection or copying.

''(h) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A person to whom a request under subsection (a) is made shall permit the inspection and copying of any reasonably segregable portion of a record after deletion of any portion that the person is not required to disclose under this section.

''(i) DEADLINE.—A person described in subsection (a) shall comply with or deny, in accordance with this section, a request for inspection or copying of protected health information under this section not later than 30 days after the date on which the person receives the request.

''(j) RULES GOVERNING AGENTS.—An agent of a person described in subsection (a) shall not be required to provide for the inspection and copying of protected health information, except where—

''(1) the protected health information is retained by the agent; and

''(2) the agent has been asked by the person to fulfill the requirements of this section.

''SUPPLEMENTATION OF PROTECTED HEALTH INFORMATION

''SEC. 1182. (a) IN GENERAL.—Subject to subsection (b), not later than 45 days after the date on which a person who is a health care provider, health plan, employer, health or life insurer, or educational institution receives, from an individual who is a subject of protected health information that is maintained by the person, a request in writing to amend the information by adding a concise written supplement to it, the person—

''(1) shall make the amendment requested;

''(2) shall inform the individual of the amendment that has been made; and

''(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person's last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

''(b) REFUSAL TO AMEND.—If a person described in subsection (a) refuses to make an amendment requested by an individual under such subsection, the person shall inform the individual, in writing, of—

''(1) the reasons for the refusal to make the amendment;

''(2) any procedures for further review of the refusal; and

''(3) the individual's right to file with the person a concise statement setting forth the requested amendment and the individual's reasons for disagreeing with the refusal.

''(c) STATEMENT OF DISAGREEMENT.—If an individual has filed a statement of disagreement with a person under subsection (b)(3), the person, in any subsequent disclosure of the disputed portion of the information—

''(1) shall include a notation that such individual has filed a statement of disagreement; and

''(2) may include a concise statement of the reasons for not making the requested amendment.

''(d) RULES GOVERNING AGENTS.—The agent of a person described in subsection (a) shall not be required to make amendments to individually identifiable health information, except where—

''(1) the information is retained by the agent; and

''(2) the agent has been asked by such person to fulfill the requirements of this section.

''(e) DUPLICATIVE REQUESTS FOR AMENDMENTS.—If a person described in subsection (a) receives a duplicative request for an amendment of information as provided for in such subsection and a statement of disagreement with respect to the request has been filed pursuant to subsection (c), the person shall inform the individual of such filing and shall not be required to carry out the procedures under this section.

''(f) RULE OF CONSTRUCTION.—This section shall not be construed—

''(1) to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests; or

''(2) to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

''NOTICE OF CONFIDENTIALITY PRACTICES

''SEC. 1183. (a) PREPARATION OF WRITTEN NOTICE.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and in a clear and conspicuous manner, notice of the person's protected health information confidentiality practices. The notice shall include—

''(1) a description of an individual's rights with respect to protected health information;

''(2) the intended uses and disclosures of protected health information;

''(3) the procedures established by the person for the exercise of an individual's rights with respect to protected health information; and

''(4) the procedures established by the person for obtaining copies of the notice.

''(b) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), shall develop and disseminate, not later than 6 months after the date of the enactment of the Patient Protection Act of 1998, model notices of confidentiality practices, for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

''ESTABLISHMENT OF SAFEGUARDS

''SEC. 1184. (a) IN GENERAL.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of protected health information created, received, obtained, maintained, used, transmitted, or disposed of by the person.

''(b) FACTORS TO BE CONSIDERED.—A person subject to subsection (a) shall consider the following factors in establishing safeguards under such subsection:

''(1) The need for protected health information.

''(2) The categories of personnel who will have access to protected health information.

''(3) The feasibility of limiting access to individual identifiers.

''(4) The appropriateness of the policy or procedure to the person, and to the medium in which protected health information is stored and transmitted.

''(5) The value of audit trails in computerized records.

''(c) RELATIONSHIP TO PART C REQUIREMENT.—Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

''(d) CONVERSION TO NONIDENTIFIABLE HEALTH INFORMATION.—A person subject to subsection (a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into nonidentifiable health information.

''AVAILABILITY OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS

''SEC. 1185. DISCLOSURE.—Any person who maintains protected health information may disclose the information to a health care provider or a health plan for the purpose of permitting the provider or plan to conduct health care operations.

''(b) USE.—A health care provider or a health plan that maintains protected health information may use it for the purposes described in subsection (a).

''RELATIONSHIP TO OTHER LAWS

''SEC. 1186. (a) STATE LAW.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the provisions of this part shall preempt a provision of State law to the extent that such provision—

''(A) otherwise would be preempted as inconsistent with this part under article VI of the Constitution of the United States;

''(B) relates to authorization for the use or disclosure of—

''(i) protected health information for health care operations; or

''(ii) nonidentifiable health information; or

''(C) relates to any of the following:

''(i) Inspection or copying of protected health information by a person who is a subject of the information.

''(ii) Amendment of protected health information by a person who is a subject of the information.

''(iii) Notice of confidentiality practices with respect to protected health information.

''(iv) Establishment of safeguards for protected health information.

''(2) EXCEPTIONS.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to protected health information and—

''(A) the confidentiality of the records maintained by a licensed mental health professional;

''(B) the provision of health care to a minor, or the disclosure of information about a minor to a parent or guardian of the minor;

''(C) condition-specific limitations on disclosure;

''(D) the use or disclosure of information for use in legally authorized—

''(i) disease or injury reporting;

''(ii) public health surveillance, investigation, or intervention;

''(iii) vital statistics reporting, such as reporting of birth or death information;

''(iv) reporting of abuse or neglect information;

''(v) reporting of information concerning a communicable disease status; or

''(vi) reporting concerning the safety or effectiveness of a biological product regulated under section 351 of the Public Health Service Act (42 U.S.C. 262) or a drug or device regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.);

''(E) the disclosure to a person by a health care provider of information about an individual, in any case in which the provider has determined—

''(i) in the provider's reasonable medical judgment, that the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of the protected health information; and

''(ii) in the provider's reasonable judgment, that the person is a spouse, relative, guardian, or close friend of the individual's; or

''(F) the use of information by, or the disclosure of information to, a person holding a valid and applicable power of attorney that includes the authority to make health care decisions on behalf of an individual who is a subject of the information.

''(3) PRIVILEGES.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to a privilege of a witness or other person in a court of that State.

''(b) FEDERAL LAW.—Nothing in this part shall be construed to preempt, modify, or repeal a provision of any other Federal law relating to protected health information or relating to an individual's access to protected health information or health care services. Nothing in this part shall be construed to preempt, modify, or repeal a provision of Federal law to the extent that such provision relates to a privilege of a witness or other person in a court of the United States.

''CIVIL PENALTIES

''SEC. 1187. (a) VIOLATION.—A person who the Secretary determines has substantially and materially failed to comply with this part shall be subject, in addition to any other penalties that may be prescribed by law—

''(1) in a case in which the violation relates to section 1181 or 1182, to a civil penalty of not more than $500 for each such violation but not to exceed $5,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year;

''(2) in the case in which the violation relates to section 1183 or 1184, to a civil penalty of not more than $10,000 for each such violation, but not to exceed $50,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year; or

''(3) in a case in which the Secretary finds that such violations have occurred with such frequency as to constitute a general business practice, to a civil penalty of not more than $100,000.

''(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil or monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A.

''DEFINITIONS

''SEC. 1188. As used in this part:

''(1) AGENT.—The term 'agent' means a person, including a contractor, who represents and acts for another under the contract or relation of agency, or whose function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between the principal and a third person.

''(2) CONDITION-SPECIFIC LIMITATIONS ON DISCLOSURE.—The term 'condition-specific limitations on disclosure' means State laws that prohibit the disclosure of protected health information relating to a health condition or disease that has been identified by the Secretary as posing a public health threat.

''(3) DISCLOSE.—The term 'disclose' means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than an individual who is the subject of such information.

''(4) EDUCATIONAL INSTITUTION.—The term 'educational institution' means an institution or place accredited or licensed for purposes of providing for instruction or education, including an elementary school, secondary school, or institution of higher learning, a college, or an assemblage of colleges united under one corporate organization or government.

''(5) 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.

''(6) HEALTH CARE.—The term 'health care' means—

''(A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, service, or procedure—

''(i) with respect to the physical or mental condition of an individual; or

''(ii) affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

''(B) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care-related item to an individual, or for the use of an individual.

''(7) HEALTH CARE OPERATIONS.—The term 'health care operations' means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes:

''(A) Coordinating health care, including health care management of the individual through risk assessment, case management, and disease management.

''(B) Conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion.

''(C) Carrying out utilization review activities, including precertification and preauthorization of services, and health plan rating activities, including underwriting and experience rating.

''(D) Conducting or arranging for auditing services.

''(8) HEALTH CARE PROVIDER.—The term 'health care provider' means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

''(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

''(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

''(C) an officer or employee of a person described in subparagraph (A) or (B).

''(9) HEALTH OR LIFE INSURER.—The term 'health or life insurer' means a health insurance issuer, as defined in section 9832(b)(2) of the Internal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

''(10) HEALTH PLAN.—The term 'health plan' means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d)), or other program providing or arranging for the provision of health benefits.

''(11) HEALTH RESEARCHER.—The term 'health researcher' means a person (or an officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

''(12) NONIDENTIFIABLE HEALTH INFORMATION.—The term 'nonidentifiable health information' means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide a direct means of identifying the individual (such as name, address, and social security number) have been removed, encrypted, or replaced with a code, such that the identity of the individual is not evident without (in the case of encrypted or coded information) use of a key.

''(13) ORIGINATING PROVIDER.—The term 'originating provider', when used with respect to protected health information, means the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

''(14) PAYMENT ACTIVITIES.—The term 'payment activities' means—

''(A) activities undertaken—

''(i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or

''(ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health plan, or provided based on a determination by the health plan of responsibility for coverage under the plan; and

''(B) includes the following activities, when performed in a manner consistent with subparagraph (A):

''(i) Billing, claims management, medical data processing, other administrative services, and actual payment.

''(ii) Determinations of coverage or adjudication of health benefit or subrogation claims.

''(iii) Review of health care services with respect to coverage under a health plan or justification of charges.

''(15) PERSON.—The term 'person' means—

''(A) a natural person;

''(B) a government or governmental subdivision, agency, or authority;

''(C) a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or

''(D) any other legal entity.

''(16) PROTECTED HEALTH INFORMATION.—The term 'protected health information', when used with respect to an individual who is a subject of information means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that—

''(A) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution;

''(B) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components);

''(C) is derived from—

''(i) the provision of health care to an individual; or

''(ii) payment for the provision of health care to an individual; and

''(D) is not nonidentifiable health information.

''(17) STATE.—The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(18) TREATMENT.—The term 'treatment' means the provision of health care by a health care provider.

''(19) WRITING.—The term 'writing' means writing either in a paper-based, computer-based, or electronic form, including electronic signatures.''.

(b) ENFORCEMENT OF PROVISIONS THROUGH CONDITIONS ON PARTICIPATION.—

(1) PARTICIPATING PHYSICIANS AND SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

''(9) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been found to have violated a provision of part D of title XI.''.

(2) MEDICARE+CHOICE ORGANIZATIONS.—Section 1852(h) of the Social Security Act (42 U.S.C. 1395w–22(h)) is amended—

(A) in the matter preceding paragraph (1), by striking ''procedures—'' and inserting ''procedures, consistent with sections 1181 through 1185—''; and

(B) in paragraph (1), by striking ''privacy of any individually identifiable enrollee information;'' and inserting ''confidentiality of protected health information concerning enrollees;''.

(3) MEDICARE PROVIDERS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by inserting a semicolon at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (S) the following new subparagraph:

''(T) to comply with sections 1181 through 1184.''.

(4) HEALTH MAINTENANCE ORGANIZATIONS WITH RISK-SHARING CONTRACTS.—Section 1876(k)(4) of the Social Security Act (42 U.S.C. 1395mm(k)(4)) of the Social Security Act is amended by adding at the end the following:

''(E) The confidentiality and accuracy procedure requirements under section 1852(h).''.

(c) CONFORMING AMENDMENTS.—

(1) TITLE HEADING.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION''.

(2) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k)(5) of the Public Health Service Act (42 U.S.C. 242(k)(5)) is amended—

(A) in subparagraphs (A)(viii) and (D), by striking ''part C'' and inserting ''parts C and D'';

(B) in subparagraph (C), by striking ''and'' at the end;

(C) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(E) shall study the issues relating to section 1184 of the Social Security Act (as added by the Patient Protection Act of 1998), and, not later than 1 year after the date of the enactment of the Patient Protection Act of 1998, shall report to the Congress on such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 1 year after the date of the enactment of this Act, except that subsection (c)(2), and section 1183(b) of the Social Security Act (as added by subsection (a)), shall take effect on the date of the enactment of this Act.

SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW ON HEALTH-RELATED RESEARCH.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study on the effect of State laws on health-related research subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

SEC. 5003. STUDY AND REPORT ON STATE LAW ON PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

(2) analyzing the effect of such laws on the provision of health care and securing payment for such care.

(b) MODIFICATION OF DEADLINE.—Section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) is amended by striking ''36 months after the date of the enactment of this Act,'' and inserting ''6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998,''.

SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

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

(1) The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term ''health care provider'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(5) The term ''State'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

SEC. 6001. MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES.

(a) MEDICAL SAVINGS ACCOUNTS.—

(1) CONTRIBUTIONS.—Title 5, United States Code, is amended by redesignating section 8906a as section 8906c and by inserting after section 8906 the following:

"§ 8906a. Government contributions to medical savings accounts

''(a) An employee or annuitant enrolled in a high deductible health plan is entitled, in addition to the Government contribution under section 8906(b) toward the subscription charge for such plan, to have a Government contribution made, in accordance with succeeding provisions of this section, to a medical savings account of such employee or annuitant.

''(b)(1) The biweekly Government contribution under this section shall, in the case of any such employee or annuitant, be equal to the amount by which—

''(A) the biweekly equivalent of the maximum Government contribution for the contract year involved (as defined by paragraph (2)), exceeds (if at all)

''(B) the amount of the biweekly Government contribution payable on such employee's or annuitant's behalf under section 8906(b) for the period involved.

''(2) For purposes of this section, the term 'maximum Government contribution' means, with respect to a contract year, the maximum Government contribution that could be made for health benefits for an employee or annuitant for such contract year, as determined under section 8906(b) (disregarding paragraph (2) thereof)).

''(3) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee or annuitant for any period—

''(A) if, as of the first day of the month before the month in which such period commences, such employee or annuitant (or the spouse of such employee or annuitant, if coverage is for self and family) is entitled to benefits under part A of title XVIII of the Social Security Act;

''(B) to the extent that such contribution, when added to previous contributions made under this section for that same year with respect to such employee or annuitant, would cause the total to exceed—

''(i) the highest annual limit deductible permitted under clause (i) or (ii) of section 220(c)(2)(A) of the Internal Revenue Code of 1986, as appropriate (determined taking into account any changes in coverage that may occur), for the calendar year in which such period commences; or

''(ii) such lower amount (relative to the limitation that would otherwise apply under clause (i)) as the employee or annuitant may specify in accordance with regulations of the Office, including an election not to receive contributions under this section for a year or the remainder of a year; or

''(C) for which any information (or documentation) under subsection (d) that is needed in order to make such contribution has not been timely submitted.

''(4) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee for any period in a contract year unless that employee was enrolled in a health benefits plan under this chapter as an employee for not less than—

''(A) the 1 year of service immediately before the start of such contract year, or

''(B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management, in which he is eligible to enroll in the plan and the day before the start of such contract year,

whichever is shorter.

''(5) The Office shall provide for the conversion of biweekly rates of contributions specified by paragraph (1) to rates for employees and annuitants whose pay or annuity is provided on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

''(c) A Government contribution under this section—

''(1) shall be made at the same time that, and the same frequency with which, Government contributions under section 8906(b) are made for the benefit of the employee or annuitant involved; and

''(2) shall be payable from the same appropriation, fund, account, or other source as would any Government contributions under section 8906(b) with respect to the employee or annuitant involved.

''(d) The Office shall by regulation prescribe the time, form, and manner in which an employee or annuitant shall submit any information (and supporting documentation) necessary to identify any medical savings account to which contributions under this section are requested to be made.

''(e) Nothing in this section shall be considered to entitle an employee or annuitant to any Government contribution under this section with respect to any period for which such employee or annuitant is ineligible for a Government contribution under section 8906(b).

"§ 8906b. Individual contributions to medical savings accounts

''(a) Upon the written request of an employee or annuitant enrolled in a high deductible health plan, there shall be withheld from the pay or annuity of such employee or annuitant and contributed to the medical savings account identified by such employee or annuitant in accordance with applicable regulations under subsection (c) such amount as the employee or annuitant may specify.

''(b) Notwithstanding subsection (a), no withholding under this section may be made from the pay or annuity of an employee or annuitant for any period—

''(1) if, or to the extent that, a Government contribution for such period under section 8906a would not be allowable by reason of subparagraph (A) or (B)(i) of subsection (b)(3) thereof;

''(2) for which any information (or documentation) that is needed in order to make such contribution has not been timely submitted; or

''(3) if the employee or annuitant submits a request for termination of withholdings, beginning on or after the effective date of the request and before the end of the year.

''(c) The Office of Personnel Management shall prescribe any regulations necessary to carry out this section, including provisions relating to the time, form, and manner in which any request for withholdings under this section may be made, changed, or terminated.''.

(2) RULES OF CONSTRUCTION.—Nothing in this section or in any amendment made by this section shall be considered—

(A) to permit or require that any contributions to a medical savings account (whether by the Government or through withholdings from pay or annuity) be paid into the Employees Health Benefits Fund; or

(B) to affect any authority under section 1005(f) of title 39, United States Code, to vary, add to, or substitute for any provision of chapter 89 of title 5, United States Code, as amended by this section.

(3) CONFORMING AMENDMENTS.—

(A) The table of sections at the beginning of chapter 89 of title 5, United States Code, is amended by striking the item relating to section 8906a and inserting the following:

''8906a. Government contributions to medical savings accounts.

''8906b. Individual contributions to medical savings accounts.

''8906c. Temporary employees.''.

(B) Section 8913(b)(4) of title 5, United States Code, is amended by striking ''8906a(a)'' and inserting ''8906c(a)''.

(b) INFORMATIONAL REQUIREMENTS.—Section 8907 of title 5, United States Code, is amended by adding at the end the following:

''(c) In addition to any information otherwise required under this section, the Office shall make available to all employees and annuitants eligible to enroll in a high deductible health plan, information relating to—

''(1) the conditions under which Government contributions under section 8906a shall be made to a medical savings account;

''(2) the amount of any Government contributions under section 8906a to which an employee or annuitant may be entitled (or how such amount may be ascertained);

''(3) the conditions under which contributions to a medical savings account may be made under section 8906b through withholdings from pay or annuity; and

''(4) any other matter the Office considers appropriate in connection with medical savings accounts.''.

(c) HIGH DEDUCTIBLE HEALTH PLAN AND MEDICAL SAVINGS ACCOUNT DEFINED.—Section 8901 of title 5, United States Code, is amended—

(1) in paragraph (10) by striking ''and'' after the semicolon;

(2) in paragraph (11) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(12) the term 'high deductible health plan' means a plan described by section 8903(5) or section 8903a(d); and

''(13) the term 'medical savings account' has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.''.

(d) AUTHORITY TO CONTRACT FOR HIGH DEDUCTIBLE HEALTH PLANS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

''(p)(1) The Office shall contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan and, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offers a health benefits plan under this chapter.

''(2) The Office may contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan, but does not, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offer a health benefits plan under this chapter.''.

(e) DESCRIPTION OF HIGH DEDUCTIBLE HEALTH PLANS AND BENEFITS TO BE PROVIDED THEREUNDER.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—(A) One or more plans described by paragraph (1), (2), (3), or (4), which—

''(i) are high deductible health plans (as defined by section 220(c)(2) of the Internal Revenue Code of 1986); and

''(ii) provide benefits of the types referred to by section 8904(a)(5).

''(B) Nothing in this section shall be considered—

''(i) to prevent a carrier from simultaneously offering a plan described by subparagraph (A) and a plan described by paragraph (1) or (2); or

''(ii) to require that a high deductible health plan offer two levels of benefits.''.

(2) TYPES OF BENEFITS.—Section 8904(a) of title 5, United States Code, is amended by inserting after paragraph (4) the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both.''.

(3) CONFORMING AMENDMENTS.—

(A) Section 8903a of title 5, United States Code, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following:

''(d) The plans under this section may include one or more plans, otherwise allowable under this section, that satisfy the requirements of clauses (i) and (ii) of section 8903(5)(A).''.

(B) Section 8909(d) of title 5, United States Code, is amended by striking ''8903a(d)'' and inserting ''8903a(e)''.

(4) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding after paragraph (5) (as added by paragraph (1) of this subsection) as a flush left sentence, the following:

''The Office shall prescribe regulations in accordance with which the requirements of section 8902(c), 8902(n), 8909(e), and any other provision of this chapter that applies with respect to a plan described by paragraph (1), (2), (3), or (4) of this section shall apply with respect to the corresponding plan under paragraph (5) of this section. Similar regulations shall be prescribed with respect to any plan under section 8903a(d).''.

SEC. 6002. EFFECTIVE DATE.

The amendments made by this title shall apply with respect to contract years beginning on or after January 1, 2000. The Office of Personnel Management shall take appropriate measures to ensure that coverage under a high deductible health plan under chapter 89 of title 5, United States Code (as amended by this section) shall be available as of the beginning of the first contract year described in the preceding sentence.

The SPEAKER pro tempore. Pursuant to House Resolution 509, the amendments printed in House Report 105–643 are adopted.

The text of H.R. 4250, as amended pursuant to House Resolution 509, is as follows:

H.R. 4250

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—The Act may be cited as the ''Patient Protection Act of 1998''.

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

Sec. 1. Short title and table of contents.

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

Subtitle A—Patient Protections.

Sec. 1001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 1101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 1102. Effective date.

Subtitle C—New Procedures and Access to Courts for Grievances Arising under Group Health Plans

Sec. 1201. Special rules for group health plans.

Sec. 1202. Effective date.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

Sec. 1301. Short title of subtitle.

Sec. 1302. Rules governing association health plans.

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.

''Sec. 802. Certification of association health plans.

''Sec. 803. Requirements relating to sponsors and boards of trustees.

''Sec. 804. Participation and coverage requirements.

''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

''Sec. 807. Requirements for application and related requirements.

''Sec. 808. Notice requirements for voluntary termination.

''Sec. 809. Corrective actions and mandatory termination.

''Sec. 810. Trusteeship by the secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

''Sec. 811. State assessment authority.

''Sec. 812. Special rules for church plans.

''Sec. 813. Definitions and rules of construction.

Sec. 1303. Clarification of treatment of single employer arrangements.

Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.

Sec. 1305. Enforcement provisions relating to association health plans.

Sec. 1306. Cooperation between Federal and State authorities.

Sec. 1307. Effective date and transitional and other rules.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

Subtitle B—Patient Access to Information

Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 2102. Effective date.

Subtitle C—HealthMarts

Sec. 2201. Short title of subtitle.

Sec. 2202. Expansion of consumer choice through HealthMarts.

''TITLE XXVIII—HEALTHMARTS

''Sec. 2801. Definition of HealthMart.

''Sec. 2802. Application of certain laws and requirements.

''Sec. 2803. Administration.

''Sec. 2804. Definitions.

SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

Sec. 2301. Promotion of provision of insurance by community health organizations.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 3002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 3102. Effective date.

Subtitle C—Medical Savings Accounts

Sec. 3201. Expansion of availability of medical savings accounts.

Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

Sec. 3203. Sense of the House of Representatives.

Subtitle D—Revenue Offsets

Sec. 3301. Clarification of definition of specified liability loss.

Sec. 3302. Property subject to a liability treated in same manner as assumption of liability.

Sec. 3303. Limitation on required accrual of amounts received for performance of certain personal services.

Sec. 3304. Returns relating to cancellations of indebtedness by organizations lending money.

Sec. 3305. Clarifications and expansion of mathematical error assessment procedures.

Sec. 3306. Inclusion of rotavirus gastroenteritis as a taxable vaccine.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 4001. Federal reform of health care liability actions.

Sec. 4002. Definitions.

Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 4011. Statute of limitations.

Sec. 4012. Calculation and payment of damages.

Sec. 4013. Alternative dispute resolution.

Sec. 4014. Reporting on fraud and abuse enforcement activities.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

Sec. 5001. Confidentiality of protected health information.

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''Sec. 1181. Inspection and copying of protected health information.

''Sec. 1182. Supplementation of protected health information.

''Sec. 1183. Notice of confidentiality practices.

''Sec. 1184. Establishment of safeguards.

''Sec. 1185. Availability of protected health information for purposes of health care operations.

''Sec. 1186. Relationship to other laws.

''Sec. 1187. Civil penalties.

''Sec. 1188. Definitions.

Sec. 5002. Study and report on effect of State law on health-related research.

Sec. 5003. Study and report on State law on protected health information.

Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

Sec. 5005. Effective date for standards governing unique health identifiers for individuals.

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

Subtitle A—Patient Protections

SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, AND PEDIATRIC CARE.

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

"SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

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

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

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

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)), except for items or services specifically excluded—

''(A) the plan or issuer shall provide benefits, without requiring preauthorization and without regard to otherwise applicable network limitations, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I).

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

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

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

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

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

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

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

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

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

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

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

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

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

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

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

''Sec. 713. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.''.

SEC. 1002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 713 of the Employee Retirement Income Security Act of 1974 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

(d) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, section 2101, and subtitle A of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(e) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers religious nonmedical providers,

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers,

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers,

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers, or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider, or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

Subtitle B—Patient Access to Information

SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

''DISCLOSURE BY GROUP HEALTH PLANS

''SEC. 111. (a) DISCLOSURE REQUIREMENT.—

''(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

''(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b), including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or

issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) includes a recommendation for modification or reversal of an internal review decision under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage, but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.

''(h) DEFINITIONS.—For purposes of this section—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 503(b)(6).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by striking ''section 733(a)(1)'' each place it appears and inserting ''section 503(b)(6)''; and

(B) by inserting before the period at the end the following: ''; and, in the case of a group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a)''.

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

''Sec. 111. Disclosure by group health plans.
''Sec. 112. Repeal and effective date.''.

SEC. 1102. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, subtitle B of title II, and subtitle B of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

Subtitle C—New Procedures and Access to Courts for Grievances Arising Under Group Health Plans

SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.'';

(2) by inserting ''(other than a group health plan)'' after ''employee benefit plan''; and

(3) by adding at the end the following new subsection:

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

''(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the participant,

''(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision,

''(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named

fiduciary who did not make the initial decision, and

''(D) meet the additional requirements of this subsection.

''(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

''(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

''(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (9)(J) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT AND EMERGENCY MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

''(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

''(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

''(i) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

''(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

''(I) does not meet the plan's requirements for medical appropriateness or necessity, or

''(II) would constitute experimental treatment or technology.

''(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

''(i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or

''(ii) $25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (C)(iii) is to reverse or modify the coverage decision.

''(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

''(i) one or more independent medical experts will be selected in accordance with subparagraph (E) to review the coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title,

''(ii) the record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record,

''(iii) such expert or experts will report in writing to the plan their recommendation, based on the determination made under clause (i), as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the recommendation, and

''(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

''(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

''(E) INDEPENDENT MEDICAL EXPERTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

''(I) who is a physician or, if appropriate, another medical professional,

''(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

''(III) who was not involved in the initial decision or any earlier review thereof, and

''(IV) who is selected in accordance with clause (ii) and meets the requirements of clause (iii).

''(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

''(I) the expert is selected by an intermediary which itself meets the requirements of clause (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in

connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert,

''(II) the expert is selected, by an appropriately credentialed panel of physicians meeting the requirements of clause (iii) established by a fully accredited teaching hospital meeting such requirements,

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of clause (iii),

''(IV) the expert is selected by an external review organization which meets the requirements of clause (iii) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary, or

''(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (iii).

''(iii) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in clause (ii) meets the independence requirements of this clause if—

''(I) the expert or entity is not affiliated with any related party,

''(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity,

''(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review, and

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

''(iv) RELATED PARTY.—For purposes of clause (ii)(I), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(III) the institution at which the medical care involved in the coverage decision is provided,

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

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

''(v) AFFILIATED.—For purposes of clause (iii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(F) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to review under this paragraph, unless such determination is found in such decision to be based solely on the fact that the item or service—

''(i) does not meet the plan's requirements for medical appropriateness or necessity, or

''(ii) would constitute experimental treatment or technology (as defined under the plan).

''(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

''(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

''(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries, or

''(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of any alternative dispute resolution procedure,

''(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure,

''(iii) any applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures), is incorporated in such alternative dispute resolution procedure, and

''(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

''(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

''(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

''(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations, and

''(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

''(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.— In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term 'specialist' means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

''(8) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

''(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

''(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

''(9) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after such medical care has been provided.

''(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

''(C) ADVANCE DETERMINATION OF COVERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

''(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before such medical care is provided.

''(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

''(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either—

''(i) the imminent death of the participant or beneficiary, or

''(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant or beneficiary.

''(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

''(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

''(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(II) serious impairment to bodily functions, or

''(III) serious dysfunction of any bodily organ or part,

or

''(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

''(J) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(K) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(L) URGENT DECISION PERIOD.—The term 'urgent decision period' means a period of 10 days, or such longer period as may be prescribed in regulations of the Secretary.

''(M) EMERGENCY DECISION PERIOD.—The term 'emergency decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(N) SPECIALTY DECISION PERIOD.—The term 'specialty decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(O) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

''(i) in the case of a decision involving urgent medical care, such term means the urgent decision period, and

''(ii) in the case of a decision involving emergency medical care, such term means the emergency decision period.

''(P) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

''(Q) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

''(R) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

''(S) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

''(T) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

''(U) WRITTEN OR IN WRITING.—

''(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

''(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.''.

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A)(i) In any case in which—

''(I) a benefit under a group health plan (as defined in section 503(b)(8)) is not timely provided to a participant or beneficiary pursuant to a final decision of the plan which was not in accordance with the terms of the plan or this title, and

''(II) such final decision of the plan is contrary to a recommendation described in section 503(b)(4)(C)(iii),

any person acting in the capacity of a fiduciary of such plan so as to cause such failure may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

''(ii) Such civil penalty shall be in the amount of up to $500 a day (or up to $1,000 a day in case of a bad faith failure) from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed $250,000.

''(B) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan (as defined in section 503(b)(8)) in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act, and

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

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

''(C)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fidicuary of one or more group health plans (as defined in section 503(b)(8)) for—

''(I) any pattern or practice of repeated adverse coverage decisions in violation of the terms of the plan or plans or this title, or

''(II) any pattern or practice of repeated violations of the requirements of section 503 with respect to such plan or plans.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

''(ii) Such penalty shall be in an amount not to exceed the lesser of—

''(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice, or

''(II) $100,000.

''(iii) Any person acting in the capacity of a fiduciary of a group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, and may be precluded from returning to any such position or involvement for a period determined by the court.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking '', or (6)'' and inserting '', (6), or (7)''.

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking ''or'' at the end;

(2) in subsection (a)(9), by striking the period and inserting ''; or'';

(3) by adding at the end of subsection (a) the following new paragraph:

''(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).''.

(4) by adding at the end of subsection (b) the following new paragraph:

''(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.''.

(d) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(e) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking ''under subsection (a)(1)(B) of this section'' and inserting ''under subsection (a)(1)(A) for relief

under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)''; and

(2) in the last sentence, by striking ''of actions under paragraphs (1)(B) and (7) of subsection (a) of this section'' and inserting ''of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)''.

SEC. 1202. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

SEC. 1301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Small Business Affordable Health Coverage Act of 1998''.

SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

''(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

''(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

''(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the applicable authority shall certify an association health plan as meeting the requirements of this part only if the applicable authority is satisfied that—

''(1) such certification—

''(A) is administratively feasible,

''(B) is not adverse to the interests of the individuals covered under the plan, and

''(C) is protective of the rights and benefits of the individuals covered under the plan, and

''(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part, including requirements relating to commencement of new benefit options by plans which do not consist of health insurance coverage.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

''(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

''(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(B) LIMITATION.—

''(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

''(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

''(2) the requirements of section 804(a)(1) shall be deemed met.

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

''(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

''(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

''(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

''(C) the requirements of section 804 shall be deemed met.

''(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

''(A) the plan is a multiemployer plan, or

''(B) the plan is in existence on April 1, 1997, and would be described in section

3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

''(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—

''(1) IN GENERAL.—Subject to paragraph (2), the requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer, unless—

''(A) the affiliated member was an affiliated member on the date of certification under this part, or

''(B) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(2) LIMITATION.—The requirements of this subsection shall apply only in the case of plans which were in existence on the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating employer, unless participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer,

''(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

''(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from

''(i) setting contribution rates based on the claims experience of the plan, or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market,

subject to the requirements of section 702(b) relating to contribution rates.

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority may prescribe by regulation as necessary to carry out the purposes of this part.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage, or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions,

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

''(iii) a reserve sufficient for any other obligations of the plan, and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan, and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than $200,000). The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to $2,000,000, reduced in accordance with a scale, prescribed in regulations of the applicable authority to an amount not less than $500,000, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements

relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

''(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

''(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS STOP/LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2), or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means , in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

''(1) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination),

''(2) which is guaranteed renewable and noncancellable for any reason (except as may be provided in regulations of the applicable authority), and

''(3) which allows for payment of premiums by any third party on behalf of the insured plan.

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as may be prescribed in regulations of the applicable authority.

''(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED RULEMAKING.—The regulations under this section shall be prescribed under negotiated rulemaking in accordance with subchapter III of chapter 5 of title 5, United States Code, except that, in establishing the negotiated rulemaking committee for purposes of such rulemaking, the applicable authority shall include among persons invited to membership on the committee at least one of each of the following:

''(1) a representative of the National Association of Insurance Commissioners,

''(2) a representative of the American Academy of Actuaries,

''(3) a representative of the State governments, or their interests,

''(4) a representative of existing self-insured arrangements, or their interests,

''(5) a representative of associations of the type referred to in section 801(b)(1), or their interests, and

''(6) a representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the applicable authority, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor, and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the applicable authority as necessary to carry out the purposes of this part.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the applicable authority. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority).

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

''(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the applicable authority.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

''(7) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

''(8) to terminate the plan (or provide for its termination accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship,

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options, and

''(10) to do such other acts as may be necessary to comply with this title or any order

of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator,

''(2) each participant,

''(3) each participating employer, and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations of the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals,

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

''(3) such tax is otherwise nondiscriminatory, and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

''SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

''(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

''(b) EFFECT OF ELECTION.—

''(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

''(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

''(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) STATE LAW.—The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

''(B) STATE.—The term 'State' includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

''(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

''(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

''(A) for the exclusive purpose of:

''(i) providing benefits to participants and their beneficiaries; and

''(ii) defraying reasonable expenses of administering the plan;

''(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

''(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

''(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

''(A) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

''(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

''(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

''(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

''(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

''(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

''(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

''(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

''(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

''(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

''(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

''(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

''SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

''(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan, or

''(ii) if there if no State referred to in clause (i), the Secretary.

''(B) EXCEPTIONS.—

''(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

''(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section (3)(6)) includes any partner in relation to the partnership, and

''(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms

'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

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

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Patient Protection Act of 1998 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''Sec. 807. Requirements for application and related requirements.
''Sec. 808. Notice requirements for voluntary termination.
''Sec. 809. Corrective actions and mandatory termination.
''Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
''Sec. 811. State assessment authority.
''Sec. 812. Special rules for church plans.
''Sec. 813. Definitions and rules of construction.''.

SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement;'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

''(ii)(I) the plan or arrangement is a multiemployer plan; and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998, or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

''(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8,

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8, or

''(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

''(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 1302, 1305, and 1306 shall take effect on January 1, 2000. The amendments made by sections 1303 and 1304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle before January 1, 2000.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 1302) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on April 1, 1997, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act,

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement,

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote, and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement,

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement,

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan,'' ''medical care,'' and ''participating employer'' shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

(d) PILOT PROGRAM FOR SELF-INSURED ASSOCIATION HEALTH PLANS.—

(1) IN GENERAL.—During the pilot program period, association health plans which offer benefit options which do not consist of health insurance coverage may be certified under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 only if such plans consist of the following:

(A) plans which offered such coverage on the date of the enactment of this Act,

(B) plans under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(C) plans whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plans in accordance with regulations which the Secretary shall prescribe, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

(2) PILOT PROGRAM PERIOD.—For purposes of this subsection, the term ''pilot program period'' means the 5-year period beginning on January 1, 1999.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

''SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

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

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

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

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan or issuer shall provide benefits, and without regard to otherwise applicable network limitations, without requiring preauthorization and without regard to otherwise applicable network limitations, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

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

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

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

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

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

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

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

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

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

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

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

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

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

(c) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall first issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(2) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this paragraph, any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

''SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

''(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

''(1) is a health maintenance organization (as defined in section 2791(b)(3)), and

''(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a

coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

''(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

''(c) EXCEPTIONS.—

''(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

''(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

''(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

''(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization, and

''(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently that once every two years.

''(4) INCREASED COSTS.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently that once every two years. This paragraph shall be applied on an average per enrollee or similar basis.

''(5) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

''(d) DEFINITIONS.—For purposes of this section:

''(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' has the meaning given such term in section 2706(a)(2).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage offered on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subtitle B—Patient Access to Information

SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

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

''SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage for the relevant coverage terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted in connection with such coverage pursuant to section 503(b) of the Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications, and

''(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) of such Act includes a recommendation for modification or reversal of an internal review decision under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant and an employee who, under the terms of the plan, is eligible for coverage but not enrolled in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

SEC. 2102. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

Subtitle C—HealthMarts

SEC. 2201. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Health Care Consumer Empowerment Act of 1998''.

SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—HEALTHMARTS

''SEC. 2801. DEFINITION OF HEALTHMART.

''(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

''(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of representatives of not fewer than 2 and in equal numbers from each of the following:

''(A) Small employers.

''(B) Employees of small employers.

''(C) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

''(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

''(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

''(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

''(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

''(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

''(3) GEOGRAPHIC AREAS.—

''(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

''(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

''(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

''(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

''(6) FILING INFORMATION.—The HealthMart—

''(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

''(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health insurance coverage pursuant to section 330B(a)),

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b), and

''(iii) offers the coverage under a contract with the HealthMart;

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

''(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

''(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

''(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

''(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

''(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

''(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

''(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

''(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

''(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

''(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

''(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

''(A) Coverage through a health maintenance organization.

''(B) Coverage in connection with a preferred provider organization.

''(C) Coverage in connection with a licensed provider-sponsored organization.

''(D) Indemnity coverage through an insurance company.

''(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

''(F) Coverage that includes a point-of-service option.

''(G) Coverage offered by a community health organization (as defined in section 330B(e)).

''(H) Any combination of such types of coverage.

''(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

''(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) PURCHASERS.—

''(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

''(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

''(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

''(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

''(2) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

''(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

''(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

''(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

''(3) HEALTH INSURANCE ISSUERS.—

''(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

''(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

''(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

''(d) PREVENTION OF CONFLICTS OF INTEREST.—

''(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

''(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

''(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

''(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

''(B) CONSTRUCTION.—For purposes of subparagraph (A), the term ''affiliated'' does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

''(e) CONSTRUCTION.—

''(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

''(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

''(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

''(i) a change of employers through which the coverage is provided, or

''(ii) a change in place of employment to an area not served by the previous HealthMart.

''(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

''(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

''SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

''(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

''(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

''(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

''(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

''(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

''(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

''(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

''(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

''(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

''(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

''(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

''(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

''(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of

applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

''(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

''(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

''(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

''SEC. 2803. ADMINISTRATION.

''(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

''(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

''(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title.

''(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

''(A) oversight of the operations of HealthMarts under this title; and

''(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

''(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

''SEC. 2804. DEFINITIONS.

''For purposes of this title:

''(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services.

''(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

''(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

''(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term group health insurance coverage in section 2791(b)(4).

''(5) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

''(7) HEALTHMART.—The term 'HealthMart' is defined in section 2801(a).

''(8) MEMBER.—The term 'member'' means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

''(9) PURCHASER.—The term 'purchaser' means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

''(10) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term for purposes of title XXVII.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2000. The Secretary of Health and Human Services shall first issue all regulations necessary to carry out such amendment before such date.

Subtitle D—Community Health Organizations

SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public Health Service Act is amended by adding at the end the following new section:

''WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

''SEC. 330B. (a) WAIVER AUTHORIZED.—

''(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

''(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the 'Secretary') by not later than November 1, 2003, and

''(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (A), (B), or (C) of paragraph (2) has been met.

''(2) GROUNDS FOR APPROVAL OF WAIVER.—

''(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

''(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

''(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

''(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

''(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

''(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in paragraph (5).

''(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

''(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

''(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

''(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

''(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

''(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the

Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2003.

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization;

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

''(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

''(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

''(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

''(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

''(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

''(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

''(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

''(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

''(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 1999.

''(e) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH ORGANIZATION.—The term 'community health organization ' means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

''(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 2791(b)(1).

''(4) CONTROL.—The term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.''.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

''SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

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

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

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

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

''(1) IN GENERAL.—To the extent that the group health plan provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan shall provide benefits, without requiring preauthorization and without regard to otherwise applicable network limitations, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in clause (i) of section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan—

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

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

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

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

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

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

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

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

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

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

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

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

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.''

SEC. 3002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON PENALTY FOR CERTAIN FAILURES.—No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs before the date of issuance of regulations issued in connection with such requirement if the plan has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 9813 of the Internal Revenue Code of 1986 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

''SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.

''(a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 of Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) contains the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any health insurance issuer offering health insurance coverage in connection with such plan provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the requirements under section 4980B.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b) of Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan shall, upon written request (made not more frequently than annually), make available to

participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or a health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) of such Act includes a recommendation for modification or reversal of an internal review decision under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9814. Disclosure by group health plans.''

SEC. 3102. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of the Treasury or the Secretary's delegate shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking ''and such employer is a small employer''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the taxpayer's coverage under the high deductible health plan.''

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (5) of section 220(b) of such Code is amended to read as follows:

''(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply

under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999'', and

(B) by striking ''1997'' and inserting ''1998''.

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS ACCOUNTS.—Paragraph (1) of section 220(c) of such Code (defining eligible individual), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULES FOR INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

''(i) IN GENERAL.—Subparagraph (A)(iii) and subsection (b)(4) shall not apply for any month to an individual—

''(I) who, as of the 1st day of such month, is enrolled in a high deductible health plan under chapter 89 of title 5, United States Code, and

''(II) who is entitled to receive for such month any amount by reason of being an annuitant (as defined in section 8901(3) of such title 5).

''(ii) SPECIAL RULE FOR SPOUSE OF ANNUITANT.—In the case of the spouse of an individual described in clause (i) who is not also described in clause (i), subsection (b)(4) shall not apply to such spouse if such individual and spouse have family coverage under the same plan described in clause (i)(I).''

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN CASE OF MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 220(d)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) INSURANCE OFFERED BY COMMUNITY HEALTH CENTERS.—

''(I) IN GENERAL.—Subject to clauses (II) and (III), clause (i) shall not apply to any expense for coverage under insurance offered by a health center (as defined in section 330(a)(1) of the Public Health Service Act) if the coverage consists solely of coverage for required primary health benefits (as defined in section 330(b)(1)(A) of such Act) provided on a capitated basis.

''(II) INCOME LIMITATION.—Subclause (I) shall only apply to expenses for coverage of an individual who, in the taxable year involved, has income that is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(III) LIMITATION ON NUMBER OF CONTRACTS.—For a taxable year ending in a calendar year, subclause (I) shall apply only to expenses for coverage for the first 15,000 individuals enrolled in insurance described in such subclause in the year.''.

(b) REPORTS ON ENROLLMENT.—Section 330(j)(3) of the Public Health Service Act (42 U.S.C. 254c(j)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (K),

(2) by striking the period at the end of subparagraph (L) and inserting ''; and'', and

(3) by inserting after subparagraph (L) the following new subparagraph:

''(M) if the center offers insurance coverage to an individual with a medical savings account under subclause (I) of section 220(d)(2)(B)(iii), the center shall provide such reports in such time and manner as may be required by the Secretary and the Secretary of the Treasury in order to carry out subclause (III) of such section.''.

SEC. 3203. SENSE OF THE HOUSE OF REPRESENTATIVES.

It is the sense of the House of Representatives that patients are best served when they are empowered to make informed choices about their own health care. The same is true regarding an individual's choice of health insurance. A system that gives people the power to choose the coverage that best meets their needs, combined with insurance market reforms, offers great promise of increased choices and greater access to health insurance for Americans.

Subtitle D—Revenue Offsets

SEC. 3301. CLARIFICATION OF DEFINITION OF SPECIFIED LIABILITY LOSS.

(a) IN GENERAL.—Subparagraph (B) of section 172(f)(1) of the Internal Revenue Code of 1986 (defining specified liability loss) is amended to read as follows:

''(B)(i) Any amount allowable as a deduction under this chapter (other than section 468(a)(1) or 468A(a)) which is in satisfaction of a liability under a Federal or State law requiring—

''(I) the reclamation of land,

''(II) the decommissioning of a nuclear power plant (or any unit thereof),

''(III) the dismantlement of a drilling platform,

''(IV) the remediation of environmental contamination, or

''(V) a payment under any workers compensation act (within the meaning of section 461(h)(2)(C)(i)).

''(ii) A liability shall be taken into account under this subparagraph only if—

''(I) the act (or failure to act) giving rise to such liability occurs at least 3 years before the beginning of the taxable year, and

''(II) the taxpayer used an accrual method of accounting throughout the period or periods during which such act (or failure to act) occurred.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to net operating losses arising in taxable years ending after the date of the enactment of this Act.

SEC. 3302. PROPERTY SUBJECT TO A LIABILITY TREATED IN SAME MANNER AS ASSUMPTION OF LIABILITY.

(a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY TEST.—

(1) SECTION 357.—Section 357(a) of the Internal Revenue Code of 1986 (relating to assumption of liability) is amended by striking '', or acquires from the taxpayer property subject to a liability'' in paragraph (2).

(2) SECTION 358.—Section 358(d)(1) of such Code (relating to assumption of liability) is amended by striking ''or acquired from the taxpayer property subject to a liability''.

(3) SECTION 368.—

(A) Section 368(a)(1)(C) of such Code is amended by striking '', or the fact that property acquired is subject to a liability,''.

(B) The last sentence of section 368(a)(2)(B) of such Code is amended by striking '', and the amount of any liability to which any property acquired from the acquiring corporation is subject,''.

(b) CLARIFICATION OF ASSUMPTION OF LIABILITY.—

(1) IN GENERAL.—Section 357 of such Code is amended by adding at the end the following new subsections:

''(d) DETERMINATION OF AMOUNT OF LIABILITY ASSUMED.—

''(1) IN GENERAL.—For purposes of this section, section 358(d), section 362(d), section 368(a)(1)(C), and section 368(a)(2)(B), except as provided in regulations—

''(A) a recourse liability (or portion thereof) shall be treated as having been assumed if, as determined on the basis of all facts and circumstances, the transferee has agreed to, and is expected to, satisfy such liability (or portion), whether or not the transferor has been relieved of such liability, and

''(B) a nonrecourse liability shall be treated as having been assumed by the transferee of any asset subject to such liability.

''(2) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection and section 362(d). The Secretary may also prescribe regulations which provide that the manner in which a liability is treated as assumed under this subsection is applied, where appropriate, elsewhere in this title.''

(2) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—Section 362 of such Code is amended by adding at the end the following new subsection:

''(d) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—

''(1) IN GENERAL.—In no event shall the basis of any property be increased under subsection (a) or (b) above fair market value (determined without regard to section 7701(g)) by reason of any gain recognized to the transferor as a result of the assumption of a liability.

''(2) TREATMENT OF GAIN NOT SUBJECT TO TAX.—Except as provided in regulations, if—

''(A) gain is recognized to the transferor as a result of an assumption of a nonrecourse liability by a transferee which is also secured by assets not transferred to such transferee, and

''(B) no person is subject to tax under this title on such gain,

then, for purposes of determining basis under subsections (a) and (b), the amount of gain recognized by the transferor as a result of the assumption of the liability shall be determined as if the liability assumed by the transferee equaled such transferee's ratable portion of such liability determined on the basis of the relative fair market values (determined without regard to section 7701(g)) of all of the assets subject to such liability.''

(c) APPLICATION TO PROVISIONS OTHER THAN SUBCHAPTER C.—

(1) SECTION 584.—Section 584(h)(3) of such Code is amended—

(A) by striking '', and the fact that any property transferred by the common trust fund is subject to a liability,'' in subparagraph (A),

(B) by striking clause (ii) of subparagraph (B) and inserting:

''(ii) ASSUMED LIABILITIES.—For purposes of clause (i), the term 'assumed liabilities' means any liability of the common trust fund assumed by any regulated investment company in connection with the transfer referred to in paragraph (1)(A).

''(C) ASSUMPTION.—For purposes of this paragraph, in determining the amount of any liability assumed, the rules of section 357(d) shall apply.''.

(2) SECTION 1031.—The last sentence of section 1031(d) of such Code is amended—

(A) by striking ''assumed a liability of the taxpayer or acquired from the taxpayer property subject to a liability'' and inserting ''assumed (as determined under section 357(d)) a liability of the taxpayer'', and

(B) by striking ''or acquisition (in the amount of the liability)''.

(d) CONFORMING AMENDMENTS.—

(1) Section 351(h)(1) of such Code is amended by striking '', or acquires property subject to a liability,''.

(2) Section 357 of such Code is amended by striking ''or acquisition'' each place it appears in subsection (a) or (b).

(3) Section 357(b)(1) of such Code is amended by striking ''or acquired''.

(4) Section 357(c)(1) of such Code is amended by striking '', plus the amount of the liabilities to which the property is subject,''.

(5) Section 357(c)(3) of such Code is amended by striking ''or to which the property transferred is subject''.

(6) Section 358(d)(1) of such Code is amended by striking ''or acquisition (in the amount of the liability)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers after the date of the enactment of this Act.

SEC. 3303. LIMITATION ON REQUIRED ACCRUAL OF AMOUNTS RECEIVED FOR PERFORMANCE OF CERTAIN PERSONAL SERVICES.

(a) IN GENERAL.—Paragraph (5) of section 448(d) of the Internal Revenue Code of 1986 (relating to special rule for services) is amended by inserting ''in fields referred to in paragraph (2)(A)'' after ''services by such person''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1998.

(c) COORDINATION WITH SECTION 481.—In the case of any taxpayer required by this section to change its method of accounting for any taxable year—

(1) such change shall be treated as initiated by the taxpayer,

(2) such change shall be treated as made with the consent of the Secretary of the Treasury, and

(3) the period for taking into account the adjustments under section 481 by reason of such change shall be 3 years.

SEC. 3304. RETURNS RELATING TO CANCELLATIONS OF INDEBTEDNESS BY ORGANIZATIONS LENDING MONEY.

(a) IN GENERAL.—Paragraph (2) of section 6050P(c) of the Internal Revenue Code of 1986 (relating to definitions and special rules) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by inserting after subparagraph (C) the following new subparagraph:

''(D) any organization a significant trade or business of which is the lending of money.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness after December 31, 1998.

SEC. 3305. CLARIFICATION AND EXPANSION OF MATHEMATICAL ERROR ASSESSMENT PROCEDURES.

(a) TIN DEEMED INCORRECT IF INFORMATION ON RETURN DIFFERS WITH AGENCY RECORDS.—Section 6213(g)(2) of the Internal Revenue Code of 1986 (defining mathematical or clerical error) is amended by adding at the end the following flush sentence:

''A taxpayer shall be treated as having omitted a correct TIN for purposes of the preceding sentence if information provided by the taxpayer on the return with respect to the individual whose TIN was provided differs from the information the Secretary obtains from the person issuing the TIN.''.

(b) EXPANSION OF MATHEMATICAL ERROR PROCEDURES TO CASES WHERE TIN ESTABLISHES INDIVIDUAL NOT ELIGIBLE FOR TAX CREDIT.—Section 6213(g)(2) of such Code is amended by striking ''and'' at the end of subparagraph (J), by striking the period at the end of the subparagraph (K) and inserting '', and'', and by adding at the end the following new subparagraph:

''(L) the inclusion on a return of a TIN required to be included on the return under section 21, 24, or 32 if—

''(i) such TIN is of an individual whose age affects the amount of the credit under such section, and

''(ii) the computation of the credit on the return reflects the treatment of such individual as being of an age different from the individual's age based on such TIN.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3306. INCLUSION OF ROTAVIRUS GASTROENTERITIS AS A TAXABLE VACCINE.

(a) IN GENERAL.—Section 4132(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

''(K) Any vaccine against rotavirus gastroenteritis.''.

(b) EFFECTIVE DATE.—

(1) SALES.—The amendment made by this section shall apply to sales after the date of the enactment of this Act.

(2) DELIVERIES.—For purposes of paragraph (1), in the case of sales on or before the date of the enactment of this Act for which delivery is made after such date, the delivery date shall be considered the sale date.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4002. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against—

(A) a health care provider,

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 4003. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court, and

(2) any health care liability claim subject to an alternative dispute resolution system,

that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 4011. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 4012(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(3) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded

for future economic and non-economic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

SEC. 4014. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to that guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on Commerce, the Committee on the Judiciary, and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

''SEC. 1181. (a) IN GENERAL.—Subject to the succeeding provisions of this section, upon the request of an individual who is the subject of protected health information, a person who is a health care provider, health plan, employer, health or life insurer, or educational institution shall make available to the individual (or, in the discretion of the person, to a health care provider designated by the individual), for inspection and copying, protected health information concerning the individual that the person maintains, including records created under section 1182.

''(b) ACCESS THROUGH ORIGINATING PROVIDER.—Protected health information that is created by an originating provider, and subsequently received by another health care provider or a health plan as part of treatment or payment activities, shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

''(c) INVESTIGATIONAL INFORMATION.—With respect to protected health information that was created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established to review health research with respect to potential risks to human subjects pursuant to Federal regulations adopted under section 1802(b) of the Public Health Service Act (42 U.S.C. 300v–1(b)) and the notice (informally referred to as the 'Common Rule') promulgated in the Federal Register at 56 Fed. Reg. 28003), a request under subsection (a) shall be granted only to the extent and in a manner consistent with such regulations.

''(d) OTHER EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, a person to whom a request under subsection (a) is made is not required to grant the request, if—

''(1) the person determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of, or cause substantial harm to, any individual; or

''(2) the information is compiled principally—

''(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

''(B) for use in such action or proceeding.

''(e) DENIAL OF REQUEST FOR INSPECTION OR COPYING.—If a person to whom a request under subsection (a) is made denies a request for inspection or copying pursuant to this section, the person shall inform the individual making the request, in writing, of—

''(1) the reasons for the denial of the request;

''(2) the availability of procedures for further review of the denial; and

''(3) the individual's right to file with the person a concise statement setting forth the request.

''(f) STATEMENT REGARDING REQUEST.—If an individual has filed with a person a statement under subsection (e)(3) with respect to protected health information, the person, in any subsequent disclosure of the information—

''(1) shall include a notation concerning the individual's statement; and

''(2) may include a concise statement of the reasons for denying the request for inspection or copying.

''(g) PROCEDURES.—A person providing access to protected health information for inspection or copying under this section may set forth appropriate procedures to be followed for such inspection or copying and may require an individual to pay reasonable costs associated with such inspection or copying.

''(h) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A person to whom a request under subsection (a) is made shall permit the inspection and copying of any reasonably segregable portion of a record after deletion of any portion that the person is not required to disclose under this section.

''(i) DEADLINE.—A person described in subsection (a) shall comply with or deny, in accordance with this section, a request for inspection or copying of protected health information under this section not later than 30 days after the date on which the person receives the request.

''(j) RULES GOVERNING AGENTS.—An agent of a person described in subsection (a) shall not be required to provide for the inspection and copying of protected health information, except where—

''(1) the protected health information is retained by the agent; and

''(2) the agent has been asked by the person to fulfill the requirements of this section.

''SUPPLEMENTATION OF PROTECTED HEALTH INFORMATION

''SEC. 1182. (a) IN GENERAL.—Subject to subsection (b), not later than 45 days after the date on which a person who is a health care provider, health plan, employer, health or life insurer, or educational institution receives, from an individual who is a subject of protected health information that is maintained by the person, a request in writing to amend the information by adding a concise written supplement to it, the person—

''(1) shall make the amendment requested;

''(2) shall inform the individual of the amendment that has been made; and

''(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person's last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

''(b) REFUSAL TO AMEND.—If a person described in subsection (a) refuses to make an amendment requested by an individual under such subsection, the person shall inform the individual, in writing, of—

''(1) the reasons for the refusal to make the amendment;

''(2) any procedures for further review of the refusal; and

''(3) the individual's right to file with the person a concise statement setting forth the requested amendment and the individual's reasons for disagreeing with the refusal.

''(c) STATEMENT OF DISAGREEMENT.—If an individual has filed a statement of disagreement with a person under subsection (b)(3), the person, in any subsequent disclosure of the disputed portion of the information—

''(1) shall include a notation that such individual has filed a statement of disagreement; and

''(2) may include a concise statement of the reasons for not making the requested amendment.

''(d) RULES GOVERNING AGENTS.—The agent of a person described in subsection (a) shall not be required to make amendments to individually identifiable health information, except where—

''(1) the information is retained by the agent; and

''(2) the agent has been asked by such person to fulfill the requirements of this section.

''(e) DUPLICATIVE REQUESTS FOR AMENDMENTS.—If a person described in subsection (a) receives a duplicative request for an amendment of information as provided for in such subsection and a statement of disagreement with respect to the request has been filed pursuant to subsection (c), the person shall inform the individual of such filing and shall not be required to carry out the procedures under this section.

''(f) RULE OF CONSTRUCTION.—This section shall not be construed—

''(1) to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests; or

''(2) to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

''NOTICE OF CONFIDENTIALITY PRACTICES

''SEC. 1183. (a) PREPARATION OF WRITTEN NOTICE.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and in a clear and conspicuous manner, notice of the person's protected health information confidentiality practices. The notice shall include—

''(1) a description of an individual's rights with respect to protected health information;

''(2) the intended uses and disclosures of protected health information;

''(3) the procedures established by the person for the exercise of an individual's rights with respect to protected health information; and

''(4) the procedures established by the person for obtaining copies of the notice.

''(b) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), shall develop and disseminate, not later than 6 months after the date of the enactment of the Patient Protection Act of 1998, model notices of confidentiality practices, for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

''ESTABLISHMENT OF SAFEGUARDS

''SEC. 1184. (a) IN GENERAL.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of protected health information created, received, obtained, maintained, used, transmitted, or disposed of by the person.

''(b) FACTORS TO BE CONSIDERED.—A person subject to subsection (a) shall consider the following factors in establishing safeguards under such subsection:

''(1) The need for protected health information.

''(2) The categories of personnel who will have access to protected health information.

''(3) The feasibility of limiting access to individual identifiers.

''(4) The appropriateness of the policy or procedure to the person, and to the medium in which protected health information is stored and transmitted.

''(5) The value of audit trails in computerized records.

''(c) RELATIONSHIP TO PART C REQUIREMENT.—Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

''(d) CONVERSION TO NONIDENTIFIABLE HEALTH INFORMATION.—A person subject to subsection (a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into nonidentifiable health information.

''AVAILABILITY OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS

''SEC. 1185. (a) DISCLOSURE.—Any person who maintains protected health information may disclose the information to a health care provider or a health plan for the purpose of permitting the provider or plan to conduct health care operations.

''(b) USE.—A health care provider or a health plan that maintains protected health information may use it for the purposes described in subsection (a).

''(c) LIMITATION ON SALE OR BARTER.—Notwithstanding subsection (b), no health care provider or health plan may, as part of conducting health care operations, sell or barter protected health information.

''RELATIONSHIP TO OTHER LAWS

''SEC. 1186. (a) STATE LAW.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the provisions of this part shall preempt a provision of State law to the extent that such provision—

''(A) otherwise would be preempted as inconsistent with this part under article VI of the Constitution of the United States;

''(B) relates to authorization for the use or disclosure of—

''(i) protected health information for health care operations; or

''(ii) nonidentifiable health information; or

''(C) relates to any of the following:

''(i) Inspection or copying of protected health information by a person who is a subject of the information.

''(ii) Amendment of protected health information by a person who is a subject of the information.

''(iii) Notice of confidentiality practices with respect to protected health information.

''(iv) Establishment of safeguards for protected health information.

''(2) EXCEPTIONS.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to protected health information and—

''(A) the confidentiality of the records maintained by a licensed mental health professional;

''(B) the provision of health care to a minor, or the disclosure of information about a minor to a parent or guardian of the minor;

''(C) condition-specific limitations on disclosure;

''(D) the use or disclosure of information for use in legally authorized—

''(i) disease or injury reporting;

''(ii) public health surveillance, investigation, or intervention;

''(iii) vital statistics reporting, such as reporting of birth or death information;

''(iv) reporting of abuse or neglect information;

''(v) reporting of information concerning a communicable disease status; or

''(vi) reporting concerning the safety or effectiveness of a biological product regulated under section 351 of the Public Health Service Act (42 U.S.C. 262) or a drug or device regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.);

''(E) the disclosure to a person by a health care provider of information about an individual, in any case in which the provider has determined—

''(i) in the provider's reasonable medical judgment, that the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of the protected health information; and

''(ii) in the provider's reasonable judgment, that the person is a spouse, relative, guardian, or close friend of the individual's; or

''(F) the use of information by, or the disclosure of information to, a person holding a valid and applicable power of attorney that includes the authority to make health care decisions on behalf of an individual who is a subject of the information.

''(3) PRIVILEGES.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to a privilege of a witness or other person in a court of that State.

''(b) FEDERAL LAW.—Nothing in this part shall be construed to preempt, modify, or repeal a provision of any other Federal law relating to protected health information or relating to an individual's access to protected health information or health care services. Nothing in this part shall be construed to preempt, modify, or repeal a provision of Federal law to the extent that such provision relates to a privilege of a witness or other person in a court of the United States.

''CIVIL PENALTIES

''SEC. 1187. (a) VIOLATION.—A person who the Secretary determines has substantially and materially failed to comply with this part shall be subject, in addition to any other penalties that may be prescribed by law—

''(1) in a case in which the violation relates to section 1181 or 1182, to a civil penalty of not more than $500 for each such violation but not to exceed $5,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year;

''(2) in the case in which the violation relates to section 1183 or 1184, to a civil penalty of not more than $10,000 for each such violation, but not to exceed $50,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year; or

''(3) in a case in which the Secretary finds that such violations have occurred with such frequency as to constitute a general business practice, to a civil penalty of not more than $100,000.

''(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil or monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A.

''DEFINITIONS

''SEC. 1188. As used in this part:

''(1) AGENT.—The term 'agent' means a person, including a contractor, who represents and acts for another under the contract or relation of agency, or whose function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between the principal and a third person.

''(2) CONDITION-SPECIFIC LIMITATIONS ON DISCLOSURE.—The term 'condition-specific limitations on disclosure' means State laws that prohibit the disclosure of protected health information relating to a health condition or disease that has been identified by the Secretary as posing a public health threat.

''(3) DISCLOSE.—The term 'disclose' means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than an individual who is the subject of such information.

''(4) EDUCATIONAL INSTITUTION.—The term 'educational institution' means an institution or place accredited or licensed for purposes of providing for instruction or education, including an elementary school, secondary school, or institution of higher learning, a college, or an assemblage of colleges united under one corporate organization or government.

''(5) 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.

''(6) HEALTH CARE.—The term 'health care' means—

''(A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, service, or procedure—

''(i) with respect to the physical or mental condition of an individual; or

''(ii) affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

''(B) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care-related item to an individual, or for the use of an individual.

''(7) HEALTH CARE OPERATIONS.—The term 'health care operations' means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes:

''(A) Coordinating health care, including health care management of the individual through risk assessment, case management, and disease management.

''(B) Conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion.

''(C) Carrying out utilization review activities, including precertification and preauthorization of services, and health plan rating activities, including underwriting and experience rating.

''(D) Conducting or arranging for auditing services.

''(8) HEALTH CARE PROVIDER.—The term 'health care provider' means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

''(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

''(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

''(C) an officer or employee of a person described in subparagraph (A) or (B).

''(9) HEALTH OR LIFE INSURER.—The term 'health or life insurer' means a health insurance issuer, as defined in section 9832(b)(2) of the Internal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

''(10) HEALTH PLAN.—The term 'health plan' means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d)), or other program providing or arranging for the provision of health benefits.

''(11) HEALTH RESEARCHER.—The term 'health researcher' means a person (or an officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

''(12) NONIDENTIFIABLE HEALTH INFORMATION.—The term 'nonidentifiable health information' means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide a direct means of identifying the individual (such as name, address, and social security number) have been removed, encrypted, or replaced with a code, such that the identity of the individual is not evident without (in the case of encrypted or coded information) use of a key.

''(13) ORIGINATING PROVIDER.—The term 'originating provider', when used with respect to protected health information, means the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

''(14) PAYMENT ACTIVITIES.—The term 'payment activities' means—

''(A) activities undertaken—

''(i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or

''(ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health plan, or provided based on a determination by the health plan of responsibility for coverage under the plan; and

''(B) includes the following activities, when performed in a manner consistent with subparagraph (A):

''(i) Billing, claims management, medical data processing, other administrative services, and actual payment.

''(ii) Determinations of coverage or adjudication of health benefit or subrogation claims.

''(iii) Review of health care services with respect to coverage under a health plan or justification of charges.

''(15) PERSON.—The term 'person' means—

''(A) a natural person;

''(B) a government or governmental subdivision, agency, or authority;

''(C) a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or

''(D) any other legal entity.

''(16) PROTECTED HEALTH INFORMATION.—The term 'protected health information', when used with respect to an individual who is a subject of information means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that—

''(A) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution;

''(B) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components);

''(C) is derived from—

''(i) the provision of health care to an individual; or

''(ii) payment for the provision of health care to an individual; and

''(D) is not nonidentifiable health information.

''(17) STATE.—The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(18) TREATMENT.—The term 'treatment' means the provision of health care by a health care provider.

''(19) WRITING.—The term 'writing' means writing either in a paper-based, computer-based, or electronic form, including electronic signatures.''.

(b) ENFORCEMENT OF PROVISIONS THROUGH CONDITIONS ON PARTICIPATION.—

(1) PARTICIPATING PHYSICIANS AND SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

''(9) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been found to have violated a provision of part D of title XI.''.

(2) MEDICARE+CHOICE ORGANIZATIONS.—Section 1852(h) of the Social Security Act (42 U.S.C. 1395w–22(h)) is amended—

(A) in the matter preceding paragraph (1), by striking ''procedures—'' and inserting ''procedures, consistent with sections 1181 through 1185—''; and

(B) in paragraph (1), by striking ''privacy of any individually identifiable enrollee information;'' and inserting ''confidentiality of protected health information concerning enrollees;''.

(3) MEDICARE PROVIDERS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by inserting a semicolon at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (S) the following new subparagraph:

''(T) to comply with sections 1181 through 1184.''.

(4) HEALTH MAINTENANCE ORGANIZATIONS WITH RISK-SHARING CONTRACTS.—Section 1876(k)(4) of the Social Security Act (42 U.S.C. 1395mm(k)(4)) of the Social Security Act is amended by adding at the end the following:

''(E) The confidentiality and accuracy procedure requirements under section 1852(h).''.

(c) CONFORMING AMENDMENTS.—

(1) TITLE HEADING.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION''.

(2) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k)(5) of the Public Health Service Act (42 U.S.C. 242(k)(5)) is amended—

(A) in subparagraphs (A)(viii) and (D), by striking ''part C'' and inserting ''parts C and D'';

(B) in subparagraph (C), by striking ''and'' at the end;

(C) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(E) shall study the issues relating to section 1184 of the Social Security Act (as added by the Patient Protection Act of 1998), and, not later than 1 year after the date of the enactment of the Patient Protection Act of

1998, shall report to the Congress on such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 1 year after the date of the enactment of this Act, except that subsection (c)(2), and section 1183(b) of the Social Security Act (as added by subsection (a)), shall take effect on the date of the enactment of this Act.

SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW ON HEALTH-RELATED RESEARCH.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study on the effect of State laws on health-related research subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

SEC. 5003. STUDY AND REPORT ON STATE LAW ON PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

(2) analyzing the effect of such laws on the provision of health care and securing payment for such care.

(b) MODIFICATION OF DEADLINE.—Section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) is amended by striking ''36 months after the date of the enactment of this Act,'' and inserting ''6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998,''.

SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

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

(1) The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term ''health care provider'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(5) The term ''State'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

SEC. 5005. EFFECTIVE DATE FOR STANDARDS GOVERNING UNIQUE HEALTH IDENTIFIERS FOR INDIVIDUALS.

Section 1174 of the Social Security Act (42 U.S.C. 1320d–3) is amended by adding at the end the following:

''(c) UNIQUE HEALTH IDENTIFIERS.—Notwithstanding subsections (a) and (b), the Secretary may not promulgate or adopt a final standard under section 1173(b) providing for a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard or containing provisions consistent with the standard.''.

The SPEAKER pro tempore. After 1 hour of debate on the bill, as amended, it shall be in order to consider the further amendment printed in the CONGRESSIONAL RECORD numbered 2, which shall be considered read and debatable for 1 hour, equally divided and controlled by the proponent and an opponent.

The gentleman from Illinois (Mr. HASTERT) and the gentleman from Michigan (Mr. DINGELL) each will control 30 minutes of debate on the bill.

The Chair recognizes the gentleman from Illinois (Mr. HASTERT).

□ 1045

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GOODLING), the distinguished chairman of the Committee on Education and the Workforce.

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

Mr. GOODLING. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. This is truly a historic occasion which rivals the passage of ERISA in 1974. Thanks to ERISA, 150 million Americans are covered by employer-sponsored health care plans. Thanks to the gentleman from Illinois (Mr. FAWELL), most of the 4 million uninsured will have quality affordable health coverage available to them when we pass this legislation.

Increasingly, the American people tell us that they need common sense elements in health insurance reform, and that is what is in the Patient Protection Act, including basic protections such as guaranteed access to emergency medical care, doctors being able to speak freely with patients about their health care options without being gagged and ensuring that a patient can quickly obtain the benefits promised by their health care.

The Patient Protection Act will also provide health care accessibility to patients by requiring that patients have full access to plan information such as what benefits are covered, the participant's financial responsibility, and a complete description of the claims procedure and appeals process. Women and families with small children will be ensured direct access to key specialists such as OB/GYNs and pediatricians.

As I see it, however, our plan differs from other proposals in two key ways. First, we make sure that patients get the care they deserve in a timely manner before harm can occur. We get them into hospital rooms, not into courtrooms.

We take serious, comprehensive steps to expand availability and affordability of health insurance to American working families who have no health insurance. No other plan does this.

I have held a lot of town meetings in my district over the years, and not once has a constituent said to me, ''I would really like to be able to sue my health plan.'' What they have said to me over and over again is ''When are you going to do something about the high costs of health insurance?'' Today, I am happy to say we are doing something about it.

Simply put, the Patient Protection Act will increase access to affordable health insurance for millions of Americans. It is amazing to me that all the other proposals ignore the 42 million uninsured Americans.

The gentleman from Illinois (Mr. FAWELL) has pushed this through our committee on two occasions to make sure that we do something about the uninsured. The problem of the uninsured, both children and adults, is the problem of small business lacking access to affordable health coverage.

Over 80 percent of the 82 million uninsured Americans live in families where someone is working, someone is employed usually by a small employer, or they are self-employed.

To address the affordability problem of the uninsured, the Association Health Plan proposals in the Patient Protection Act would give franchise networks, bona fide trades, business and professional associations, and organizations such as the Chamber of Commerce, and the National Federation of Independent Business the ability to form large group health plans within and across State lines.

Again, the best patient protection is access to affordable health care.

I would like to take a minute to go into a little more detail about some of the claims procedure provisions in the Patient Protection Act as they pertain to ERISA.

The provisions relating to internal review and external review claims procedures and remedies are contained in Subtitle C of Title I and will hold plans accountable and insure patients get the care they deserve in a timely manner.

The current claims procedures that apply to employee benefit plans under federal law are contained in ERISA Title I section 503. The exclusive remedies that apply to such plans are contained in Part 5 of that Act. With minor exception as provided in regulations, the procedures under 503 do not distinguish between group health plans (i.e. employee benefit plans providing medical care) and other plans, including pension plans and other employee welfare benefit plans. In general, plans may take up to 90 days to inform claimants of initial decisions and up to 60 days to inform them of decisions upon internal appeal. Generally, upon satisfaction of administrative remedies, claimants may proceed, pursuant to Part 5, to enforce their rights under the plan and the ERISA law in court. In general, remedies relating to adverse coverage decisions are limited to the payment of benefits as found to be provided under the terms of the plan and to such reasonable attorney's fees as may be provided in the discretion of the court. Certain other civil remedies may also apply.

Under Subtitle C of Title I the ERISA claims procedures are modernized to take into account the rules as they apply to the many diverse kinds of group health plans in today's evolving health care delivery system. Section 503 of ERISA is amended to require group health plans to provide written—and understandable—notice to a participant of any negative coverage decision on requested benefits under the plan within 30 days of the request. If the request is for urgent medical care, the plan must provide the notice within 10 days; for emergencies, the requirement is 72 hours. If the request is for a referral to a physician specialist, the coverage decision must be within 72 hours. This notice also must be sent to the participant's medical provider if the provider initiated the claim or seeks reimbursement from the plan. The participant must be informed in the notice that he or she may file a written request for review (i.e. internal appeal to an appropriate named fiduciary under the plan) of the coverage decision within 180 days after the notice is received. Internal reviews of coverage request denials involving medical necessity and experimental treatment or technology must be conducted by a physician who did not make the initial decision. The same time frames apply to internal review as to the initial coverage decision.

If the internal appeal results in a coverage denial, the participant may make a request within 30 days for an external review, which must be conducted by one or more independent medical experts (in general, a physician with expertise in the matters involved) selected in accordance with procedures that must be specified under the plan. The procedures of selection required under the plan allow for independent intermediaries to select the reviewing medical experts so as to ensure they meet the strict independence rules preventing conflict of interest. The external review must be completed within 25 days of the request. If the final decision under the plan by a physician, who did not make the earlier decision, is an adverse coverage decision, then the participant has recourse to the courts. Alternative dispute resolution procedures would be permitted, however they would have to conform to the requirements for physician review of medical necessity and with the external review procedures.

The remedies under section 502 of ERISA are improved to include civil penalties for fiduciaries who do not provide benefits in accordance with the recommendation of the external review medical expert. If after external review, a participant is denied coverage, a civil court may impose a penalty of up to $500 a day ($1,000 in the case of bad faith violations) starting on the date on which the recommendation was made. The total penalty may be up to $250,000. Also, fiduciaries in an expedited court action or who took or failed to take action that resulted in a denial of coverage after an external review would be liable in such court actions to pay attorney fees and other reasonable costs to the plaintiff—i.e., the patient. In the case of a pattern or practice of violation, the Secretary of Labor may, in a court proceeding, impose a penalty of up to $100,000. In cases in which a physician certifies to a court that the time needed to carry out administrative remedies and procedures for review of coverage denials would run the risk of causing irreparable harm to the health of the participant, the provisions under section 502 allows such participants to take civil action to obtain an injunction or other equitable relief.

This claims process will ensure patients get the care they deserve in a timely manner. It is one of many reasons the Patient Protection Act should be passed by Congress and signed into law.

Mr. DINGELL. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, we face a clear choice today between two different approaches. The first, the Patients' Bill of Rights was written last year and revised in March. The other piece of legislation, the Republican leadership bill, was still being written after midnight last night.

The Patients' Bill of Rights has been scored by the CBO at a cost of $2 per month per patient, and we provided revenue offsets to ensure fiscal responsibility.

The leadership's bill was never even seen by the CBO and has not been read by the Members. Only minutes ago did we get a final score from CBO. Since it does nothing, it costs nothing. I think my colleagues should note, a bill that does nothing costs nothing.

The Patients' Bill of Rights guarantees real patient rights. It puts health back into the Health Maintenance Organization. The Republican leadership bill has the word HMO. In that bill, HMO stands for hide my opposition.

If our primary concern is health care for the American people, the choice is clear. The Patients' Bill of Rights puts medical decisions, especially the question of medical necessity into the hands of doctors and takes them away from insurance company bureaucrats who now are hurting the American public.

The Patients' Bill of Rights guarantees that we can see a medical specialist when we need one. The Patients' Bill of Rights says that, if you are a pregnant woman or cancer patient, you will continue to be able to see your doctor when you need continuity of care.

The Patients' Bill of Rights guarantees that we will be able to get the prescriptions that we need. The Patients' Bill of Rights holds health plans accountable when they have denied health care and when their decision kills or injures somebody.

The Patients' Bill of Rights protects the confidentiality of our medical records, and the Republican bill does not. The Republican bill even has one interesting thing. It goes so far as to repeal existing consumer protection laws that help patients. I want my colleagues to hear that.

Last of all, I want my colleagues to look at the roster of supporters of the Patients' Bill of Rights: AMA, all the health care specialists, the nurses, and all of the consumers and aging organizations. The American people want the Patients' Bill of Rights. If we want to serve them, we will vote for the Patients' Bill of Rights today.

I want to particularly single out my good friend and colleague, Dr. GANSKE for his leadership and courage on this issue. He is a man of integrity and stands up for what he believes in. He deserves great credit.

I also want to commend the work of the staff in the development of the Patients Bill of Rights.

Among our staff Bridgett Taylor, Amy Droskoski, and Bernadette Fernandez have worked tirelessly on the bill for many months.

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Virginia (Mr. BLILEY), chairman of the Committee on Commerce.

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

Mr. BLILEY. Mr. Speaker, when it comes to health care, patients and their doctors should be in the driver's seat. Right now, they are mere passengers. Fortunately, the Patient Protection Act of 1998 puts patients back at the wheel where they belong.

Our bill gives Americans the care they need when they need it. It protects patients without expanding big government, and it promises patients greater choice and the ability to stick with a favorite doctor.

The Patient Protection Act addresses a major flaw in our health care system, the lack of a real marketplace where patients can shop for the lowest cost and highest quality care.

Even Ron Pollack of Families U.S.A., a staunch supporter of President Clinton's efforts to nationalize health care agrees this is needed. He recently said, and I quote, ''There is no true marketplace today to drive health care quality.'' He is right. Think about it.

When we buy a new car, we do not go to a bank, credit union, or GMAC first. We choose the car we want; then we arrange the financing. In other words,

we, not the lender, choose what car to buy. We, not our employer, choose the financing.

Why can health care not work the same way? Why do health care choices have to be dictated by the terms of health insurance than by consumers' needs and preferences. Why must employers choose the health coverage that finances so many Americans' care?

HealthMarts answer these important questions in a way that puts patients first. HealthMarts are private, voluntary, and competitive health insurance supermarkets. They transfer choice within the employer-based health insurance market from small employers to employees.

HealthMarts give consumers the freedom to choose health coverage from a broad menu of options. Here is how they work: A small business joins a HealthMart because it offers lower cost coverage, makes more options available to employees, and does the administrative work.

Employees choose from among the HealthMart's coverage options. Each can choose a different plan and still benefit from group rates. Sound familiar? It should. It is the type of choice today that is available only to Members of Congress, our staffs, and other Federal employees.

This type of consumer choice is essential to the quality of health care coverage and services. After all, if all Americans had the freedom to choose their coverage, they would be able to get the highest quality care that best meets their needs. HealthMarts will achieve that critical objective.

The bottom line is this: By making quality as important in the selection of health coverage as cost, HealthMarts will move the Nation toward a true health care marketplace.

This new idea gives patients more choice and better quality health care. It puts them back in the driver's seat. It is yet another reason why the Patient Protection Act deserves our strong support.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE) and note that he has been instrumental in bringing us to where we are today. I salute him for it and thank him on behalf of my colleagues.

Mr. GANSKE. Mr. Speaker, I rise in opposition to H.R. 4250 and in support of the Ganske-Dingell substitute. There is going to be a lot of debate today about the legal situation. I have been for legal reform. I have stood in this well arguing for medical malpractice reform. I voted for securities litigation reform, product liability reform.

I, as a physician, would never want Congress to pass a law that says physicians should be immune from their malpractice. Yet, that is a situation that we have with ERISA.

The problem with H.R. 4250 is it does not remove ERISA preemption for State causes of action. The Ganske-Dingell bill says that Federal law may not preempt State law, but we have a provision in there that protects the employer.

If the employer is not making the decision, if the HMO is making the decision, the employer is not subject to liability. That is a very important distinction. It is fair.

But let me just ask my colleagues something, it is very clear that HMOs have committed malpractice that has resulted in loss of life and limb. ERISA, through the interpretation of the courts, has extended that legal exemption to health plans. However, we have never had our personal fingerprints on that legal immunity and the problems with it.

If we vote for the GOP bill, we are going to be codifying, giving HMOs legal immunity. Would we do that for tobacco companies? I think not. Would we do that for companies that are making life and death decisions? I hope not.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. CUNNINGHAM).

Mr. CUNNINGHAM. Mr. Speaker, I have no doubt that Members on both sides of the aisle want to focus on health care, but I personally feel that, in an election year, political pandering on both sides is not a benefit for the American public.

I look at the Democratic ''Bill of Fights'' that is going to drive up health care cost by letting trial lawyers take over. California is a leader in HMOs, but I also see good, bad, and ugly in the HMOs in California. We are losing good doctors in California because of HMOs and managed health care.

□ 1100

But yet there are still some good ones, and we need to attend to that.

Whether the lawyers drive up costs or CEO's from HMOs rip off the system and drive up health care, both are bad, and that is why I say that neither one of these bills are good for the American consumer, and we need to help.

The gentleman from California (Mr. FAZIO) brought over a list of things that are preempted in state law. I do not want that. But, at the same time, I looked into it, and the unions right now are under ERISA. Your supporters are exempt under state law, the unions and large companies. We wanted the small businesses to be able to band together and have the same benefits for low health care costs.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from California (Mr. STARK).

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

Mr. STARK. Mr. Speaker, I ask unanimous consent that my infirmity not be taken as support for the Republican bill, which is a cynical sham and should be defeated. I wish to announce my support for the Dingell bill.

Mr. Speaker, today's vote on managed care reform is a complete sham.

It wasn't long ago when the Republican leadership called on their friends in the health insurance industry ''get off your butts and get off your wallets'' to defeat real reform.

Today, they are here to put another nail in the coffin of real reform.

Their answer to managed care reform is the same as their answer to campaign finance reform and tobacco legislation: Make it look like they are doing something, but then work to kill it with the addition of divisive provisions.

H.R. 4250 flunks the fundamental test of real reform—it doesn't hold health plans accountable for their medical decision making. This bill precludes an injured patient or their family from suing a managed care plan that maims or kills them.

Under the Republican bill, health plans could continue to get away with cases like that of Mrs. Florence Corcoran, who lost her baby because of her health plan's refusal to follow her doctors' advice.

Today, if a doctor commits malpractice on a patient, the patient has the right to sue that doctor. If a hospital maims a patient, they are liable for their action. If a defective car causes a person's death, the care manufacturer is liable.

Why should we let managed care plans off the hook? What makes them worthy of legal immunity that we don't grant doctors and hospitals—or any other profession or industry?

In addition, the Gingrich managed care bill before us today includes a number of ''poison pills'' that Congress has rejected numerous times in the past.

Among the poison pills are:

Expansions of medical savings accounts to help the healthy and wealthy at a cost of billions to American taxpayers;

MEWA and HealthMart provisions that would destroy small group market reforms in the states, increase adverse selection and weaken state enforcement authority.

But the cherry on top of this sundae for the managed care industry is the permission this bill gives health plans to withhold even more access to care than they can under current law. This bill gives HMOs the right to define—each plan for itself—what the medically necessary care is that it will provide to its enrollees. Today, medically necessary care is defined by doctors and other medical experts as the best that science and human ability can deliver. But this bill says plans can decide what their version of medically necessary care is, and how much of it they will give you. It lets bureaucrats, not doctors, determine your health care.

Even those managed care reforms where there has been widespread agreement—such as access to emergency care—are botched in the Gingrich bill.

This bill does not provide the protections to the private sector that are enjoyed by Medicare and Medicaid beneficiaries today.

An emergency physician who testified earlier this week, Dr. Charlotte Yeh, got it right when she said that she thought the Republicans had performed some ''unnecessary surgery on the prudent lay person standard to the point where it is hardly recognizable as the consumer protection we envisioned.''

The Gingrich bill destroys medical record confidentiality. It would trample on Fourth Amendment rights by giving health plans and

health providers the right to disclose your medical record to any entity—without your permission. Your medical record, with your name and full history, could wind up in the hands of a drug company's marketing department . . . a credit card company . . . a consultant working on a political campaign . . . a divorce lawyer . . . a newspaper.

The public deserves better from Congress than this shoddy piece of work.

This bill also allows plans to charge people up to $100 to get external appeals—and doesn't allow patients or doctors to present any evidence at that external appeal review. Talk about a sham!

This Republican bill is worse than doing nothing. If Members of Congress took the Hippocratic oath to do no harm, they would not be able to vote for this bill. Vote to defeat H.R. 4250.

I support the Ganske-Dingell substitute. It is a real bill, with real protections.

The Republican bill is a sham. It provides none of the major consumer protections that patients need.

The Republican bill actually does harm. It overrides hundreds and hundreds of State consumer protection laws, leaving people with less protection than they now have. It will drive up the cost of health insurance for most people. It makes your most private medical records available to every Tom, Dick, and Harry salesman. It spends billions on a new tax break for the wealthiest and healthiest in our society. It takes away your right for compensation for pain and suffering because of medical malpractice.

These harmful features are poison pills, designed to cause controversy and confusion in the Senate and to prevent a bill from passing. The Republican bill is another testament to the need for campaign finance reform: it is a bill designed to make their PAC contributors happy.

The Democratic substitute bill, on the other hand, is a real patient protection bill endorsed by the doctors, by the nurses, and all the consumer groups.

It will require that health plans provide you care that is based on the consensus of the latest, best quality of care. The Republican bill, on the other hand, lets each profit-making HMO define what they believe is adequate medical care: they will provide care based on what their accountants tell them—not their doctors.

The choice could not be clearer. We can pass the Republican sham bill today—or we can pass a real bill—the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the gentleman from Missouri (Mr. CLAY) the ranking member on the Committee on Education and the Workforce.

Mr. CLAY. Mr. Speaker, I rise to oppose H.R. 4250. This bill is nothing more than a cynical propaganda effort promoted by the Republican leadership to convince the public that they are doing something about the abuse of HMOs. This bill is loaded with special interest provisions that do far more harm than good to consumers of health care.

The Republican bill includes a provision to establish Association Health Plans that would enable small businesses and self-employed individuals to band together and purchase health insurance coverage. The chairman of our Committee on Education and the Workforce has stated that the committee has approved this provision and so no one should be concerned about it. The fact is, the bill was reported over Democrat's vehement objections, because it is clear that the arrangements will do more harm than good.

The National Governors Association and the National Conference of State Legislators join with the National Association of Insurance Commissioners in stating that Association Health Plans would undermine positive state regulatory reforms already in place, would destroy important consumer protections, and would contribute to the collapse of small group health insurance in many states.

According to CBO, Association Health Plans would increase the risk of health plan failure and would disrupt the insurance market, because Federal regulatory standards would probably be less strict than the state standards that apply under current law. Association Health Plans would present state regulations covering such vital matters as sovereignty, mandated care and the policing of fraud and abuse.

Mr. Speaker, I urge my colleagues to reject H.R. 4250 and instead support H.R. 3605, the bipartisan Patients' Bill of Rights act.

Mr. HASTERT. Mr. Speaker, I yield three minutes to the distinguished gentleman from Texas (Mr. ARCHER), the Chairman of the Committee on Ways and Means.

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

Mr. Speaker, two principles have forever guided our Nation, individual freedom and liberty. As a democratic Nation whose strength derives from its people, we have achieved high degrees of each, unsurpassed by any nation in all history. It is no wonder that people around the globe want to come here and be called Americans. We are the envy of the world. Now, as we consider a plan to protect and strengthen a free people who worry about the health care needs of themselves and their families, we must do so with our guiding principles in mind.

Our Nation's health care system is the best in the world. Americans do not travel abroad to get health care, but visitors come here from all over the world, to the Mayo Clinic, to Mount Sinai, and, yes, to my own City of Houston to the Texas Medical Center Memorial, because we are the best.

The reason our health care system is the best is because it is based on capitalism, on choice and on individualism. That is why the one aspect of the bill before us today that gives me great pride is the expansion and the unfettered opportunity for Americans to choose medical savings accounts, free and unencumbered.

The source of America's frustrations with HMOs is the lack of control which both patients and doctors feel. There is always a third party making a decision. Patients want to be able to pick up the phone and get a quick appointment to see their doctor. Patients want to see the doctor of their choice for all their health needs.

Doctors want to take more time to be with their patients. Doctors want to treat their patients as they see fit, without interference from a third-party payer or an insurance company, and that is why we need medical savings accounts. With MSAs, patients, not insurance companies, control their choices. There are no gatekeepers, there are no middlemen, and there are no third-party payers, except in the case of a catastrophic event.

MSAs let patients and employers deposit money tax-free into accounts that patients control. Like an IRA for retirement needs, MSAs are IRAs for health care needs. When people control their own money, the general use of capitalism will come into play. It has in all things American; it will in health care too.

Our Nation's greatness is based on freedom and liberty. So, too, is our future. While I originally introduced this bill with a Democrat Congressman, Andy Jacobs, six years ago, I realize even more today that MSAs are and should be the future of health care.

I urge support of the bill.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the distinguished gentleman from Texas (Mr. HALL).

Mr. HALL of Texas. Mr. Speaker, I would start by saying that my speech will probably fall on some closed minds, because many already have your minds made up. Many of you have decided or pledged to take a particular vote, or taken an oath to do it, or been whipped by either the Democrat or Republican Whip.

I speak though to those who do not have their feet set in concrete today, I think those that really and truly want the facts about this situation.

I did not speak on the rule. As a matter of fact, I voted for the rule. I think it is about as fair a rule as a majority will give a minority, so I had no problem with the rule. The rule was not good, but I think the worst is yet to come, and let me talk about a little of it.

It does not please me, by the way, to oppose the likes of the U.S. Chamber and the NFIB. I have had 100 percent with them for years and years, but I differ with them on this because I think they are wrong.

I think that ERISA is what this is all about. ERISA is what all these meetings have been about. ERISA is what the insurance companies can hide behind to escape liability, and it is not right, it is not fair, it is not just, and it should have been changed.

All the conferences that have been had over on this side, all the committee meetings, way into the night, last night, late, late, late, war gaming amendments, it is how can we compromise ERISA? That is what the

whole thrust has been, how can we keep ERISA on the table for insurance companies to hide behind when they err, when they guess wrong?

I tell you, H.R. 4250 preempts states patient protections too. I think we need to know that. This bill will remove stronger patient protection bills in over 40 states. I think the facts are out on the sheet that show how your various states are affected.

Tonight we are going to finish this. We are going to go home, we are going to issue press releases carefully worded, but the hard cold fact is you are offending people when you leave ERISA in place as a hiding place for those that ought to be liable.

Mr. Speaker, as I close, I urge Members to vote against 4250.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the distinguished gentlewoman from New Jersey (Mrs. ROUKEMA).

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

Mrs. ROUKEMA. Mr. Speaker, I must tell my colleagues that I rise in reluctant opposition to this bill, and I am constrained to ask, not facetiously, is this as good as it gets? I am sorry, that is a facetious reference to the movie that we all say identified the backlash out there, and that backlash has promoted our party, both parties, to seek a solution. But I do not believe that this bill is as good as it should get.

I wanted to say that I recognize that there are a lot of benefits to the Republican task force bill, but we have to go beyond that.

Let me point out the issues that are of continuing concern to me. I do not believe we have the patients' access to clinical trials that they need. I do not believe there is expanded access to specialists in a meaningful way, and that is very important to me. I think that the external appeals process, as I read it, and, of course, we only got it really this morning, but as I read it, the appeals process is not even binding. This concerns me, because a right without enforcement is no right at all, as far as I can tell.

I do also want to get to the point of the ERISA question, the health plans. I want to particularly reference the fact that I believe that the gentleman from Iowa (Mr. GANSKE) in his analysis was absolutely correct, and I agree with him. I am concerned that this ERISA preemption as it is supplied to the Association Health Plans and the HealthMarts would be an expanded loophole to legitimate care, particularly for the small business community employees, and I am deeply concerned about that.

These potential loopholes would greatly diminish the quality of care and the medical protections in states such as New Jersey. This is a prime problem. We can have these association pools, we can do these small business pools, without expanding the ERISA preemption.

So I must reluctantly again say, bottom line, the question is whether or not patients will have better access to health care, and health care through the doctors and the professional health care providers, not bureaucrats.

INTRODUCTION

I rise in reluctant opposition to the bill placed before the House today. And I am constrained to ask: Is this ''As good as it get?'' This is my own reference and its not facetious to the motion picture that made graphically clear to policymakers the backlash I long ago predicted against HMOs. This building backlash was the reason I introduced my own bill H.R. 1222, ''The Quality Health Care and Consumer Protection Act'' in 1996 to focus the debate.

Today I say that this bill is clear movement in the right direction. But it is not ''as good as it should get.''

We need to put health care decisions back in the hands of doctors and other health care professionals, and take them away from the managed care companies who are practicing ''bottom line'' medicine and ''rationing'' healthcare.

It is for this reason that I introduced legislation to ensure that managed-care networks provide high-quality, efficient care, not just low-case care that boosts profits. But at the same time my bill guards against unjustified health care costs.

CONCERNS WITH TODAY'S HURRIED PROCESS

But today I must decide between one of two proposals. Before I discuss the proposals I do want to raise a concern wit the process.

The state of our nation's health care is an issue that should be debated through Committee discussions, through hearings, and through floor debate, instead of a limited up or down vote.

BENEFITS OF THE REPUBLICAN TASK FORCE BILL

The bill we have before us today is not altogether bad. There certainly are areas that could use significant improvement; however, the base bill does include information disclosure, internal and external appeals and grievances, a ban on gag clauses, and access to OB/GYNs and pediatricians. These are all moving in the right direction.

However, we are not yet there! Again, this is not ''As Good As It Should Get!''

PROBLEMS WITH THE REPUBLICAN TASK FORCE BILL

This bill does not include a provision to provide patients access to clinical trials, expanded access to specialists, and physician involvement in the development of drug formularies.

This bill also has an external appeals process that is not even binding. This concerns me, because it is a right without enforcement. And a right with no enforcement is no right at all!

In addition I am concerned this legislation does not have a provision relating to provider incentive language to ensure that physicians and pharmacists are consulted in the development of drug formularies when medically necessary.

ASSOCIATION HEALTH PLANS AND HEALTHMARTS

I am also deeply concerned about expanding the ERISA pre-emption to even more businesses than those already able to escape State laws.

We must carefully weigh the benefits of allowing associations the protections of being covered by national laws with the benefits of allowing state laws to determine consumer protection. Association Health Plans and Healthmarts would both allow more people to escape the coverage of state laws. These are potential loopholes that would diminish necessary medical protections in states such as New Jersey.

Businesses have long argued that ERISA is necessary for companies that operate in more than one state because it avoids the onerous burden of complying with 50 different sets of regulations and offering 50 different sets of rules and coverage for their employees. This is a valid argument.

However, in today's market, this has led to loopholes where employers are able to avoid the protections fought for, and placed at the state level. I agree with Dr. Ganske's analysis of how inadequate this provision is.

RIGHT TO SUE

I must also address the right to sue. While I understand the merits to this important right, I am also very concerned that this right would add tremendous costs and affect the quality of health care—doctors and HMOs and hospitals would be practicing defensive medicine—namely executing procedures and conducting tests merely to protect themselves against lawsuits. This concerns me, because this could lead to a reduction in the number of people able to afford health care.

CONCLUSION

The bottom line is whether patients will have better access to health care and whether doctors and health care professionals will be put back in charge instead of insurance company bureaucrats. We need to return the power over medical decisions to those with the medical training and expertise—the doctors and the nurses. This will restore the quality of care that has been our American tradition and leave the field of ''bottom line medicine'' practiced by bureaucrats and so-called ''gatekeepers.''

Mr. HASTERT. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, I would like to just remind the gentlewoman from New Jersey that the people that we are bringing under the umbrella of new health care do not have health care today, part of the 40 million people who work for a living, who are out there that do not have health care. We are trying to expand and bring those people under the umbrella of health care.

Mr. Speaker, I yield two minutes to my colleague, the gentleman from Illinois (Mr. FAWELL), the distinguished chairman of the Subcommittee on Employer-Employee Relations, and certainly someone who has worked on this issue of bringing people under the umbrella of health care for a long time.

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

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

Mr. Speaker, right now there can be no patient's bill of rights for 43 million people, because they have no access to affordable health care, and we can change that in this legislation with Association Health Plans.

What do Association Health Plans do? By allowing small businesses to

band together under multiple employer health plans, Association Health Plans simply allow the little guys, the small businesses, the self-employed, to have precisely what large employers have had for many years. Thus, small businesses can gain the economies of size, so they can do what, self-insure, and thereby they have the clout to bargain and to discount the price of health care in dealing with health care providers and in dealing with insurance companies.

□ 1115

Who are these association health plans? They are long-standing and respected, not-for-profit, professional business and trade and church associations which, like the large employers, they are not in the business of insurance, but that they will, like large employers, assume the responsibility of sponsoring self-insured and fully-insured plans for the members of their associations.

Examples of these associations, yes, include the National Chamber of Commerce and the NFIB, the National Restaurant Association, but also include the Agricultural Field Workers Association, who cannot get health insurance in the market. National Church Associations, National Farm Bureau, the Boys and Girls Clubs of America with 700 units, and they cannot get regular indemnity policies.

Why are the association health plans important? Because most of the 43 million people who do not have health insurance in America, including most of the uninsured children, are people who live in families with the breadwinners employed by small business or are self-employed. They have to simply go into the individual and small business market, and my colleagues know what happens when one goes into that individual and small business market. The insurance companies and the HMOs do not want to give up and have new competition.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the gentleman from Minnesota (Mr. OBERSTAR).

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

Mr. OBERSTAR. Mr. Speaker, I rise in opposition to the bill before us and in support of the Dingell substitute.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. FORBES), my distinguished friend.

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

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

For an increasing number of years now Americans across this country have made it clear that they are dissatisfied with the manner in which some health maintenance organizations oversee the delivery of their health care services. In fact, just a few years ago the ''hue and cry'' got so loud that on this floor, this very floor, a bipartisan majority of Democrats and Republicans saw fit to pass legislation that corrected the practice of some insurance providers that forced women out of the hospital barely 24 hours after they gave birth.

Yes, the House and Senate together, along with the President, decided that it was wrong and we must mandate, yes, mandate a minimum hospital stay for women who give birth.

Well, unfortunately, that is not the sole example of some of the problems with the HMOs and that is why we are here today. Unfortunately, the Republican initiative, which I would have loved to have supported, does not adequately meet the needs that most Americans are calling for.

The Patients' Bill of Rights, in fact, is the best alternative to restoring common sense in the HMO equation. Only the Patients' Bill of Rights allows patients access to key clinical trials, those experimental, innovative and emergency processes that are the last resort for the severely ill. The Patients' Bill of Rights gives access to important drug therapies that a doctor may believe are important to restoring one's health and cost thousands of dollars and would otherwise mean literally life or death for the patient.

A gross omission in the Republican bill, I am afraid, is something even worse than the early release after giving birth, and that is the so-called omission of preventing drive-by mastectomies, the practice that too many HMOs use to force a woman who has undergone a mastectomy out of the hospital before she is physically able to resume normal activities.

Absent, too, and I believe it should be her right, that every woman who has undergone a mastectomy have the right to access to reconstructive surgery and not have it deemed cosmetic by an uncaring HMO.

Finally, the Patients' Bill of Rights is the only one that ends the special protections for HMOs under ERISA. HMOs should not be exempt from lawsuits if bad decisions lead to injury or death.

Mr. Speaker, I urge adoption of the Patients' Bill of Rights by the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE).

Mr. HASTERT. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Louisiana (Mr. McCrery).

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

Mr. MCCRERY. Mr. Speaker, if one believes in the free market, if one believes in the power of individual choice, if one believes our private health care system is, in most respects, the best in the world and is worth preserving, then listen up.

I am going to tell my colleagues about the best part of the Patient Protection Act. It is the part of this bill that really empowers patients. It gives them the ability to choose their own doctors and hospitals. It gives them the economic power to deal effectively with the costs of their health care. It gives individuals the power to take advantage of preventive health care, if they choose. It even offers people the prospect of a sizable nest egg in their later years which they could use for long-term care expenses or retirement.

Mr. Speaker, this Patient Protection Act will finally make medical savings accounts available to everyone, and it removes the burdensome regulations that have prevented many individuals and small businesses from obtaining MSAs. This bill allows both small and large employers to make deductible contributions to an employee's MSA. It allows both employers and employees to make tax-favored contributions to a medical savings account.

Mr. Speaker, if we really want people to be able to take control of their health care choices, if we really want to make the doctor-patient relationship what it used to be and what it should be, if we really want to create a market with forces that can control health care costs, then we must be for the expansion of this valuable, free market tool: medical savings accounts. That alone should make my colleagues vote for this bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I rise in opposition to H.R. 4250 and in support of the Dingell-Ganske bill. The Republican bill is bad for small business, bad for America, and it is shameful. It is a fiscally-irresponsible sham that does nothing to address the real concerns of employers, employees and real people.

This legislation creates a new Federal Commission of Insurance at the Department of Labor, a Department that my Republican colleagues tried to do away with just 2 years ago. It authorizes the hiring of hundreds, perhaps thousands, of new employees at a new Federal Commission of Insurance.

What will this new Federal Commission do? Absolutely nothing. Because its powers are so limited by the Republican bill that its ability to remedy health plan wrongdoing is almost nil.

How much will this new Republican Federal Insurance Commission cost? No one knows, because we still have not seen a CBO score.

Let us see. A multimillion dollar new Federal bureaucracy, thousands of new employees with nothing to enforce, all at the American taxpayers' expense, release of medical records. Your competitors in business, your opponents in politics will have access to your medical records. Protection of insurance company profits, abuse of patients, no access to emergency care or specialists. My Republican colleagues should be ashamed.

Have my colleagues read this bill? My colleagues will be shocked. I urge

my colleagues to vote down this irresponsible proposal. Vote for the Dingell-Ganske substitute. This Republican proposal is a useless drain on our Treasury and a threat to our balanced budget.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. CHABOT).

Mr. CHABOT. Mr. Speaker, I rise in support of the Patient Protection Act. There have been numerous managed care reform proposals offered in Congress this year, and many share similar consumer protections.

The Patient Protection Act guarantees that patients can choose their own doctor, gain access to emergency care, communicate openly with health care providers, and independently appeal decisions made by managed care companies.

This bill also contains a number of pro-consumer provisions that the other proposals do not. This legislation increases patient access to affordable care by expanding health care coverage options for workers and their families, many who have no health care coverage at all now.

American families know that the most important patient protection is access to affordable care. Families should not be forced to choose between expensive health care coverage and putting food on the kitchen table.

This legislation will protect consumers from abuses in the managed care industry, while increasing access and affordability. That is why I support the Patient Protection Act.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT).

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

Mr. MCDERMOTT. Mr. Speaker, as the public listens to this debate, I am sure they will wind up confused, so I want to give 10 reasons why my colleagues should vote against the Hastert proposal and for the Ganske-Dingell bill. I borrowed these from the gentleman from Iowa (Mr. GANSKE) who is a Republican and a doctor. I am a Democrat and a doctor, and we agree.

He says, the substitute provides, that means the Democratic substitute, patients with access to clinical trials. The Hastert bill does not.

The substitute allows doctors to override drug formularies when medically necessary. The Hastert does not.

The substitute provides for ongoing access to specialists for chronic conditions. The Hastert bill does not.

The Ganske-Dingell substitute prevents plans from giving doctors financial incentives to deny care. The Hastert bill does not.

The substitute has hospital-stay protection for mastectomy patients. The Hastert bill does not.

The substitute provides choice of doctors within the plan. The Hastert bill does not.

The substitute has a provision guaranteeing continuity of care when providers leave the network. The Hastert bill does not.

The Ganske-Dingell plan requires plans to collect quality data and maintain a quality improvement program. The Hastert bill does not.

In addition, the Hastert bill allows the plan to decide what is medically necessary. If one has chest pain and one feels like one should go to an emergency room, one cannot decide whether that is medically necessary, one's plan will tell you if it was medically necessary. Maybe after you get to the hospital, they will say, well, it is just indigestion, so it is not medically necessary to go to an emergency room.

There are more reasons than I can get in in 10 minutes. This cynical process requires a ''no'' vote on Hastert and a ''yes'' vote on Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield myself 30 seconds.

I appreciate the gentleman from Washington, who is a doctor and certainly sees things from a different perspective, but I have to tell my colleagues he named 10 mandates that our bill does not have, 10 mandates. And he also talked about the Federal Government, the HCFA agency starting to lay out what one's health plan should do and what it should not do.

The gentleman from Washington has certainly been an advocate of big health care, government takeover of health care, and that is exactly what this plan is not, and I want the people in this country to know that. We think the decision on what one owes health care should be between the patient and the doctor, and that is exactly what this bill does.

Mr. Speaker, I yield 3 minutes and 15 seconds to the gentlewoman from Texas (Ms. GRANGER) for the purpose of a colloquy.

Ms. GRANGER. Mr. Speaker, I rise today in support of H.R. 4250, and I thank the gentleman from Illinois (Mr. HASTERT) and all of the members of the working group for their ability to listen and their desire to lead.

It has often been said that there is a time in the life of every problem when it is large enough to see and yet small enough to solve. The issue of health care reform is one we can see and solve, and our bill does that.

The Republican goal is to provide quality health care and peace of mind for every American. The Republican plan gives peace of mind when the nearest emergency room can mean the fastest care in the case of a heart attack. Our plan gives peace of mind for mothers because there is no barrier for care by a pediatrician. Our plan gives peace of mind for women because they can go directly to an OB-GYN for their health care. And our plan gives peace of mind for small businesses because they will have choices for their health plans through health marts and association health plans.

□ 1130

Overall, our bill gives HMOs accountability to their patients, not their profits. Our bill says that doctors, not bureaucrats, will be authorized to make medical decisions.

Our bill is the only bill that would provide affordable health care to millions of uninsured Americans. Even Senator DASCHLE agrees with us on that.

In short, our bill, the Patient Protection Act, will ensure that all Americans have access they deserve to the health care they need at a price they can afford.

Mr. Speaker, at this time I would like to engage the gentleman from Illinois (Chairman FAWELL) in a colloquy. Among the most important protections that this legislation affords to patients is the right to internal and external review of decisions made by HMOs. Those reviews will be made by qualified independent doctors.

My home State of Texas has a law that allows HMOs to be liable in court. There is some uncertainty as to whether or not and the extent to which this Texas law is preempted by the ERISA law. In fact, this is a question that is before the courts.

Mr. Speaker, I would like to engage in a colloquy with the gentleman from Illinois regarding the possible effects of this new legislation's internal and external review procedures on whether the ERISA law preempts the State statute.

As one of the authors of this legislation, the principal author of the internal and external review procedures, and one of the leading experts on ERISA, are these new procedures intended in any way to indicate congressional intent about whether the Texas State law is preempted by ERISA?

Mr. FAWELL. Mr. Speaker, if the gentlewoman from Texas (Ms. GRANGER) would yield, no, they are not. The more explicit internal and external review provisions under this new legislation do not and are not intended to expand or contract existing ERISA law.

Therefore, these new procedures do not and are not intended to affect whether or the extent to which ERISA does or does not preempt any particular State statute. These new procedures do not indicate congressional intent either way about whether Texas law is preempted by ERISA.

Ms. GRANGER. Mr. Chairman, reclaiming my time, are the legislation's more explicit internal and external review procedures intended to in any way affect the outcome of any matters pending in court examining the extent or scope of ERISA preemption of State laws?

Mr. FAWELL. Again, no, they are not. The legislation's more explicit internal and external review procedures under ERISA are not intended to expand or contract existing provisions of law. Therefore, it is not intended to have any impact on pending litigation examining the possible scope of ERISA preemption. Accordingly, this new legislation is not intended to and should not affect the outcome of the Texas legislation either way.

Ms. GRANGER. Mr. Speaker, I thank the gentleman from Illinois for this clarification.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from the Virgin Islands (Ms. CHRISTIAN-GREEN), a physician of family medicine who has good advice for my colleagues.

(Ms. CHRISTIAN-GREEN asked and was given permission to revise and extend her remarks.)

Ms. CHRISTIAN-GREEN. Mr. Speaker, I rise to speak against H.R. 4250 and for the Patients' Bill of Rights. As has been pointed out over and over again by physicians and patients alike, what H.R. 4250, if passed, does is codify or write into law the very practices which time and time again have denied needed and appropriate medical care to us and our families.

On the issue of access to emergency care, the Ganske-Dingell bill assures that if patients reasonably think that they have an emergency illness, they can go to an emergency room and receive care that their plan will pay for. In the Republican bill, severe pain could not be used as a reason to access emergency care. That means if someone thinks they are having a heart attack, where often the only symptom is pain, they have to go to a phone and answer a laundry list of questions from some paper pusher maybe millions of miles away, before they can go to the hospital. And if it is not a typical pain, as often happens, that care would be denied.

If we pass H.R. 4250, severe pain, the most common symptom of a severe or serious medical condition, would not be a standard that a reasonable person could apply in going to an emergency room. Emergency care is just one more instance of where H.R. 4250 does not measure up to the demands of the American people.

The Ganske-Dingell bill is true managed care reform. It puts decisions back in the hands of the patient and their doctors and allows access to needed medical care. I urge its passage. Vote against H.R. 4250.

Mr. HASTERT. Mr. Speaker, what is the remaining time for both?

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Illinois (Mr. HASTERT) has 11½ minutes remaining, and the gentleman from Michigan (Mr. DINGELL) has 12½ minutes remaining.

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

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me this time and for his outstanding leadership on this issue.

Mr. Speaker, a mother of a 6-month-old child who was having trouble breathing called her HMO at 3:30 a.m. An HMO bureaucrat told the mother to go to the plan's network hospital 42 miles from her home. On the way to the hospital, the baby suffered cardiac arrest and later had both arms and legs amputated.

For the past 2 years, Democrats in Congress have been fighting to pass the Patients' Bill of Rights that could have protected this mother and child.

Last week, I met with a number of area residents in a restaurant in North Ridgeville who told story after story about coverage denied for emergency care and bureaucratic refusals of doctor-ordered tests to detect breast cancer.

But rather than protecting patients, the Republican leadership in Washington has introduced a proposal that protects millionaire insurance company executives.

A friend has diabetes or breast cancer. The Patients' Bill of Rights would guarantee access to a specialist. The insurance company Republican bill does not.

A grandfather experiences chest pains that may be a warning sign of a heart attack. The Patients' Bill of Rights would ensure he gets immediate attention at the nearest emergency room by requiring his HMO to cover this care. The insurance company Republican bill does not.

A child has been denied access to a pediatric specialist for asthma. The Patients' Bill of Rights would allow a parent to have access to an independent patient's appeal process. The insurance company Republican bill does not.

Under present law, the only people in America who enjoy complete immunity from lawsuits are HMOs and foreign diplomats. The Patients' Bill of Rights holds HMOs accountable in State court if they make a medical decision that harms the patient. The insurance company Republican bill does not.

Our bill provides real patient protections at a mere $2 per patient per month, according to the Republican-appointed Congressional Budget Office. Our bill is supported by the Cancer Society and the National Breast Cancer Coalition.

Mr. Chairman, I urge my colleagues to defeat the Republican insurance company bill. Pass the Patients' Bill of Rights.

Mr. HASTERT. Mr. Speaker, I yield 45 seconds to the gentleman from California (Mr. MCKEON)

Mr. MCKEON. Mr. Speaker, I rise in support of this historic legislation that addresses the problem of the rising number of Americans who cannot afford health insurance. For the first time, we will be able to extend health care options to the 42 million people in our country who remain uninsured, while the Democratic substitute ignores the problem.

We know that most people without health insurance have one thing in common: They cannot afford health care. They are either self-employed or they work in small businesses that cannot afford to pay for health benefits. This bill solves this problem.

The Patient Protection Act creates association health plans to combat high costs of health care in our country. This new and unique solution allows small businesses and those that are self-employed to join together under the umbrella of trade and professional organizations to buy health insurance for themselves and their employees. Consequently, small businesses will have access to the same kind of health care options that big corporations currently enjoy.

Mr. Speaker, I urge my colleagues to support this bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE), the chairman of our task force on this matter.

Mr. PALLONE. Mr. Speaker, I just wanted to mention, the Republicans keep talking about the number of uninsured in this country. I would point out that 4 years ago, when President Clinton tried to put forward a health care plan that would insure all Americans, they fought it vigorously. The fact that we have more Americans now without health insurance is their fault, because they would not allow the Clinton plan to come forward. So now the numbers of uninsured continue to grow.

Mr. Speaker, I just want to explain why the Democrats' bill is a vastly superior bill in terms of ensuring and expanding patients' access to physicians.

For example, the Patients' Bill of Rights ensures access to specialists. The Republican bill does not. Under the Democratic bill, if a patient has cancer, they could go directly to an oncologist. If their child has a specific problem, they could bring their child to whatever type of specialist their child might need. But under the Republican plan that child would still have to go to their primary physician for a referral, and there is no guarantee that they would get to see a specialist if they need one.

The differences between the two bills are more pronounced when it comes to seeing specialists outside of one's HMO. The Patients' Bill of Rights ensures that patients will be able to go outside their network, at no cost to them, if they need to see a specialist that their HMO does not have. Under the Republican bill, they are out of luck.

Another difference between the access each bill would provide is standing referrals. If a patient is fortunate enough to have an HMO that has the type of specialist they need when they get sick, under the Republican plan they still have to jump through hoops. The Republican plan does not allow patients who need care over a long period of time by a specialist to have standing referrals.

The Patients' Bill of Rights does not require patients to go back time and again to renew referrals. If a patient needs to see a specialist over a long period of time, they are guaranteed the right to see that doctor.

The Patients' Bill of Rights would also allow patients to designate that specialist as their primary care physician. Women could choose their OB/GYN as their primary physician. The Republican bill does not allow patients to designate their specialist as their primary care physician, nor their OB/GYN.

Another major difference is with the continuity of care issue. The Republican bill does not allow patients to continue to have the same doctor.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health and Environment of the Committee on Commerce.

Mr. BILIRAKIS. Mr. Speaker, I rise in favor of H.R. 4250. I am proud of this bill. Whereas the Democratic bill focuses on patient protections, our bill focuses on basically the same patient protections and additionally places great emphasis on expanding health coverage and access for the insured and the uninsured, but both are accomplished without imposing burdensome government mandates.

Guaranteeing access to quality health care must always be a top priority. What good, in fact, are patient protections if access is not there? We do this through the creation of Health Marts and by broadening the role of the community health centers, so that for those who live in medically underserved areas it will be simpler to receive critical services.

The proposal creates community health organizations, which are basically managed care plans controlled by community health centers. It encourages more competition to lower prices for health consumers. Community health centers will have more money because they will have more private-paying patients using their facilities. As a result, these health centers will be able to provide care to even more uninsured people.

Of course, the bill before us includes important new patient protections. For months, people across the country have told Congress that they want to choose their own doctors. We listened to our constituents, and I am proud to say that through our bill, patients will now be guaranteed their choice of medical providers, contrary to what some others on the other side have said, and be better able to understand their health care policies.

Mr. Speaker, is it a surprise in fact to anyone that the other party is attacking a Republican bill? I think not. But we have been able, I think, to accomplish and to do what they did not even attempt during their many years of control of the United States House of Representatives.

Mr. Speaker, I say to my colleagues: Help us pass a bill which will help people now.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Speaker, Democrats initiated the effort in this Congress to protect patients and their doctors from interference by insurance company bureaucrats. The Dingell-Ganske bill provides these protections and eliminates the complete exemption from accountability that many HMOs enjoy today under the Federal ERISA law.

The Republican bill, on the other hand, in an effort to preserve the insurance companies' shield of protection from accountability for their mistakes, creates a Federal bureaucracy in the Department of Labor and a complex appeals process diagramed here on this chart to my right. Look at this. An endless maze of bureaucratic nightmare created by the Republican bill.

In September of 1991, Phyllis Cannon was diagnosed with leukemia. On August 10 of 1992, her doctor sought approval from her HMO for a bone marrow treatment. Forty-three days later, her doctor pleaded for authorization and it was repeatedly denied.

□ 1145

By the time the HMO finally agreed, it was too late for the treatment and Phyllis Cannon died.

Could she have gone through this maze under the Republican bill and done any better? I think not. And if she had made it through the maze under the Republican bill, after her death she would have been entitled to only $500 a day; under the Republican bill, a total recovery for her family of only $20,000.

Is this what we call protecting patients? I think not. Vote against the Republican bill, vote for the Ganske-Dingell bill and prevent this kind of endless bureaucratic interference with medical decisions from happening to the patients of this country.

Mr. HASTERT. Mr. Speaker, I yield 45 seconds to the gentleman from Oregon (Mr. SMITH).

Mr. SMITH of Oregon. Mr. Speaker, H.R. 4250 moves us in the right direction. One of the ways it does this is by allowing community health centers to establish community health organizations. These would be health plans sponsored by health centers and the doctors themselves to give people the extra choice in their health care.

I used to serve on one of these boards and I recently visited these facilities in Michigan. Patients get first-class treatment and these centers do a great job, and this bill will increase the chance that these small hospitals can survive by allowing them to have the community health organizations. These provisions are going to help create the competition needed to make more regulation from Washington, D.C. unnecessary.

Support this bill.

Mr. HASTERT. Mr. Speaker, what is the remaining time?

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Illinois (Mr. HASTERT) has 8 minutes remaining and the gentleman from Michigan (Mr. DINGELL) has 6½ minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Speaker, we have included some special provisions in the Patient Protection Act that recognize the distinctive health care needs of patients, especially women and children. Medically, women are not just small men. Their bodies are different and their needs are different. And children are not little adults. They need specific and sometimes immediate care.

This bill provides women with direct access to their OB-GYN without preauthorization or referral by a primary care physician. It also lets parents get to a pediatrician directly.

As a former florist, I also know how costly it is to provide coverage to employees, and I know how frightening it is to an employee not to be sure that their health care will be there when they need it. And although the cost continues to skyrocket, my colleagues on the other side of the aisle continue to turn their backs on small businesses and the burden that these employers face.

The Patient Protection Act is the only proposal that addresses the growing health insurance crisis among the small business community, and the fact is the fastest growing segment of small business owners are businesswomen. These women-owned businesses are the businesses that we use every day: The woman who does our taxes, who cuts our hair, who runs the local day care center.

We have 8 million women-owned businesses that employ 18.5 million people, one out of every four U.S. workers, yet only 48 percent of the women-owned businesses with less than 25 employees can afford to offer health care insurance. We confront that problem by providing affordable health insurance to small businesses so they can provide peace of mind and security for their workers and their families.

I encourage each and every one of my colleagues to vote for this bill.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Florida (Mr. DEUTSCH).

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

Mr. DEUTSCH. Mr. Speaker, I rise against the proposed bill by the majority, which does not address any of the major needs the people of America are asking for in this proposal.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Pennsylvania (Mr. KLINK).

Mr. KLINK. Mr. Speaker, I thank the gentleman for yielding me this time and for his leadership on this issue.

Mr. Speaker, I am a pro-life Democrat, and that means, quite often, that the Democrats get mad at me because I am pro life, and the pro-life people get mad at me because I am a Democrat. But I can handle that.

I say that because whether someone gets to remain in a hospital when they need to, whether they get the drugs that their doctor wants, whether they

can see that specialist that can save their life, to me, is a life or death matter.

I have a lot of problems today standing on the floor of the House and sitting on the floor of the House listening to this debate after we went through this partial-birth abortion debate yesterday. Because to me, this is life and death. And if National Right to Life does not score this vote today, something is wrong. If the Catholic Church does not score this, something is wrong.

We cannot be pro life at conception and then abandon people once they are born, when their life is on the line, when they are fighting to get medical care that they need to live, and that is exactly what this debate is all about.

Let us compare the two bills. The Democratic Patients' Bill of Rights leaves medical decisions in the hands of doctors and parents. The Republican bill leaves the decision still in the hands of insurance companies.

The Dingell-Ganske bill of rights gives everyone the right to see a specialist. The Republican bill does not.

The Patients' Bill of Rights gives everyone the right to a real external appeals process. The Republican insurance company bill allows the insurance companies to make individuals pay for their appeal. So first an individual pays their premium, then they are denied coverage, then they pay the insurance company for an appeal.

The Patients' Bill of Rights that I am supporting gives everyone the right to hold their insurers accountable. If they are denied something and someone dies, if they lose a limb, then the decision-maker must be responsible for that decision. The Republican bill, the Insurance Company Protection Act, does not hold the decision-makers in the insurance companies accountable.

That is the difference between these bills. It is ridiculous. The American public wants us to change it. The Republicans are here today refusing to do that. I say we must vote today to protect life. We must vote for the Ganske-Dingell bill. We must vote also pro choice. Give patients and their doctors the choice, not the insurance companies.

Support Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Speaker, I thank the gentleman for yielding me this time, and very quickly let me tell my colleagues my experience and what I bring to the debate, I believe.

Unlike most Republicans, I was a trial lawyer. I made my living trying to enforce the rights of people, and at one time I had the largest medical malpractice verdict in the State of South Carolina. And I can tell my colleagues, my client would rather have had good health care than the money.

I know what I am talking about. I have sued doctors who are medically negligent, and it takes years and it is no fun. The goal that I have today is to get people the treatment they need.

Let us talk about the lady who died of cancer. My mother died of cancer. Under this bill that I am supporting here, this is what would happen. An individual does not have to wait 43 days and get told no. The first thing that is a difference today is when a doctor calls up and says the patient needs cancer treatment, they are talking to a doctor, not a nurse. In their bill it can be a nurse. It does not have to be a doctor. So it is doctor-to-doctor. We require that now. No more clerks. The clerks are taken out of the mix and we replace it with a medical doctor.

I have lived in the real world, and sometimes doctors have an allegiance to the company and not to what is good for medicine. Under our bill, if it is an emergency situation, we take that case and send it to a panel of independent doctors who have no idea who the company is that is involved, has no idea the doctor who is treating the patient. They are just looking at the facts. Under our bill they have to give a decision in 6 days of whether or not the treatment is medically necessary. That lady will get the treatment.

If the patient is awarded at the independent review process, if there is a finding for the patient, our bill has a $500 per-day penalty that kicks in. An individual can go to court right after that, get attorney fees, get the full benefit plus $500 a day. And if the judge finds out the decision was made in bad faith to provide care, it is $1,000 a day, up to $250,000. This happens up front. And give me that any time, rather than a 4-year lawsuit.

If the HMO doctor says no, an individual can go get a lawyer, like myself, and go to court within 24 hours and get a temporary restraining order ordering the treatment be paid, by a judge in State or Federal court, and I can get my attorney fees. The lady does not die.

The penalties in this bill are to force people to make the right decision, not awards 4 years later. I will tell my colleagues about the $500 claim in the next part of this debate and how our bill is better.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I rise in strong opposition to 4250, and let me tell the American people why. Privacy, privacy, privacy. Under the Republican bill our medical records are not safe. Any hospital, HMO or pharmacy that keeps our medical records can disclose them without our consent.

Imagine suffering from depression, paying for prescriptions out of our own pocket to keep our condition private. Under the Republican plan, a pharmacy could disclose the use of these prescriptions to an employer. Imagine a health care bureaucrat reviewing someone's family's medical history without their knowledge. Even more frightening is the very real threat that our medical history could then be used against us to deny us employment or when we apply for a mortgage.

Anyone obtaining our medical records could distribute them to a divorce lawyer, to a newspaper or a political campaign. A business could investigate its employees to find out who has potential health problems. They could review our family's medical records to find out if any of our children were sick and how seriously they were, and the insurance company could then raise our premiums.

Wake up, America. Under the Republican plan the patient does not have to give their consent or be informed about the transfer of their medical records. This is an outrage of the highest order. This plan does not protect patients, it destroys the privacy that exists between doctors and patients. It should be called the Puncture of Privacy Act, and the American people should reject it and the Members of the House of Representatives should, too.

Vote for the Dingell-Ganske bill and reject H.R. 4250 on the grounds of privacy; if nothing else, on the grounds of privacy.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from California (Mr. FAZIO).

Mr. FAZIO of California. Mr. Speaker, I rise in opposition to the last-minute Republican sham before us today. This is not the first time Republicans have buckled to pressure from their insurance industry contributors. It is not the first time under Speaker Gingrich Republicans have tried to pull one over on the American people by crafting something that sounds good in a 30-second campaign ad but does nothing fundamental to fix the problem. This is perhaps, however, the most cruel farce the Republicans have brought to this body since they took control.

For those on the other side of the aisle, who have already written the press releases and started patting themselves on the back and scheduled the air time for those 30-second spots, I ask them to look inside their souls and admit that what they have brought forth today will not end families' tragedies and needless human suffering.

If we pass this bill today, those managed care plans that do not operate as honorably as others will still go on putting profits over patients. Only now the blood will be on our hands. Under this bill, a health plan could still unhook a critically ill patient from the intensive care monitors and transfer the patient to an in-plan hospital. A health insurance bureaucrat could still withhold life-saving cancer treatment until it is too late and face no responsibility for that human life.

□ 1200

In my home State of California, State laws protecting patients who need prenatal care, well-child care, mammography screening, cervical cancer screening, diabetic supplies, and

nine other benefits would be overridden by this law, preempted.

This bill is a sham. Support the Dingell-Ganske bill, which doctors and patients support.

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Michigan (Mr. DINGELL) has 1 minute remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Massachusetts (Mr. OLVER).

Mr. OLVER. Mr. Speaker, I thank the gentleman for yielding.

What this people's House is doing today is the most cynical action I have seen them take in 7 years in Congress.

H.R. 4250, the so-called Patient Protection Act, is based on deception and a big lie. The only thing protected is the insurance industry. The best protection we could provide Americans would be to return decisions about their care to them and their doctors.

Instead, this bill drives the wedge between them and their doctor. The people of Massachusetts will be hurt by H.R. 4250 because it overrides patient protections already provided by State law. The mammography and cervical cancer screening for women, blood lead screening for children, bone marrow transplants for victims of leukemia, home health care for the aged, and a good many more are endangered under the Republican bill.

My constituents and the people of Massachusetts would be better off with no bill rather that 4250, the insurance industry protection act. But Massachusetts has a large insurance industry, and they will be happy with this Republican bill.

Support the Ganske-Dingell bill.

The SPEAKER pro tempore. The gentleman from Illinois (Mr. HASTERT) has 4 minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 4 minutes to the gentleman from California (Mr. THOMAS), the distinguished chairman of the Subcommittee on Health of the Committee on Ways and Means.

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

Mr. THOMAS. Mr. Speaker, some of this debate has literally taken my breath away. If anyone listening to this debate wonders how in the world Republicans could get away with treating Americans the way we do, listening to the Democrats, I ask them to just look at the calendar. This is the pre-election warm-up.

Remember Medicare? Pre-election, Republicans were going to destroy Medicare. Well, the American people did not listen to them. We were returned as the majority. And as chairman of the Subcommittee on Health, we prepared a Medicare reform package that was passed in my subcommittee 11–0, no Democrats dissenting. Prior to the election, it would destroy Medicare. After the election, post-politics, everything is okay.

Today we are debating patient protections. Here we go again. It is pre-election time. Have things changed out there in America? Of course they have. In 1988, health care inflation was 18½ percent. Today it is less than 5 percent. Why? To a very good extent, just 5 years ago, in 1993, about a majority of Americans, about half, got their health care from managed care. Today, if they get it from their employer, it is about 85 percent.

So health care markets have changed. Have there been distortions? Yes, there have been distortions. Do there need to be corrections? Of course there need to be corrections. But when we unite egos and politics, we get some pretty ugly offspring.

There have been Members who have taken the well and virtually every word they spoke about the Republican plan is absolutely, totally false. This headline that says ''the bill would allow sale of patient data'' in today's Washington Post is totally, absolutely false.

If my colleagues will turn to the bill, on page 260, the language is clear. If we read on, it says, ''Limitation on Sale or Barter. Notwithstanding subsection (c) which is a limit which guarantees that State law is not overridden,'' it says, ''no health care provider or health plan may as part of conducting health care operations sell or barter protected health information,'' period.

What was said to be contained in the Republican bill is absolutely, totally false. What we heard from my colleagues was that they want ''medical necessity'' defined in law. Who defines ''medical necessity'' in law? Bureaucrats, Health Care Financing Administration. We get specific items, medical necessity. That is cookbook medicine.

Who do we have define ''medical necessity,'' for example, in an emergency room? Quote, page 144: ''A prudent emergency medical professional.'' It is the medical professional there looking at the patient and their problem that determines what needs to be done, not some book drawn up by bureaucrats that lists what is and what is not medically necessary.

It has been said that it does not say ''pain.'' What this bill says is that ''a prudent lay person who possesses an average knowledge of health and medicine would determine such examinations to be necessary.'' Not itemized; across the board.

I heard my colleague the gentlewoman from North Carolina (Mrs. CLAYTON) say she cannot find the gag rule. I will tell her page 141, section 2706, says, ''patient access to unrestricted medical advice.''

So please understand, it is a pre-election season. But let me tell my colleagues something else. The Congressional Budget Office has laid out the numbers on the plan. Their plan increases premiums. Our plan reduces premiums.

Under the Republican plan, CBO, ''lower medical malpractice costs would reduce Federal direct spending for Medicare and Medicaid by $1.5 billion over 10 years.''

We have heard them say ours is a sham and it drives prices up. It is simply not true. CBO says their plan will drive premiums up. CBO says our plan will drop premiums. Correct the marketplace and Federal costs. Vote ''yes'' on 4250.

Mr. DREIER. Mr. Speaker, I rise in support of H.R. 4520, the Patient Protection Act, because it upholds a patient's most fundamental right—the right to choose his/her own health care. As much as I believe that health insurance bureaucrats should not be able to decide what is best for patients, the federal government also should not be issuing onerous mandates and regulations that micromanage the care that patients receive. Instead, we should provide consumers with additional choices that may not be available from their employer-provided health care plan.

Many employees are frustrated because they are forced by their employer to join a health plan that does not offer the level of benefits or protections that they want. This occurs because the federal tax code prevents employees from making important decisions about their health care. Under a quirk in the federal tax code, employers receive a tax subsidy for providing health care to their employees, and since employers pay for the health care, there is an incentive to purchase a plan based on costs, not on level of benefits. To give employees the option to choose coverage with a higher level of benefits, the solution then is not to add another layer of mandates, but to alter the system so that employees can choose the health plan that is best for them.

To accomplish this goal, H.R. 4520 creates a system similar to the Federal Employees Health Benefits program known as HealthMarts which are private non-profit organizations that offer a variety of health benefits to small businesses and the self-insured. Employers pay a set fee to the HealthMart, and it provides a variety of health insurance options, including health maintenance organizations, paid provider organizations, and fee-for-service plans, to employees. With a HealthMart, the employee, not the employer, has the flexibility to choose the type of plan based on the level of benefits, protections and costs. HealthMarts eliminate the possibility that employees feel dissatisfied with the health coverage and empowers them to choose the best provider that meets their needs.

Unlike the Democrat substitute, H.R. 4520 actually addresses the 41 million Americans lacking access to affordable health insurance. Regrettably, many of these Americans are in families in which one member works in a job that does not provide health care coverage. Because they lack the purchasing power of large businesses, many small businesses often find the cost of providing coverage too prohibitive. H.R. 4520 gives small businesses and the self-insured the ability to bank together to obtain more affordable health care coverage. These Association Health Plans allow employers to join together through a trade association or their local Chamber of Commerce to broaden their risk pool and give them the same purchasing power as large corporations.

Mr. Speaker, H.R. 4520 provides an effective means to protect patients by offering them more choices. The Patient Protection Act restores accountability to health plans without raising premiums on the most vulnerable. It

will also reduce the number of uninsured through innovative reforms and the creation of health care ''supermarkets'' so that the average American can have more available choices. I would like to commend my colleagues who served on the Working Group on Health Care Quality for their tremendous efforts in bringing forth this responsible legislation, and I urge support of this measure.

Mr. KOLBE. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. This bill lays an excellent foundation and contains many important pro-patient provisions. This bill adapts for the changing health care market without the unintended consequences of increased costs, increased bureaucracies and an explosion of lawsuits. This bill expands access to health care for millions of Americans, makes health care more affordable for working families and small businesses, and holds health insurance companies accountable for their decisions about your care.

First, the Patient Protection Act allows individual's access to the best type of health care based on their and their families' needs. Women would have direct access, without having to go through a gatekeeper, to an ob/gyn as their primary care physician. It would also allow families to utilize a pediatrician for the health care of their children without the interference of an insurance gatekeeper.

The Patient Protection Act also makes it easier for individuals to learn more about what their health care plan covers and discuss options with our doctors to determine the best form of treatment. This bill requires health plans to cover emergency room care for conditions which a prudent layperson would view as requiring emergency treatment.

Second, the Patient Protection Act will make health more affordable for individuals. Most people without health insurance can not afford to pay for health benefits. They usually work in small businesses or are self-employed, but cannot afford to purchase health care insurance. This bill will make it affordable for small business owners to provide their employees with health insurance coverage.

Through the creation HealthMarts, and Community Health Centers Organizations, Association Health Plans, and Medical Savings Accounts, small business will have the same access to health insurance as large business, therefore creating a more affordable health insurance market for workers. Workers that currently are caught between being too poor for Medicaid, but not cannot afford health insurance.

And third, the Patient Protection Act makes health plans accountable for the health care services that are provided. Through the creation of an expedited review process—both internally and externally—individuals will be able to receive the care they need first, rather than being thrown into a long, drawn-out legal process controlled by trial lawyers, with no resolution until long after they've been harmed or killed. This is the only bill that truly relies on getting patients treated first in hospital rooms, rather than in the courtroom.

Mr. Speaker, I am pleased to vote in support H.R. 4250, the Patient Protection Act, and urge my colleagues to join us in protecting patients and guaranteeing choices without the heavy-hand of big government and provide patients, especially the 42 million un-insured, with access to affordable health care, when they need it, where they need it, and with whom they need it.

Mr. MICA. Mr. Speaker, the question before us is whether we want to pay more and get less or correct some of the problems we have experienced with managed care.

It is true that the law and regulations have not kept up with changes in health care delivery.

It is also true that increasing costs are depriving millions of Americans affordable health care.

Unfortunately the Democrat plan will do three things we know will drive up costs. Their solution is more regulation, more bureaucracy, and more litigation.

In hearings I conducted on the President's fancy titled ''Patients' Bill of Rights'' for Federal employees, every administration official testified that his similar Executive Order would impose more paperwork at high cost without any benefit in coverage.

The Democrat plan proposes over 300 new mandates, thousands of new federal bureaucrats, and 59 new federal regulations.

The CBO estimates the Democrat plan will increase costs 4 percent. Add to that cost of living and they escalate health care premiums 7 percent per year.

The Democrat plan increases lawsuits which also increase health care costs. So what do you get? More costly regulation. More costly bureaucracy. More costly litigation.

I submit that's not what the patient, consumer or doctor ordered.

Mr. HILL. Mr. Speaker, recent polls show a growing desire on the part of Americans to address some concerns facing our health care system, including the number of uninsured working adults and dependents, the increased costs being passed to employees, and the lack of choice in health plans.

While Americans enjoy the best quality health care in the world, our system for delivering care often frustrates patients, providers and employers. Moreover, people are concerned that their health plan may not deliver the care they need when they are sick.

Today, we are addressing what the people want and deserve—a patients bill of rights. They do not want a trial lawyers right to work. H.R. 4250, the Patient Protection Act, which I am a cosponsor, will move ahead what I call the three A's—Accessibility, Affordability and Accountability.

The Patient Protection Act promotes accessibility by requiring basic protections to ensure high-quality health care coverage, promotes affordability by creating more choices and access to affordable health care coverage for all Americans, particularly the over 100,000 Montanans that are uninsured, and ensures accountability by holding insurance companies accountable so patients are guaranteed to receive high-quality care.

We achieve this by expanding the eligibility for medical savings accounts, allowing for the creation of new 'health marts' and permitting small employers to pool their risks with others, which will make health care become more affordable as well as more available.

The vast majority of the uninsured have one thing in common, they are either self-employed, work, or have a family member who works in a small business that cannot afford to pay for health benefits.

Furthermore, for those small businesses that are able to offer their employees coverage, often they can only afford to offer one coverage option. In Montana, I constantly hear concerns with the affordability of health care. The Congressional Budget Office estimates that premiums would increase and the number of uninsured Americans will actually increase by 1.4 million if H.R. 3605 became law.

The question is who are we trying to help—patients, employees. We should look at who is opposed to H.R. 3605:

NFIB, Small Business Survival Committee, US Chamber, National Association of Wholesalers-Distributors, National Restaurant Association, the Coalition for Patient Choice, Citizens for a Sound Economy, NAM, National Retail Association among others.

Who supports the H.R. 3605—Trial Lawyers.

We address the very real concern patients in managed care plans have that their health plan won't provide the benefits they are entitled to if they get sick. We should do this by empowering patients, not trial lawyers. I want patients to get the care they are entitled to when they need it, not allow their heirs to sue for some large settlement after they die. The other proposal that I touched on earlier seen to concentrate on courtrooms over hospital rooms and would only increase health care costs by taking money away from care and putting it into the pockets of attorneys.

The Patient Protection Act will build upon what's good about our private health care system—without big government or more bureaucracy. It will make health insurance more accessible, affordable and accountable, while giving patients more choices.

Mr. HOBSON. Mr. Speaker, I rise today in strong support of the House Republican Health Care Proposal, the Patient Protection Act. I believe this bill strikes a good balance between protecting patient rights without the heavy hand of big government. I am excited about many of the large protections in this bill, like giving patients a better and quicker appeal process when the HMO denies their claim, lifting any gag orders on physicians to ensure that patients are better informed, and providing greater access to specialists for women and children. I believe this bill addresses the frustrating problems that upset so many people about their HMOs.

As many of you know, Representative TOM SAWYER and I wrote the Administrative Simplification language in the Health Insurance Portability and Accountability Act—Kassebaum-Kennedy. Administrative Simplification will reduce paper work, speed the processing and payment of medical transactions, and let physicians spend less time on paper work so they can do what they do best: treat patients. In putting together this legislation some estimated that Medicare could save $60–90 billion per year if individual patients' financial records were kept from getting confused. Because of the confusion over individual Medicare financial records, the U.S. Department of Health and Human Services (HHS) which runs the Medicare program, often pays claims for beneficiaries that have outside supplemental insurance. After paying the claim, Medicare's only recourse to get its money back is to sue the insurance company, which it seldom does. The most obvious solution to this problem is a unique identifier for health care beneficiaries.

In these days of increased government scrutiny and tight federal budgets there are tremendous pressures on HHS to recover

these funds. Quite frankly, with these pressures on HHS I was afraid that they would rush to get in place a one-size fits all solution that might compromise patient privacy. To ensure that the system was not run by the bureaucrats at HHS and to guarantee public input, Congress instructed the National Committee on Vital and Health Statistics, an independent research organization, to hold hearings to gather information from private and public sector organizations to develop recommendations on establishing a way to keep individual patients' financial records from getting confused with one another.

After the hearings, the Committee will write a report that will be published in the Federal Register. Moreover, an amendment I introduced to the Patient Protection Act will guarantee that Congress reviews and approves any suggestions made by the Secretary of HHS on individual health care identifiers before they are implemented. This provides a built-in guarantee that Congress and the public will have a chance to comment on, participate in the development of, and ultimately approve any unique health care identifier before it goes into effect. Once again, this process insures public input and oversight to prevent another ''Big-Brother'' bureaucratic solution.

However, Administrative Simplification is not complete without the Confidentiality Standards proposed in the Patient Protection Act. Section 264 of Kassebaum-Kennedy states that if Congress does not pass legislation concerning the confidentiality of patient records within 3 years after the act goes into effect, then the Secretary of HHS will adopt her own final regulations. As a result, Congress is on a very tight time frame to propose and pass confidentiality legislation.

The Medical Record Confidentiality provisions in the Patient Protection Act provide the necessary safeguards required in Kassebaum-Kennedy. It allows patients access to their medical records in order to view, copy, and amend by addition; requires providers, plans and employers to develop safeguards to protect confidentiality of medical information; requires providers, plans and employers to disclose their confidentiality policies to patients, enrollees and employers; encourages health researchers to use non-identifiable information by preempting state laws in this defined area; allows providers and plans to use information within their network for certain defined purposes, including outcomes evaluation, health promotion, and utilization review.

The Medical Record Confidentiality provisions in the Patient Protection Act guarantee accurate records and prevent unlawful use of one's medical records.

Mr. FAZIO of California. Mr. Speaker, I rise in opposition to this last minute Republican sham before us today. Mr. Speaker, this is not the first time the Republicans have buckled to pressure from their insurance industry contributors.

It is not the first time under Speaker GINGRICH, Republicans have tried to pull one over on the American people by crafting something that sounds good in a 30-second campaign ad, but does nothing—fundamental—to fix the problem.

But this is perhaps the most cruel farce the Republicans have brought to this body since they took control.

For those on the other side of the aisle who have already written the press releases patting yourselves on the back—and scheduled the air time for those 30-second spots—I say look inside your souls and admit that what you have brought forth today will not end families' tragedies and needless human suffering.

My colleagues, if you pass this bill today, those managed care plans that do not operate as honorably as others will still go on putting profits over patients. Only now, the blood will be on your hands.

Under this bill, a health plan could still unhook a critically ill patient from the intensive care monitors and transfer the patient to an ''in-plan'' hospital.

A health insurance bureaucrat could still withhold life-saving cancer treatment until it is too late—and face no responsibility for that human life.

In my home state of California, state laws protecting patients who need prenatal care, well child care, mammography screening, cervical cancer screening, and diabetic supplies and 9 other benefits—overriden—prempted by Fed law would be moot.

Put this bill to the test before you vote: Does it provide adequate access to medical specialists? No; Emergency services for severe chest pain? No; Proper care for women who have mastectomies? No; Patient recourse when needed care is denied? No.

Right down the line, the Republican bill is a failure and a cruel hoax.

If you pass this bill today, you will go on hearing the stories from your constituents who were denied care they paid for in their health plans.

If you fail to join Dr. GANSKE and Congressman DINGELL—you will guarantee that life or death decisions are made by health insurance bureaucrats, not doctors. Instead, you will be complicit in people's pain.

You are playing with people's lives here today. Don't choose a placebo over a real cure.

Vote NO on this last minute farce we have before us today. Support Dingell-Ganske which is supported by doctors and patients.

Mr. OXLEY. Mr. Speaker, I rise today in strong support of the Patient Protection Act. Since Republicans took control of Congress in 1995 we have worked diligently to pass health care reform legislation that gives Americans greater choices, makes health care more affordable, and improves the quality of the health care they receive. I believe this legislation adds to the long list of legislative accomplishments that Republicans have achieved in this arena.

Allow me to expand on some of these accomplishments. First, through passage of comprehensive Food and Drug Administration reform, the Republican Congress helped expedite the development and delivery of new healthcare technology. As a result of these reforms, which streamlined the FDA bureaucracy and cut government red tape, we will help save the lives of millions of Americans over the coming years.

Second, while many initially criticized our efforts at passing much needed Medicare reform, we succeeded in passing a bipartisan reform package designed to save this critical program until 2007 while establishing a bipartisan panel to consider options that will ensure Medicare's long-term financial health. This responsible package of reforms also included provisions to give Medicare beneficiaries greater choice, crack down on fraud and abuse, and grant beneficiaries new preventative health benefits. For the 34 million seniors that rely on Medicare for their health care needs I was pleased to support this valuable legislation.

Finally, any discussion of major health care accomplishments would not be complete without highlighting the 1996 Health Care Portability and Accountability Act. This legislation was a common-sense, market based solution to one of America's most difficult health care problems—namely the portability of health insurance. By guaranteeing that people can go from one employer to another without facing pre-existing condition restrictions or being denied coverage by a new employer's insurance plan this legislation ended the problem of job-lock by allowing workers to switch jobs without the fear of losing their insurance coverage.

Today, in our continuing efforts to strengthen the health care American's receive, we will consider legislation that address many of the concerns patients all over our country have with the health care marketplace. This legislation focuses on making health care more affordable for working families and small businesses, while holding insurance companies accountable for their decisions, and expanding access to health care for millions of Americans. I commend Congressman HASTERT for his fine work with the House Republican Working Group on Health Care Quality in bringing this legislation to the House floor. I am pleased with the outcome of the working group that I feel builds on and strengthens our previous accomplishments.

While many have advocated reforms that would significantly increase both costs and expand government bureaucracies, I support the Republican Task Force legislation because it protects patients and expands access to health care without damaging the free market health care system we enjoy today. Mr. Speaker I urge my fellow colleagues to support this much needed legislation that ensures that the health insurance Americans receive is accessible, affordable, and accountable without crippling the free market's ability to hold down health care prices.

Mr. GILMAN. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. As managed care has continued to grow as the major system of health care delivery in this country, we are increasingly aware of incidents where patients have suffered serious injury or even death because an HMO or other managed care plans denied a treatment that was necessary to protect the patient. An emphasis on cost control over the quality of care has prevented health care professionals from acting in the best interest of the patient. While looking for ways to control the cost of health care, we must also ensure that people have access to quality health care services when the need it.

The legislation before us today attempts to make significant changes in the managed care industry. H.R. 4250 guarantees access to emergency room care by applying a ''prudent layperson'' standard of what constitutes an emergency, additionally, this bill will allow women direct access to their ob/gyn and children to their pediatrician. This access will prevent patients from having to be referred to these type of specialists by their primary provider.

This bill would also provide for an independent appeal process. If a patient is unhappy

with the initial decision, he or she can ask for an independent internal review within 30 days of the decision. If that decision is unsatisfactory, they can appeal for an independent external review by an independent contracted physician. If after these two appeals, they are still unhappy, the patient can take the HMO to court and sue for damages up to $250,000.

The Patient Protection Act would require all insurance providers to provide detailed information to their customers including patients' responsibilities, the number of appeals made and granted as well as other plan information. This provision is intended to arm the consumer with all of the necessary information up front so that future appeals and litigation become unnecessary.

Although this bill provides a great number of HMO reform provisions, there are still a few items which need to be addressed and amended during the House-Senate conference. I urge the conferees to consider changes to this legislation which will provide greater patient protection and strengthen HMO liability.

Accordingly, I am pleased to support H.R. 4250, the Patient Protection Act.

Mr. UPTON. Mr. Speaker, I rise to express my strong support for the Patient Protection Act. Before I review the reasons that I support this legislation and will work hard for its enactment, I want to take this opportunity to single out two of my colleagues without whom this bill which will do so much to ensure quality of care would not be before us today. First, I want to thank CHARLIE NORWOOD, who saw early-on the need for strong patient protections. He introduced the Patient Access to Responsible Care Act and used this legislation as a vehicle to educate all of us to the need for reforms. Second, I want to express my deep regard for the leadership, patience, and effort that DENNY HASTERT has shown in the development of the Patient Protection Act, the legislation we are considering today. He had a Herculean task, and he did it with skill and grace.

I am proud to be counted as a cosponsor of the Patient Protection Act. This legislation will ensure that our nation's health care system is patient-centered, no profit-centered and that no one, no insurance clerk or green eyeshade worrying about a fat profit, stands between the patient and the physician when potentially life and death health care decisions are being made.

There are some who continue to argue that patient protection legislation is not needed—that the market will work over time to ensure patients have access to care when they need it and receive high quality care. That has not been my experience at all. Rarely a day goes by that I don't hear or read in my constituent mail of serious problems that individuals or their families are having with their managed care plans. Just yesterday, for example, I received a report of a Michigan woman who was experiencing severe pain from an ovarian cyst. She went to the nearest hospital, but her managed care plan would not cover her care at that facility. Instead, a plan clerk directed her to another, more distant facility. Unfortunately, that facility was affected by a massive power outage in the Detroit area and could not see her promptly. She requested permission to return to the first hospital, but was denied. By the time she was finally treated, she had a massive internal infection from the ruptured cyst. Her doctor said she was lucky to be alive.

We need to stop this rising drum-beat of stories of patients being denied appropriate care by their health plans, and the Patient Protection Act will do this. Had the Patient Protection Act been in place, for example, this woman could have sought and received care at the nearest emergency room rather than having to seek prior authorization and go to another, more distant facility.

Perhaps the single most important patient protection in this legislation is the right it will give patients to a timely review of plan determinations with which they disagree. Patients may seek an internal and then an independent external review, both of which must be conducted by physicians who are trained in the provision of the treatment under review. The patient may then go to court to enforce the ruling of the external review organization that a service should be provided or covered. If the court upholds the finding of the independent expert external reviewer, which is highly likely, the plan is subject to fines of $500 per day up to a total of $250,000.

I think the internal/external review appeal process in this legislation is actually more likely to hold plans' feet to the fire for their decisions and ensure appropriate access to care than would be the case if patients could simply go to court and sue their plans or employers. While the penalties leveled in state torts might be greater in some cases, such cases can drag on for years and the outcome is never certain for individuals. And the uncertain, uncapped liability exposure to which employers could be subject under the state court suit option could lead to employers terminating plans and add significantly to the number of individuals and families with no health care coverage.

In closing, I strongly urge my colleagues to join me in voting today for the Patient Protection Act. It ensures that our Nation's health care system is patient-centered, not profit-centered. It ensures that medical decisions are made by patients and their physicians with the well-being of the patient being the first consideration.

Mr. GEJDENSON. Mr. Speaker, for the past few months, my democratic colleagues and I have demanded that Republicans bring HMO reform to the floor. And now, what do we get. Barely 2 hours to debate a bill that was introduced just last week and has had no hearings, no mark-up, no public discussion of any kind.

The Republican bill will do little to fix the problems with the HMO system. The Republican bill does not allow direct access to specialty care. If you have heart disease, you must still go through a primary care doctor before seeing a cardiologist. If you have cancer, you must go through your primary care physician before you can see an oncologist. The Patient's Bill of Rights, which I support, guarantees patients access to specialists without going through a gatekeeper.

The Republican bill will not require HMOs to pay for emergency room visits if a patient has severe pain, but does not have a serious medical problem. Parents who take a child to the emergency room when they complain about pains will not know if their insurance company will cover the visit. This bill expects parents to be doctors and penalizes them for taking prudent steps. The Republican bill will not prohibit gag orders on doctors in group practice. It will not prevent plans from arbitrarily limiting medically-necessary services. It will not allow patients to sue HMOs for decisions that adversely affect them.

The Patient's Bill of Rights will fully address all of these problems. Access to medically needed care, including access to emergency rooms and specialists, is a fundamental element of the Patient's Bill of Rights. This bill will ban all gag rules on physicians. This bill will end the current practice of HMO's offering financial incentives to withhold necessary care. This bill will guarantee timely internal appeals, as well as an independent external appeals when plans deny care. Finally, the Patient's Bill of Rights holds plans legally accountable for decisions that lead to serious injury or death. People need real ways to hold HMOs responsible. In too many instances, courts are the only advocate that patients have in their battles with multi-billion dollar companies.

It is time for true HMO reform. We all know people who have been injured by HMOs. Just this week, a woman from my district got in touch with me and relayed what is probably an all too common occurance:

This Monday, she had a hysterectomy. On Tuesday, 24 hours later, her HMO wanted her out of the hospital even though she was feverish and had medical staples holding her abdomen together. Her doctor demanded that her HMO allow her to stay in the hospital at least one more day. Her HMO relented because of her fever but after the fever broke on Wednesday, she was forced out. She was sent home, still weak and groggy and not even close to recovery. How is she supposed to get well? This is not what she paid for when she paid her premium.

Republicans claim that their bill will stop this type of abuse, but it won't. Their bill has no guarantee that doctors, not HMOs will determine what amount of time is needed to recover from major surgery. The Patient's Bill of Rights will make sure that doctors and patients, not HMO plan administrators, decide when it's time to go home.

Under the Republican bill, what can patients and their families do when they are denied care? Other than jump through some hoops—not much! First, patients will have to prove during the internal appeal that their care is medically necessary. In the Republican bill, the definition of medically necessary is determined by the health plan—not by decades of medical experience, not by doctors there in the examination room with the patient. Then, if the internal appeals process doesn't work, the Republican bill will force patients to pay to have an independent review of their claim.

This is outrageous for two reasons. First, charging a fee is designed to discourage people from using this recourse. Second, HMOs will only be held accountable for failing to follow the provisions of their plan. As a result, as long as the HMO follows its own rules, patients receiving nothing from the external appeals provision even if their health is compromised.

In the Patient's Bill of Rights, the definition of medically necessary is uniform for all—a definition drafted by doctors, not HMOs. The Patient's Bill of Rights not only has internal and external appeals—both free of charge—but also sets up an Ombudsman program to assist consumers in understanding their health insurance options and filing appeals and grievances with their HMOs.

The Republicans also seem to think that it's a good thing that their bill will deny patients access to the court system when their care is denied. Somehow, Republicans believe that the health insurance industry, which makes $952 billion a year, needs protection from lawsuits. When one of your family members dies because an HMO denies access to care, the Republican bill gives you nowhere to turn. No other industry enjoys such a powerful, congressionally-mandated shield from liability for their actions. It's time to remove that protection for health plans and focus on granting more protections for patients.

If the bill in and of itself isn't bad enough, the proponents of this sham have added totally unrelated provisions which further threaten the quality of health care for all Americans. Once again, Republicans are threatening Medicare by expanding so-called Medical Savings Accounts. Remember these? They will allow healthy senior citizens to pull out of Medicare leaving it with only the poorest, sickest older Americans. This is bad medical policy and even worse fiscal policy. Other provisions preempt state laws and jeopardize patient privacy.

We must create a better system for everyone who gives or receives health care in this country. The Republican plan will do nothing to help our Nation's patients. For real reform, we must pass the Patient's Bill of Rights.

Mr. NUSSLE. Mr. Speaker, I rise today in support of the Patient Protection Act. I support this bill because it establishes Association Health Plans and Health Marts as new ways to provide health insurance to workers, many of whom work for small businesses which cannot currently afford to provide health insurance to their employees. Individuals who work for small businesses are the people most likely to be without health insurance. I also applaud the increased care options this bill provides for individuals dissatisfied with the choice of doctors provided by their health plan.

The national debate on health care has been focused almost exclusively on the care provided by HMOs. Providing appeals processes and other recourses for patients in HMOs are important and appropriate steps for Congress to take in order to ensure quality care. However, in all the talk over giving recourse and options to individuals with HMO coverage, both bills have overlooked the fact that the Patient Protection Act and the Kennedy-Dingell bill primarily address the fears and complaints of Americans who are fortunate enough to have real access to health care and a menu of health care options.

For many Iowans, access to health care doesn't mean the ability to see a specialist on demand. There are few specialists in Grundy Center, Iowa. People in Iowa's Second District have to load a family member into the car and drive miles and miles to the nearest doctor, clinic or emergency room. A patient bill of rights means little or nothing to people whose only choice of a hospital or clinic is 40 or 50 miles away. And miles mean minutes, which are crucial in the event of an emergency. Improving access to health care in Iowa means recruiting more doctors so that people will have shorter drives, and maybe a choice of where to go.

I am disappointed that neither proposal the House is considering today contains any initiatives to address the shortage of doctors in rural America. Twenty-five percent of the American population lives in rural areas. By the federal government's own count, almost 2,500 counties in our nation lack adequate medical care. Last year, Congress acted to make this shortage worse by creating a program to pay hospitals to train fewer doctors. What we need in Iowa are more doctors. The resources being spent to reduce the number of physicians would be better spent providing incentives to encourage doctors to locate in areas with inadequate access to health care.

The Patient Protection Act provides valuable protections and new health care options to many individuals, and I support those goals. However, I hope that today's vote on the Patient Protection Act is the beginning of the debate on improving access to health care and not the end. This debate is essential for people in Iowa's Second District and one in which I intend to participate vigorously.

Thank you, Mr. Speaker.

Mr. CRANE. Mr. Speaker, today, this House has an opportunity to improve the health care system for millions of Americans. Like everyone, I want a health care system that is more accessible, more affordable and more accountable. With that goal in mind, I will cast my vote for H.R. 4250, the Patient Protection Act.

It is not a perfect piece of legislation and while there are provisions I think could be improved, there are also other provisions I have long supported. I am particularly pleased with the expansion of medical savings accounts, the creation of association health plans, medical malpractice reform and improving the patient appeals process without increasing the involvement of trial lawyers. In response to the concerns we have heard from our constituents, the bill prohibits gag rules, allows women direct access to gynecological and obstetrical care and allow parents to choose a pediatrician as their child's primary care provider without having to get a referral from a health plan.

This legislation will not only improve health care for the currently insured, we expect it to also make insurance more affordable to the 41 million uninsured Americans, including the 1.3 million uninsured in my state of Illinois.

As a member of the Ways and Means Health Subcommittee, I have taken an active interest in the many innovative ideas in health care. The Patient Protection Act represents the only choice for those of us who do not want a heavy-handed, big-government takover of our health care system. The American people overwhelmingly rejected that proposal and made it clear they want quick access to the best medical care in the world at an affordable price. The Patient Protection Act moves us in that direction and I would urge my colleagues to vote in support of it.

Ms. BROWN of Florida. Mr. Speaker, I represent the 3rd District of Florida. And, senior citizens in my district which ranges from Jacksonville to Orlando have suffered at the hands of HMO providers day-after-day. They are urged to sign up for health coverage plans, and these HMOs only give them cheap gifts and inadequate health coverage.

Because I have hosted numerous town hall meetings on health care for senior citizens, I have been able to hear their stories and provide assistance when their insurance providers have failed to deliver. An 81-year-old man, who after his HMO was sold had to replace his regular hypertension drug with a lower-cost one. Within days his blood pressure skyrocketed. He switched to an HMO that covered his drug, but then the new plan changed its coverage too. Unable to pay for the drug, he went on TV as a cry for help and a local physician with compassion gave him the medication for free. Health care is such a crucial part of our lives, I believe every effort should be made to protect senior citizens and the working poor. It is our responsibility to protect and pass legislation that will protect the rights of our constituents. More importantly, we are charged with ensuring that our nation has access to quality health care at an affordable cost. There is nothing more heart wrenching, than talking with someone who desperately needs medical care and their insurance company will not cover the life-saving medical treatment or reimburse patients for much needed medicine. In another case, a baby girl was diagnosed with a hole in her heart. Chances were good that she would need surgery to fix the defect if it did not close on its own. Her mother switched HMOs for better coverage; however, the new insurance company would not cover the procedure because her daughter's heart defect was a pre-existing condition. The HMO had a 2 year limit on pre-existing conditions and would not pay for the little girl's operation. Thanks to a special state program in Florida the little girl was able to receive care. We need to hold HMOs accountable for their actions and how they treat people. That is why, I urge my colleagues to oppose the Patient Protection Act (H.R. 4250) and support the Patient Bill of Rights (H.R. 3605). H.R. 3605 is the right choice, it puts patients before profits and medical decisions are given back to doctors and nurses. This bill also holds HMOs responsible for decisions when they withhold or limit care to patients.

The challenges of quality health care will require our nation to overcome the barriers of ever-increasing medical cost and recognize the needs of our nation. In a society where technology is progressing at the speed of light, why is it so difficult for us to make the right decision for the American people?

We need to treat quality health care as a right versus a luxury for a privileged few.

Mrs. MINK of Hawaii. Mr. Speaker, I rise in opposition to H.R. 4250, the Patient Protection Act of 1998, because it falls short of addressing America's true health care issues. The essence of the health care debate is threefold: access to health care; patient protections; and patient rights. The Democratic substitute, the Patients' Bill of Rights, would address all three of these issues. This bill, the so called Patient Protection Act, does not.

First, Americans, despite being insured, are tired of having to fight every step of the way for care they are entitled to. Americans want access to care. The Patient Protection Act would not alleviate many of the existing barriers to care identified as priorities. For example:

The Patient Protection Act would not provide direct access to specialists. It does not guarantee women direct access to their OBGYN nor would it provide parents direct access to pediatricians for their children.

The Patient Protection Act would not insure a patient can continue to see the same doctor through a course of a treatment or a pregnancy if that doctor leaves the network.

The Patient Protection Act would not insure that a patient can get the prescription drug chosen by the physician, not the HMO.

The Patient Protection Act would not allow patients with ongoing conditions to have standing referrals to specialists.

The Patient Protection Act would not ensure that patients are allowed to see an outside specialist at no additional cost when specialists in their plan are unable to meet their needs.

The Patients Bill of Rights will provide all of these.

Second, patients should have the right to hold managed care administrators accountable for their decisions when it influences the care that is provided.

The Patient Protection Act does not hold managed care plans accountable when decisions to deny or delay care results in injury or death. It does not provide patients the right to sue HMOs when they are denied needed health care nor does it provide a true external independent appeals process. In fact, the Patient Protection Act reduces accountability by placing an arbitrary cap on medical malpractice awards.

In addition, the Patient Protection Act does not ensure that doctors and nurses can report quality problems without retaliation from HMO's, Insurance companies and hospitals. The Patient Protection Act would not prevent health care professionals from being financially rewarded for limiting a patient's care. Patients deserve care from health care professionals who are not rewarded for providing less care.

The Patients' Bill of Rights would provide these protections and true accountability.

Finally, patients deserve basic health care protections. After preaching a mantra of returning power to the states since taking control of Congress four years ago, Republicans take a hypocritical u-turn and pre-empt carefully constructed state health care protections. The Patients' Protection Act will allow ''Healthmarts'' to pick and choose the services covered under the plan, ignoring state mandated minimum benefit requirements. It would also eliminate state regulations enacted to insure solvency and protect against fraud and abuse.

The Patients' Bill of Rights would not preempt state mandated care nor would it eliminate solvency and fraud and abuse protections.

In closing, Americans deserve health care from qualified physicians who are not influenced by health care plan administrators. Americans deserve the right to take their health plans to court if they are denied care. America wants real managed care reform. The Patient Protection Act is not real managed care reform. This is a facade and a sham designed to provide political cover for Republican leadership who have argued that managed care reform is not necessary.

Do not judge a bill by its title. The Republican Patient Protection Act is a facade. It's meager ''protections'' do not address the real issues we are faced with. The Patients' Bill of Rights on the other hand is a comprehensive and revolutionary bill providing substantive reform.

America understands the difficulties involved with obtaining health care. The Patients' Bill of Rights provides solutions. The Patient Protection Act creates more problems.

Mr. TURNER. Mr. Speaker, it has been suggested that the Republican bill provides better protection for patients. I submit to my colleagues that the Republican bill provides fewer protections for patients than exist in current law in most of our States.

I come from Texas. The Texas Legislature passed patient protection legislation in 1997, fully intending that all HMOs be covered by the protections of State law.

The Republicans submit a bill today that would control patient protections at the Federal level. It would set forth a series of rules that are far inferior to those in the Democratic alternative.

Under the Republic proposal, if the HMO denied coverage, the only remedy, if an individual was enrolled in a self-insured plan, would be to go to Federal Court. And once the individual gets there, he or she would have no genuine recourse.

In 1991, Phyllis Cannon was diagnosed with leukemia. She appealed to her HMO for a bone narrow transplant. The HMO refused. For over 40 days the HMO refused coverage. Due to a denial of medical treatment, about a month after that Ms. Cannon died.

The court ruled that under ERISA, she had no recovery. Under the Republican bill today, her estate would be entitled to $20,000—a small price for a life. Under the Republican bill, the penalty would be $500 per day. This represents a much cheaper alternative for an HMO than providing the treatment that should have been provided to Phyllis Cannon.

I submit to my colleagues that all Members of this House needs to look at what their State has done to protect patients because a vote for the Republican bill amounts to rolling back the protections that most of our State have already provided for patients under the law. In every place in this country, protecting patients enrolled in HMOs has been a bipartisan effort. Only in Washington is patient protection partisan.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. DINGELL

Mr. DINGELL. Mr. Speaker, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 in the Nature of a Substitute Offered by Mr. DINGELL:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Bill of Rights Act of 1998''.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH INSURANCE BILL OF RIGHTS

Subtitle A—Access to Care

Sec. 101. Access to emergency care.
Sec. 102. Offering of choice of coverage options under group health plans.
Sec. 103. Choice of providers.
Sec. 104. Access to specialty care.
Sec. 105. Continuity of care.
Sec. 106. Coverage for individuals participating in approved clinical trials.
Sec. 107. Access to needed prescription drugs.
Sec. 108. Adequacy of provider network.
Sec. 109. Nondiscrimination in delivery of services.

Subtitle B—Quality Assurance

Sec. 111. Internal quality assurance program.
Sec. 112. Collection of standardized data.
Sec. 113. Process for selection of providers.
Sec. 114. Drug utilization program.
Sec. 115. Standards for utilization review activities.
Sec. 116. Health Care Quality Advisory Board.

Subtitle C—Patient Information

Sec. 121. Patient information.
Sec. 122. Protection of patient confidentiality.
Sec. 123. Health insurance ombudsmen.

Subtitle D—Grievance and Appeals Procedures

Sec. 131. Establishment of grievance process.
Sec. 132. Internal appeals of adverse determinations.
Sec. 133. External appeals of adverse determinations.

Subtitle E—Protecting the Doctor-Patient Relationship

Sec. 141. Prohibition of interference with certain medical communications.
Sec. 142. Prohibition against transfer of indemnification or improper incentive arrangements.
Sec. 143. Additional rules regarding participation of health care professionals.
Sec. 144. Protection for patient advocacy.

Subtitle F—Promoting Good Medical Practice

Sec. 151. Promoting good medical practice.
Sec. 152. Standards relating to benefits for certain breast cancer treatment.
Sec. 153. Standards relating to benefits for reconstructive breast surgery.

Subtitle G—Definitions

Sec. 191. Definitions.
Sec. 192. Preemption; State flexibility; construction.
Sec. 193. Regulations.

TITLE II—APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER PUBLIC HEALTH SERVICE ACT

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

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

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

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

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

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

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

TITLE VI—REVENUE PROVISIONS

Sec. 601. Estate tax technical correction.
Sec. 602. Treatment of certain deductible liquidating distributions of regulated investment companies and real estate investment trusts.

TITLE I—HEALTH INSURANCE BILL OF RIGHTS

Subtitle A—Access to Care

SEC. 101. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

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

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

(ii) the plan or issuer pays an amount that is not less than the amount paid to a participating health care provider for the same services; and

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

(2) DEFINITIONS.—In this section:

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

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

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

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

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable), or, in the absence of guidelines under such section, such guidelines as the Secretary shall establish to carry out this subsection.

SEC. 102. OFFERING OF CHOICE OF COVERAGE OPTIONS UNDER GROUP HEALTH PLANS.

(a) REQUIREMENT.—

(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (or health insurance coverage offered by a health insurance issuer in connection with a group health plan) provides benefits only through participating health care providers, the plan or issuer shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan or coverage and at such other times as the plan or issuer offers the participant a choice of coverage options.

(2) EXCEPTION.—Paragraph (1) shall not apply with respect to a participant in a group health plan if the plan offers the participant—

(A) a choice of health insurance coverage through more than one health insurance issuer; or

(B) two or more coverage options that differ significantly with respect to the use of participating health care providers or the networks of such providers that are used.

(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term ''point-of-service coverage'' means, with respect to benefits covered under a group health plan or health insurance issuer, coverage of such benefits when provided by a nonparticipating health care provider. Such coverage need not include coverage of providers that the plan or issuer excludes because of fraud, quality, or similar reasons.

(c) CONSTRUCTION.—Nothing in this section shall be construed—

(1) as requiring coverage for benefits for a particular type of health care provider;

(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options; or

(3) as preventing a group health plan or health insurance issuer from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option.

(d) NO REQUIREMENT FOR GUARANTEED AVAILABILITY.—If a health insurance issuer offers health insurance coverage that includes point-of-service coverage with respect to an employer solely in order to meet the requirement of subsection (a), nothing in section 2711(a)(1)(A) of the Public Health Service Act shall be construed as requiring the offering of such coverage with respect to another employer.

SEC. 103. CHOICE OF PROVIDERS.

(a) PRIMARY CARE.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall permit each participant, beneficiary, and enrollee to receive primary care from any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

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

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

SEC. 104. ACCESS TO SPECIALTY CARE.

(a) OBSTETRICAL AND GYNECOLOGICAL CARE.—

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

(A) the plan or issuer shall permit such an individual who is a female to designate a participating physician who specializes in obstetrics and gynecology as the individual's primary care provider; and

(B) if such an individual has not designated such a provider as a primary care provider, the plan or issuer—

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

(ii) may treat the ordering of other gynecological care by such a participating physician as the authorization of the primary care provider with respect to such care under the plan or coverage.

(2) CONSTRUCTION.—Nothing in paragraph (1)(B)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care so ordered.

(b) SPECIALTY CARE.—

(1) SPECIALTY CARE FOR COVERED SERVICES.—

(A) IN GENERAL.—If—

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

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

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

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

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

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

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

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

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

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

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

(2) SPECIALISTS AS PRIMARY CARE PROVIDERS.—

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

(B) TREATMENT AS PRIMARY CARE PROVIDER.—Such specialist shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in paragraph (1)(C)(i)).

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

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

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

(D) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

(3) STANDING REFERRALS.—

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

(B) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

SEC. 105. CONTINUITY OF CARE.

(a) IN GENERAL.—

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

(A) notify the individual on a timely basis of such termination, and

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

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

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

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend for at least 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee has entered the second trimester of pregnancy at the time of a provider's termination of participation, and

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

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

(4) TERMINAL ILLNESS.—If—

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

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

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

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

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

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

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

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

SEC. 106. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

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

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

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

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

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

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

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

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

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

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

(2) Either—

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

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

(c) PAYMENT.—

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

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

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

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

(d) APPROVED CLINICAL TRIAL DEFINED.—

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

(A) The National Institutes of Health.

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

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

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

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

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

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

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

SEC. 107. ACCESS TO NEEDED PRESCRIPTION DRUGS.

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

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

(2) disclose to providers and, disclose upon request under section 121(c)(6) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(3) consistent with the standards for a utilization review program under section 115, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

(b) COVERAGE OF APPROVED DRUGS AND MEDICAL DEVICES.—

(1) IN GENERAL.—A group health plan (or health insurance coverage offered in connection with such a plan) that provides any coverage of prescription drugs or medical devices shall not deny coverage of such a drug or device on the basis that the use is investigational, if the use—

(A) in the case of a prescription drug—

(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

(ii) is included in the labeling authorized by the application in effect for the drug under section 351 of the Public Health Service Act, without regard to any postmarketing requirements that may apply pursuant to such section; or

(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, an order under subsection (f) of such section, or an application approved under section 515 of such Act, without regard to any postmarketing requirements that may apply under such Act.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any coverage of prescription drugs or medical devices.

SEC. 108. ADEQUACY OF PROVIDER NETWORK.

(a) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage, that provides benefits, in whole or in part, through participating health care providers shall have (in relation to the coverage) a sufficient number, distribution, and variety of qualified participating health care providers to ensure that all covered health care services, including specialty services, will be available and accessible in a timely manner to all participants, beneficiaries, and enrollees under the plan or coverage.

(b) TREATMENT OF CERTAIN PROVIDERS.—The qualified health care providers under subsection (a) may include Federally qualified health centers, rural health clinics, migrant health centers, and other essential community providers located in the service area of the plan or issuer and shall include such providers if necessary to meet the standards established to carry out such subsection.

SEC. 109. NONDISCRIMINATION IN DELIVERY OF SERVICES.

(a) APPLICATION TO DELIVERY OF SERVICES.—Subject to subsection (b), a group health plan, and health insurance issuer in relation to health insurance coverage, may not discriminate against a participant, beneficiary, or enrollee in the delivery of health care services consistent with the benefits covered under the plan or coverage or as required by law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed as relating to the eligibility to be covered, or the offering (or guaranteeing the offer) of coverage, under a plan or health insurance coverage, the application of any pre-existing condition exclusion consistent with applicable law, or premiums charged under such plan or coverage.

Subtitle B—Quality Assurance

SEC. 111. INTERNAL QUALITY ASSURANCE PROGRAM.

(a) REQUIREMENT.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall establish and maintain an ongoing, internal quality assurance and continuous quality improvement program that meets the requirements of subsection (b).

(b) PROGRAM REQUIREMENTS.—The requirements of this subsection for a quality improvement program of a plan or issuer are as follows:

(1) ADMINISTRATION.—The plan or issuer has a separate identifiable unit with responsibility for administration of the program.

(2) WRITTEN PLAN.—The plan or issuer has a written plan for the program that is updated annually and that specifies at least the following:

(A) The activities to be conducted.

(B) The organizational structure.

(C) The duties of the medical director.

(D) Criteria and procedures for the assessment of quality.

(3) SYSTEMATIC REVIEW.—The program provides for systematic review of the type of health services provided, consistency of services provided with good medical practice, and patient outcomes.

(4) QUALITY CRITERIA.—The program—

(A) uses criteria that are based on performance and patient outcomes where feasible and appropriate;

(B) includes criteria that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate;

(C) includes methods for informing covered individuals of the benefit of preventive care and what specific benefits with respect to preventive care are covered under the plan or coverage; and

(D) makes available to the public a description of the criteria used under subparagraph (A).

(5) SYSTEM FOR REPORTING.—The program has procedures for reporting of possible quality concerns by providers and enrollees and for remedial actions to correct quality problems, including written procedures for responding to concerns and taking appropriate corrective action.

(6) DATA ANALYSIS.—The program provides, using data that include the data collected under section 112, for an analysis of the plan's or issuer's performance on quality measures.

(7) DRUG UTILIZATION REVIEW.—The program provides for a drug utilization review program in accordance with section 114.

(c) DEEMING.—For purposes of subsection (a), the requirements of—

(1) subsection (b) (other than paragraph (5)) are deemed to be met with respect to a health insurance issuer that is a qualified health maintenance organization (as defined in section 1310(c) of the Public Health Service Act); or

(2) subsection (b) are deemed to be met with respect to a health insurance issuer that is accredited by a national accreditation organization that the Secretary certifies as applying, as a condition of certification, standards at least as stringent as those required for a quality improvement program under subsection (b).

(d) VARIATION PERMITTED.—The Secretary may provide for variations in the application of the requirements of this section to group health plans and health insurance issuers based upon differences in the delivery system among such plans and issuers as the Secretary deems appropriate.

SEC. 112. COLLECTION OF STANDARDIZED DATA.

(a) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall collect uniform quality data that include a minimum uniform data set described in subsection (b).

(b) MINIMUM UNIFORM DATA SET.—The Secretary shall specify (and may from time to time update) the data required to be included

in the minimum uniform data set under subsection (a) and the standard format for such data. Such data shall include at least—

(1) aggregate utilization data;

(2) data on the demographic characteristics of participants, beneficiaries, and enrollees;

(3) data on disease-specific and age-specific mortality rates and (to the extent feasible) morbidity rates of such individuals;

(4) data on satisfaction of such individuals, including data on voluntary disenrollment and grievances; and

(5) data on quality indicators and health outcomes, including, to the extent feasible and appropriate, data on pediatric cases and on a gender-specific basis.

(c) AVAILABILITY.—A summary of the data collected under subsection (a) shall be disclosed under section 121(b)(9). The Secretary shall be provided access to all the data so collected.

(d) VARIATION PERMITTED.—The Secretary may provide for variations in the application of the requirements of this section to group health plans and health insurance issuers based upon differences in the delivery system among such plans and issuers as the Secretary deems appropriate.

SEC. 113. PROCESS FOR SELECTION OF PROVIDERS.

(a) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall, if it provides benefits through participating health care professionals, have a written process for the selection of participating health care professionals, including minimum professional requirements.

(b) VERIFICATION OF BACKGROUND.—Such process shall include verification of a health care provider's license and a history of suspension or revocation.

(c) RESTRICTION.—Such process shall not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation.

(d) NONDISCRIMINATION BASED ON LICENSURE.—

(1) IN GENERAL.—Such process shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed—

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

(B) to override any State licensure or scope-of-practice law.

(e) GENERAL NONDISCRIMINATION.—

(1) IN GENERAL.—Subject to paragraph (2), such process shall not discriminate with respect to selection of a health care professional to be a participating health care provider, or with respect to the terms and conditions of such participation, based on the professional's race, color, religion, sex, national origin, age, sexual orientation, or disability (consistent with the Americans with Disabilities Act of 1990).

(2) RULES.—The appropriate Secretary may establish such definitions, rules, and exceptions as may be appropriate to carry out paragraph (1), taking into account comparable definitions, rules, and exceptions in effect under employment-based nondiscrimination laws and regulations that relate to each of the particular bases for discrimination described in such paragraph.

SEC. 114. DRUG UTILIZATION PROGRAM.

A group health plan, and a health insurance issuer that provides health insurance coverage, that includes benefits for prescription drugs shall establish and maintain, as part of its internal quality assurance and continuous quality improvement program under section 111, a drug utilization program which—

(1) encourages appropriate use of prescription drugs by participants, beneficiaries, and enrollees and providers, and

(2) takes appropriate action to reduce the incidence of improper drug use and adverse drug reactions and interactions.

SEC. 115. STANDARDS FOR UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

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

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

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed pursuant to the program with the input of appropriate physicians. Such criteria shall include written clinical review criteria described in section 111(b)(4)(B).

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

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions. In this subsection, the term ''health care professional'' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

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

(B) PEER REVIEW OF SAMPLE OF ADVERSE CLINICAL DETERMINATIONS.—Such a program shall provide that clinical peers (as defined in section 191(c)(2)) shall evaluate the clinical appropriateness of at least a sample of adverse clinical determinations.

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

(i) provides incentives, direct or indirect, for such persons to make inappropriate review decisions, or

(ii) is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

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

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

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

(5) LIMITATION ON INFORMATION REQUESTS.—Under such a program, information shall be required to be provided by health care providers only to the extent it is necessary to perform the utilization review activity involved.

(6) REVIEW OF PRELIMINARY UTILIZATION REVIEW DECISION.—Under such program a participant, beneficiary, or enrollee or any provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with a preliminary utilization review decision has the opportunity to discuss the decision with, and have such decision reviewed by, the medical director of the plan or issuer involved (or the director's designee) who has the authority to reverse the decision.

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 3 business days after the date of receipt of information that is reasonably necessary to make such determination.

(2) CONTINUED CARE.—In the case of a utilization review activity involving authorization for continued or extended health care services for an individual, or additional services for an individual undergoing a course of continued treatment prescribed by a health care provider, the utilization review program shall make a determination concerning such

authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 1 business day after the date of receipt of information that is reasonably necessary to make such determination. Such notice shall include, with respect to continued or extended health care services, the number of extended services approved, the new total of approved services, the date of onset of services, and the next review date, if any.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination.

(4) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 101, respectively.

(e) NOTICE OF ADVERSE DETERMINATIONS.—

(1) IN GENERAL.—Notice of an adverse determination under a utilization review program shall be provided in printed form and shall include—

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

(B) instructions on how to initiate an appeal under section 132; and

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

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

SEC. 116. HEALTH CARE QUALITY ADVISORY BOARD.

(a) ESTABLISHMENT.—The President shall establish an advisory board to provide information to Congress and the administration on issues relating to quality monitoring and improvement in the health care provided under group health plans and health insurance coverage.

(b) NUMBER AND APPOINTMENT.—The advisory board shall be composed of the Secretary of Health and Human Services (or the Secretary's designee), the Secretary of Labor (or the Secretary's designee), and 20 additional members appointed by the President, in consultation with the Majority and Minority Leaders of the Senate and House of Representatives. The members so appointed shall include individuals with expertise in—

(1) consumer needs;

(2) education and training of health professionals;

(3) health care services;

(4) health plan management;

(5) health care accreditation, quality assurance, improvement, measurement, and oversight;

(6) medical practice, including practicing physicians;

(7) prevention and public health; and

(8) public and private group purchasing for small and large employers or groups.

(c) DUTIES.—The advisory board shall—

(1) identify, update, and disseminate measures of health care quality for group health plans and health insurance issuers, including network and non-network plans;

(2) advise the Secretary on the development and maintenance of the minimum data set in section 112(b); and

(3) advise the Secretary on standardized formats for information on group health plans and health insurance coverage.

The measures identified under paragraph (1) may be used on a voluntary basis by such plans and issuers. In carrying out paragraph (1), the advisory board shall consult and cooperate with national health care standard setting bodies which define quality indicators, the Agency for Health Care Policy and Research, the Institute of Medicine, and other public and private entities that have expertise in health care quality.

(d) REPORT.—The advisory board shall provide an annual report to Congress and the President on the quality of the health care in the United States and national and regional trends in health care quality. Such report shall include a description of determinants of health care quality and measurements of practice and quality variability within the United States.

(e) SECRETARIAL CONSULTATION.—In serving on the advisory board, the Secretaries of Health and Human Services and Labor (or their designees) shall consult with the Secretaries responsible for other Federal health insurance and health care programs.

(f) VACANCIES.—Any vacancy on the board shall be filled in such manner as the original appointment. Members of the board shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in the performance of their duties. Administrative support, scientific support, and technical assistance for the advisory board shall be provided by the Secretary of Health and Human Services.

(g) CONTINUATION.—Section 14(a)(2)(B) of the Federal Advisory Committee Act (5 U.S.C. App.; relating to the termination of advisory committees) shall not apply to the advisory board.

Subtitle C—Patient Information

SEC. 121. PATIENT INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

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

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

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

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

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

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

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

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 103(b)(2).

(H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals and including the provision of information in a language other than English if 5 percent of the number of participants, beneficiaries, and enrollees communicate in that language instead of English.

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

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

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

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

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

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

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

(8) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer, and the availability of assistance through an ombudsman to individuals in relation to group health plans and health insurance coverage.

(9) QUALITY ASSURANCE.—A summary description of the data on quality collected under section 112(a), including a summary description of the data on satisfaction of participants, beneficiaries, and enrollees (including data on individual voluntary disenrollment and grievances and appeals) described in section 112(b)(4).

(10) SUMMARY OF PROVIDER FINANCIAL INCENTIVES.—A summary description of the information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

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

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

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

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 115, including under any drug formulary program under section 107.

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

(3) METHOD OF PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians, including information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

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

(5) CONFIDENTIALITY POLICIES AND PROCEDURES.—A description of the policies and procedures established to carry out section 122.

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

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

(d) FORM OF DISCLOSURE.—

(1) UNIFORMITY.—Information required to be disclosed under this section shall be provided in accordance with uniform, national reporting standards specified by the Secretary, after consultation with applicable State authorities, so that prospective enrollees may compare the attributes of different issuers and coverage offered within an area.

(2) INFORMATION INTO HANDBOOK.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from making the information under subsections (b) and (c) available to participants, beneficiaries, and enrollees through an enrollee handbook or similar publication.

(3) UPDATING PARTICIPATING PROVIDER INFORMATION.—The information on participating health care providers described in subsection (b)(3)(C) shall be updated within such reasonable period as determined appropriate by the Secretary. Nothing in this section shall prevent an issuer from changing or updating other information made available under this section.

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

SEC. 122. PROTECTION OF PATIENT CONFIDENTIALITY.

Insofar as a group health plan, or a health insurance issuer that offers health insurance coverage, maintains medical records or other health information regarding participants, beneficiaries, and enrollees, the plan or issuer shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely, and

(3) to assure timely access of such individuals to such records and information.

SEC. 123. HEALTH INSURANCE OMBUDSMEN.

(a) IN GENERAL.—Each State that obtains a grant under subsection (c) shall provide for creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers. Such Ombudsman shall be responsible for at least the following:

(1) To assist consumers in the State in choosing among health insurance coverage or among coverage options offered within group health plans.

(2) To provide counseling and assistance to enrollees dissatisfied with their treatment by health insurance issuers and group health plans in regard to such coverage or plans and with respect to grievances and appeals regarding determinations under such coverage or plans.

(b) FEDERAL ROLE.—In the case of any State that does not provide for such an Ombudsman under subsection (a), the Secretary shall provide for the creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers and that is responsible for carrying out with respect to that State the functions otherwise provided under subsection (a) by a Health Insurance Ombudsman.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services such amounts as may be necessary to provide for grants to States for contracts for Health Insurance Ombudsmen under subsection (a) or contracts for such Ombudsmen under subsection (b).

(d) CONSTRUCTION.—Nothing in this section shall be construed to prevent the use of other forms of enrollee assistance.

Subtitle D—Grievance and Appeals Procedures

SEC. 131. ESTABLISHMENT OF GRIEVANCE PROCESS.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent, regarding any aspect of the plan's or issuer's services.

(2) SCOPE.—The system shall include grievances regarding access to and availability of services, quality of care, choice and accessibility of providers, network adequacy, and compliance with the requirements of this title.

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

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

(2) A system to record and document, over a period of at least 3 previous years, all grievances and appeals made and their status.

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

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

(5) Notification to the continuous quality improvement program under section 111(a) of all grievances and appeals relating to quality of care.

SEC. 132. INTERNAL APPEALS OF ADVERSE DETERMINATIONS.

(a) RIGHT OF APPEAL.—

(1) IN GENERAL.—A participant or beneficiary in a group health plan, and an enrollee in health insurance coverage offered by a health insurance issuer, and any provider or other person acting on behalf of such an individual with the individual's consent, may appeal any appealable decision (as defined in paragraph (2)) under the procedures described in this section and (to the extent applicable) section 133. Such individuals and providers shall be provided with a written explanation of the appeal process and the determination upon the conclusion of the appeals process and as provided in section 121(b)(8).

(2) APPEALABLE DECISION DEFINED.—In this section, the term ''appealable decision'' means any of the following:

(A) Denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(B) Failure to provide coverage of emergency services or reimbursement of maintenance care or post-stabilization care under section 101.

(C) Failure to provide a choice of provider under section 103.

(D) Failure to provide qualified health care providers under section 103.

(E) Failure to provide access to specialty and other care under section 104.

(F) Failure to provide continuation of care under section 105.

(G) Failure to provide coverage of routine patient costs in connection with an approval clinical trial under section 106.

(H) Failure to provide access to needed drugs under section 107(a)(3) or 107(b).

(I) Discrimination in delivery of services in violation of section 109.

(J) An adverse determination under a utilization review program under section 115.

(K) The imposition of a limitation that is prohibited under section 151.

(b) INTERNAL APPEAL PROCESS.—

(1) IN GENERAL.—Each group health plan and health insurance issuer shall establish and maintain an internal appeal process under which any participant, beneficiary, enrollee, or provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with any appealable decision has the opportunity to appeal the decision through an internal appeal process. The appeal may be communicated orally.

(2) CONDUCT OF REVIEW.—

(A) IN GENERAL.—The process shall include a review of the decision by a physician or other health care professional (or professionals) who has been selected by the plan or issuer and who has not been involved in the appealable decision at issue in the appeal.

(B) AVAILABILITY AND PARTICIPATION OF CLINICAL PEERS.—The individuals conducting such review shall include one or more clinical peers (as defined in section 191(c)(2)) who have not been involved in the appealable decision at issue in the appeal.

(3) DEADLINE.—

(A) IN GENERAL.—Subject to subsection (c), the plan or issuer shall conclude each appeal as soon as possible after the time of the receipt of the appeal in accordance with medical exigencies of the case involved, but in no event later than—

(i) 72 hours after the time of receipt of an expedited appeal, and

(ii) except as provided in subparagraph (B), 30 business days after such time (or, if the participant, beneficiary, or enrollee supplies additional information that was not available to the plan or issuer at the time of the receipt of the appeal, after the date of supplying such additional information) in the case of all other appeals.

(B) EXTENSION.—In the case of an appeal that does not relate to a decision regarding an expedited appeal and that does not involve medical exigencies, if a group health plan or health insurance issuer is unable to conclude the appeal within the time period provided under subparagraph (A)(ii) due to circumstances beyond the control of the plan or issuer, the deadline shall be extended for up to an additional 10 business days if the plan or issuer provides, on or before 10 days before the deadline otherwise applicable, written notice to the participant, beneficiary, or enrollee and the provider involved of the extension and the reasons for the extension.

(4) NOTICE.—If a plan or issuer denies an appeal, the plan or issuer shall provide the participant, beneficiary, or enrollee and provider involved with notice in printed form of the denial and the reasons therefore, together with a notice in printed form of rights to any further appeal.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of appeals under subsection (b) in situations in which the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function.

(2) PROCESS.—Under such procedures—

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

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

(C) the plan or issuer shall expedite the appeal if the request for an expedited appeal is submitted under subparagraph (A) by a physician and the request indicates that the situation described in paragraph (1) exists.

(d) DIRECT USE OF FURTHER APPEALS.—In the event that the plan or issuer fails to comply with any of the deadlines for completion of appeals under this section or in the event that the plan or issuer for any reason expressly waives its rights to an internal review of an appeal under subsection (b), the participant, beneficiary, or enrollee involved and the provider involved shall be relieved of any obligation to complete the appeal involved and may, at such an individual's or provider's option, proceed directly to seek further appeal through any applicable external appeals process.

SEC. 133. EXTERNAL APPEALS OF ADVERSE DETERMINATIONS.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2). The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—For purposes of this section, the term ''externally appealable decision'' means an appealable decision (as defined in section 132(a)(2)) if—

(A) the amount involved exceeds a significant threshold; or

(B) the patient's life or health is jeopardized as a consequence of the decision.

Such term does not include a denial of coverage for services that are specifically listed in plan or coverage documents as excluded from coverage.

(3) EXHAUSTION OF INTERNAL APPEALS PROCESS.—A plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon completion of the internal review process provided under section 132, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

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

(B) RESTRICTIONS ON QUALIFIED EXTERNAL APPEAL ENTITY.—

(i) BY STATE FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in such a manner as to assure an unbiased determination.

(ii) BY FEDERAL GOVERNMENT FOR GROUP HEALTH PLANS.—With respect to group health plans, the appropriate Secretary may exercise the same authority as a State may exercise with respect to health insurance issuers under clause (i). Such authority may include requiring the use of the qualified external appeal entity designated or selected under such clause.

(iii) LIMITATION ON PLAN OR ISSUER SELECTION.—If an applicable authority permits more than one entity to qualify as a qualified external appeal entity with respect to a group health plan or health insurance issuer and the plan or issuer may select among such qualified entities, the applicable authority—

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

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

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that the direct costs of the process (not including costs of representation of a participant, beneficiary, or enrollee) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee.

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

(A) FAIR PROCESS; DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination.

(B) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine whether a decision is an externally appealable decision and related decisions, including—

(i) whether such a decision involves an expedited appeal;

(ii) the appropriate deadlines for internal review process required due to medical exigencies in a case; and

(iii) whether such a process has been completed.

(C) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to an externally appealable decision—

(i) may submit and review evidence related to the issues in dispute,

(ii) may use the assistance or representation of one or more individuals (any of whom may be an attorney), and

(iii) may make an oral presentation.

(D) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to all its records relating to the matter of the externally appealable decision and to all provisions of the plan or health insurance coverage (including any coverage manual) relating to the matter.

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

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

(ii) be binding on the plan or issuer;

(iii) be made in accordance with the medical exigencies of the case involved, but in no event later than 60 days (or 72 hours in the case of an expedited appeal) from the date of completion of the filing of notice of external appeal of the decision;

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

(v) inform the participant, beneficiary, or enrollee of the individual's rights to seek further review by the courts (or other process) of the external appeal determination.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

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

(A) There is no real or apparent conflict of interest that would impede the entity conducting external appeal activities independent of the plan or issuer.

(B) The entity conducts external appeal activities through clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(3)(E).

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

(2) CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

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

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1) by the Secretary of Labor (or under a process recognized or approved by the Secretary of Labor); or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements by the applicable State authority (or, if the States has not established an adequate certification and recertification process, by the Secretary of Health and Human Services, or under a process recognized or approved by such Secretary).

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

(i) the information required to be submitted as a condition of recertification on the entity's performance of external appeal activities, which information shall include the number of cases reviewed, a summary of the disposition of those cases, the length of time in making determinations on those cases, and such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted; and

(ii) the periodicity which recertification will be required.

(d) CONTINUING LEGAL RIGHTS OF ENROLLEES.—Nothing in this title shall be construed as removing any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law, including the right to file judicial actions to enforce rights.

Subtitle E—Protecting the Doctor-Patient Relationship

SEC. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) PROHIBITION.—

(1) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider's patient.

(2) NULLIFICATION.—Any contract provision or agreement described in paragraph (1) shall be null and void.

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

(1) to prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a group health plan or health insurance issuer to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

(2) to permit a health care provider to misrepresent the scope of benefits covered under the group health plan or health insurance coverage or to otherwise require a group health plan health insurance issuer to reimburse providers for benefits not covered under the plan or coverage.

(c) MEDICAL COMMUNICATION DEFINED.—In this section:

(1) IN GENERAL.—The term ''medical communication'' means any communication made by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) with respect to—

(A) the patient's health status, medical care, or treatment options;

(B) any utilization review requirements that may affect treatment options for the patient; or

(C) any financial incentives that may affect the treatment of the patient.

(2) MISREPRESENTATION.—The term ''medical communication'' does not include a communication by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) if the communication involves a knowing or willful misrepresentation by such provider.

SEC. 142. PROHIBITION AGAINST TRANSFER OF INDEMNIFICATION OR IMPROPER INCENTIVE ARRANGEMENTS.

(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—

(1) IN GENERAL.—No contract or agreement between a group health plan or health insurance issuer (or any agent acting on behalf of such a plan or issuer) and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the plan, issuer, or agent (as opposed to the provider).

(2) NULLIFICATION.—Any contract or agreement provision described in paragraph (1) shall be null and void.

(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

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

(2) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

SEC. 143. ADDITIONAL RULES REGARDING PARTICIPATION OF HEALTH CARE PROFESSIONALS.

(a) PROCEDURES.—Insofar as a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits through participating health care professionals, the plan or issuer shall establish reasonable procedures relating to the participation (under an agreement between a professional and the plan or issuer) of such professionals under the plan or coverage. Such procedures shall include—

(1) providing notice of the rules regarding participation;

(2) providing written notice of participation decisions that are adverse to professionals; and

(3) providing a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

(b) CONSULTATION IN MEDICAL POLICIES.—A group health plan, and health insurance issuer that offers health insurance coverage, shall consult with participating physicians (if any) regarding the plan's or issuer's medical policy, quality, and medical management procedures.

SEC. 144. PROTECTION FOR PATIENT ADVOCACY.

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

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

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

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

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

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

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

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

the same licensure or certification and the same experience;

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

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

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

(3) EXCEPTION AND SPECIAL RULE.—

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

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

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

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

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

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

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

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

(6) CONSTRUCTIONS.—

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

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

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

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

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

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

Subtitle F—Promoting Good Medical Practice

SEC. 151. PROMOTING GOOD MEDICAL PRACTICE.

(a) PROHIBITING ARBITRARY LIMITATIONS OR CONDITIONS FOR THE PROVISION OF SERVICES.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed as prohibiting a plan or issuer from limiting the delivery of services to one or more health care providers within a network of such providers.

(3) MANNER OR SETTING DEFINED.—In paragraph (1), the term ''manner or setting'' means the location of treatment, such as whether treatment is provided on an inpatient or outpatient basis, and the duration of treatment, such as the number of days in a hospital, Such term does not include the coverage of a particular service or treatment.

(b) NO CHANGE IN COVERAGE.—Subsection (a) shall not be construed as requiring coverage of particular services the coverage of which is otherwise not covered under the terms of the plan or coverage or from conducting utilization review activities consistent with this subsection.

(c) MEDICAL NECESSITY OR APPROPRIATENESS DEFINED.—In subsection (a), the term ''medically necessary or appropriate'' means, with respect to a service or benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice.

SEC. 152. STANDARDS RELATING TO BENEFITS FOR CERTAIN BREAST CANCER TREATMENT.

(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING MASTECTOMY OR LYMPH NODE DISSECTION.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with a mastectomy for the treatment of breast cancer to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours, or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the woman involved prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by the attending provider in consultation with the woman or in a case involving a partial mastectomy without lymph node dissection.

(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to women to encourage such women to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a woman who is a participant or beneficiary—

(A) to undergo a mastectomy or lymph node dissection in a hospital; or

(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1) of the Public Health Service Act) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital

length of stay following a mastectomy performed for treatment of breast cancer and at least a 24-hour hospital length of stay following a lymph node dissection for treatment of breast cancer.

(B) Such State law requires, in connection with such coverage for surgical treatment of breast cancer, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the woman involved.

(2) CONSTRUCTION.—Section 2723(a)(1) of the Public Health Service Act and section 731(a)(1) of the Employee Retirement Income Security Act of 1974 shall not be construed as superseding a State law described in paragraph (1).

SEC. 153. STANDARDS RELATING TO BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY.

(a) REQUIREMENTS FOR RECONSTRUCTIVE BREAST SURGERY.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for breast surgery in connection with a mastectomy shall provide coverage for reconstructive breast surgery resulting from the mastectomy. Such coverage shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased when reconstruction on the diseased breast is performed and coverage of prostheses and complications of mastectomy including lymphedema.

(2) RECONSTRUCTIVE BREAST SURGERY DEFINED.—In this section, the term ''reconstructive breast surgery'' means surgery performed as a result of a mastectomy to reestablish symmetry between two breasts, and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(3) MASTECTOMY DEFINED.—In this section, the term ''mastectomy'' means the surgical removal of all or part of a breast.

(b) PROHIBITIONS.—

(1) DENIAL OF COVERAGE BASED ON COSMETIC SURGERY.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not deny coverage described in subsection (a)(1) on the basis that the coverage is for cosmetic surgery.

(2) APPLICATION OF SIMILAR PROHIBITIONS.—Paragraphs (2) through (5) of section 152 shall apply under this section in the same manner as they apply with respect to section 152.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a woman who is a participant or beneficiary to undergo reconstructive breast surgery.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for mastectomies.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for reconstructive breast surgery under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion may not be greater than such coinsurance or cost-sharing that is otherwise applicable with respect to benefits for mastectomies.

(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1) of the Public Health Service Act) for a State that regulates such coverage and that requires coverage of at least the coverage of reconstructive breast surgery otherwise required under this section.

(2) CONSTRUCTION.—Section 2723(a)(1) of the Public Health Service Act and section 731(a)(1) of the Employee Retirement Income Security Act of 1974 shall not be construed as superseding a State law described in paragraph (1).

Subtitle G—Definitions

SEC. 191. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—The provisions of section 2971 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the Secretary of the Treasury and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act, the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974, and the Secretary of the Treasury in relation to carrying out this title under chapter 100 and section 4980D of the Internal Revenue Code of 1986.

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

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

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

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

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

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional provider of health care services.

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

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

SEC. 192. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

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

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(b) RULES OF CONSTRUCTION.—Except as provided in sections 152 and 153, nothing in this title shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

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

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

SEC. 193. REGULATIONS.

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

TITLE II—APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER PUBLIC HEALTH SERVICE ACT

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

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

''SEC. 2706. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Patients' Bill of Rights Act of 1998, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to

the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2706)'' after ''requirements of such subparts''.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

''SEC. 2752. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Patients' Bill of Rights Act of 1998 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

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

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

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

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

''SEC. 713. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Patients' Bill of Rights Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

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

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Patients' Bill of Rights Act of 1998 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 101 (relating to access to emergency care).

''(B) Section 102(a)(1) (relating to offering option to purchase point-of-service coverage), but only insofar as the plan is meeting such requirement through an agreement with the issuer to offer the option to purchase point-of-service coverage under such section.

''(C) Section 103 (relating to choice of providers).

''(D) Section 104 (relating to access to specialty care).

''(E) Section 105(a)(1) (relating to continuity in case of termination of provider contract) and section 105(a)(2) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(F) Section 106 (relating to coverage for individuals participating in approved clinical trials.)

''(G) Section 107 (relating to access to needed prescription drugs).

''(H) Section 108 (relating to adequacy of provider network).

''(I) Subtitle B (relating to quality assurance).

''(J) Section 143 (relating to additional rules regarding participation of health care professionals).

''(K) Section 152 (relating to standards relating to benefits for certain breast cancer treatment).

''(L) Section 153 (relating to standards relating to benefits for reconstructive breast surgery).

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

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the grievance system and internal appeals process required to be established under sections 131 and 132, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such system and process (and is not liable for the issuer's failure to provide for such system and process), if the issuer is obligated to provide for (and provides for) such system and process.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 133, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

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

''(A) Section 109 (relating to nondiscrimination in delivery of services).

''(B) Section 141 (relating to prohibition of interference with certain medical communications).

''(C) Section 142 (relating to prohibition against transfer of indemnification or improper incentive arrangements).

''(D) Section 144 (relating to prohibition on retaliation).

''(E) Section 151 (relating to promoting good medical practice).

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

''(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 144(b)(1) of the Patients' Bill of Rights Act of 1998, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 144(b)(1) of the Patients' Bill of Rights Act of 1998 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

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

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

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

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle D (and section 115) of title I of the Patients' Bill of Rights Act of 1998 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 144(b))'' after ''part 7''.

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

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

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

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

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

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

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

''(2) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

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

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

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

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

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

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

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is not covered under the group health plan involved.''.

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

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

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

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (as amended by section 1531(a) of the Taxpayer Relief Act of 1997) is amended—

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

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

(2) by inserting after section 9812 the following:

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

''A group health plan shall comply with the requirements of title I of the Patients' Bill of Rights Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after October 1, 1999 (in this section referred to as the ''general effective date'').

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

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

SEC. 502. COORDINATION IN IMPLEMENTATION.

Section 104(1) of the Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, chapter 100 of the Internal Revenue Code of 1986, and title I of the Patients' Bill of Rights Act of 1998''.

TITLE VI—REVENUE PROVISIONS

SEC. 601. ESTATE TAX TECHNICAL CORRECTION.

(a) IN GENERAL.—Paragraph (2) of section 2001(c) of the Internal Revenue Code of 1986 is amended by striking ''$10,000,000'' and all that follows and inserting ''$10,000,000. The amount of the increase under the preceding sentence shall not exceed the sum of the applicable credit amount under section 2010(c) (determined without regard to section 2057(a)(3)) and $359,200.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendments made by section 501 of the Taxpayer Relief Act of 1997.

SEC. 602. TREATMENT OF CERTAIN DEDUCTIBLE LIQUIDATING DISTRIBUTIONS OF REGULATED INVESTMENT COMPANIES AND REAL ESTATE INVESTMENT TRUSTS.

(a) IN GENERAL.—Section 332 of the Internal Revenue Code of 1986 (relating to complete liquidations of subsidiaries) is amended by adding at the end the following new subsection:

''(c) DEDUCTIBLE LIQUIDATING DISTRIBUTIONS OF REGULATED INVESTMENT COMPANIES AND REAL ESTATE INVESTMENT TRUSTS.—If a corporation receives a distribution from a regulated investment company or a real estate investment trust which is considered under subsection (b) as being in complete liquidation of such company or trust, then, notwithstanding any other provision of this chapter, such corporation shall recognize and treat as a dividend from such company or trust an amount equal to the deduction for dividends paid allowable to such company or trust by reason of such distribution.''.

(b) CONFORMING AMENDMENTS.—

(1) The material preceding paragraph (1) of section 332(b) of such Code is amended by striking ''subsection (a)'' and inserting ''this section''.

(2) Paragraph (1) of section 334(b) of such Code is amended by striking ''section 332(a)'' and inserting ''section 332''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after May 21, 1998.

The SPEAKER pro tempore. Pursuant to House Resolution 509, the gentleman from Michigan (Mr. DINGELL) and the gentleman from Illinois (Mr. HASTERT) each will control 30 minutes.

The Chair recognizes the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from Iowa (Mr. GANSKE), my distinguished friend, for purposes of offering the amendment.

Mr. GANSKE. Mr. Speaker, I rise in support of the Ganske-Dingell substitute. This substitute is supported by Consumers Union, other consumer groups, about 170 health groups, both consumer groups and provider groups. It is supported by the AARP, it is supported by the AMA, the Nurses Association, and by the AFL–CIO. It has broad, widespread support, for a good reason.

Let me specifically address my friend LINDSEY GRAHAM's comments about the underlying Republican bill and how it relates to the substitute on liability. My friend LINDSEY GRAHAM is trying to improve the GOP bill.

Consider the family of Joyce Chiang. Her complaints of severe abdominal pain and requests for a referral to a specialist went unheeded. The delay prevented the timely discovery of a colon cancer that might have been cured. Instead, by the time she got the additional tests she requested, the cancer had perforated her bowel and no amount of surgery could save her.

Under the Hastert bill, Joyce Chiang's family could only collect $500 for every day the care was denied. But I would say that is hardly an effective remedy or deterrent, when it can cost health plans more to provide the needed care than it would potentially cost them in a subsequent legal action.

Mr. Speaker, I am not interested in granting tobacco companies legal protections for their conduct; and I cannot see how it serves our constituents to allow health plans who are making life-and-death decisions to hide from their consequences.

Republicans believe in personal responsibility, and this immunity that is preserved in the Hastert bill flies in the face of that. Health plans should be treated like any other industry and held accountable for their negligent actions.

Furthermore, the GOP bill does not get at a fundamental underlying problem, and that is that the HMOs can define what is medically necessary. Before our Committee on Commerce we had a medical reviewer describe how she had made decisions that resulted in the loss of life because she could manipulate the way the HMO defined ''medically necessary.'' Under the Ganske-Dingell bill, we address that problem. Their bill does not.

I strongly urge my Republican colleagues to vote for the best bill, the one that addresses the smart bomb of HMOs, the issue of what is defined as ''medically necessary.''

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding.

I am a practicing physician. And I do not plan on staying in this body. I plan on returning in a few short years to my practice. And I think it is a wonderful thing that we are having this debate today. We both want to do what we can to restore the doctor-patient relationship. We both want to do what we can to return quality as number one in health care in the United States. They have their plan. We have ours.

Now, I believe that there is an important feature in our bill that makes our bill the better bill over their bill. But I want to address a few points made by my colleague the gentleman from Iowa (Mr. GANSKE).

I served on the task force that produced this bill, and one of the most important things that I was going after was timely access to specialists. And contrary to the claims that were made by him and the claims by others, we have important language in our bill that will require people in managed care entities to have timely access to specialists.

Here is the difference between their bill and our bill, and I will tell my colleagues about it. I was on a radio talk show last week where a lady called in and she was saying some bad things about her HMO and she said, ''The other HMO I was in was just as bad. I had switched.'' I said, ''What do you mean, you switched from one HMO to another HMO? Are you in the FEHBP plan?'' And she said, ''Yes.'' And I said, ''Well, you know, I am in that, too; and there are some better plans that you could select. Why didn't you select one of those better coverage plans?'' And do you know what she said to me? ''Well, we cannot afford it. That is why I am in an HMO.''

Now, we are to be led to believe by our colleagues on the other side of the aisle that their bill which is going to place all these government mandates is not going to drive up costs for that lady?

Let me tell my colleagues something. Every month in my practice a clerk from my billing office brought a stack of charts of working people who were not able to pay their bills and I did what thousands of other physicians all across America do; I wrote off those bills, thousands of dollars every year. Why? Because those people had no health insurance.

Now we are led to believe by these folks that they here in Washington are going to make all these HMOs do all these wonderful things that are mandated in their bill and it is not going to drive up costs, it is not going to increase the number of uninsured?

Let me tell my colleagues something. We have a good bill here that is going to work very hard to restore quality and it is not going to drive up costs. Indeed, we believe the provisions in this bill, which allow small employers to pool, which has malpractice reform, is actually going to drive down costs. It is going to allow more people to get insurance.

We have, in my opinion, the better bill. And I can say that as somebody who is going to go back in a few short years to be working in the system.

PERMISSION TO FILE CONFERENCE REPORT ON H.R. 4059, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 1999

Mr. LIVINGSTON. Mr. Speaker, I ask unanimous consent that the managers on the part of the House may have until midnight tonight, Friday, July 24, 1998, to file a conference report on the bill (H.R. 4059) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes.

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

There was no objection.

PERMISSION FOR COMMITTEE ON APPROPRIATIONS TO FILE PRIVILEGED REPORT ON DEPARTMENT OF TRANSPORTATION AND RELATED AGENCIES APPROPRIATION BILL, 1999

Mr. LIVINGSTON. Mr. Speaker, I ask unanimous consent that the Committee on Appropriations may have until midnight tonight, July 24, 1998, to file a privileged report on a bill making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes.

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

There was no objection.

The SPEAKER pro tempore. Pursuant to the provisions of clause 8 of rule XXI, the Chair reserves all points of order on the bill.

□ 1215

PATIENT PROTECTION ACT OF 1998

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. LATOURETTE).

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

Mr. LATOURETTE. Mr. Speaker, I want to thank the dean of the House the gentleman from Michigan (Mr. DINGELL) and my classmate the gentleman from Iowa (Mr. GANSKE) for the opportunity to address my support for the Patient Bill of Rights. I also want to thank the gentleman from Illinois (Mr. HASTERT) for doing what he thinks is the right thing.

Obviously there is a slight concern when you endorse a proposal that is labeled the Democratic bill when you are a Republican and vice versa. While I am saddened that this issue has a partisan spin to it, today I am driven to support the initiative that I believe gives the greatest protection and possibility of care for the people that I represent. That bill is Ganske-Dingell.

I want to direct my remarks to the liability provisions, however, relating to employer-provided health care plans. Being a lawyer, I like that profession as well as any other, but I am sensitive to the concerns of small business owners, many of whom administer their own plans, about the liability problem. Some of the calls our office has received have been driven from K Street, but many others have come from business owners who are operating on small margins and who want to do the right thing by their employees.

Last night, therefore, I read and I reread page 66 of the Ganske bill concerning liability, and it only reinforced my belief that employers have been needlessly frightened, similar, I am sad to say, to the shameful way seniors were frightened during the Medicare debates.

The only time that an employer is exposed to liability is when the employer makes discretionary medical decisions. Not a doctor, not a hospital, not a nurse, not an HMO. I cannot even think of one situation where an employer would want to make a medical decision, good, bad or otherwise.

Nevertheless, I would ask the sponsors of the bill to tighten the language of the employers' exception in conference. The one thing that I do know about my profession is that they have a unique ability to take words that seem to say one thing and then get a judge somewhere, usually an appointed one, to interpret them in another.

I urge passage of the substitute and would ask both parties to work diligently in conference to create a product that represents the best of both bills. I would ask that we not be about the business of creating campaign commercials here on the floor today but we be about the business of helping Americans of all ages receive the care that they need.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Arkansas (Mr. DICKEY).

Mr. DICKEY. Mr. Speaker, I come here as a former small business owner and as a lawyer. When I first looked at this situation, I looked at it from the doctor's standpoint and I saw a tremendous need, dire circumstances that doctors are facing, even to the extent that we were going to lose doctors presently existing and applicants were not going to apply. And I rushed in with my philosophical approach to this and said, ''We've got to help the doctors at all costs.'' What I found out was that ''at all costs'' meant the cure was going to be worse than the disease, that the small business owners were going to be killed by being put into courtrooms without any type of protection and in greater numbers.

So what I wanted to do was to try to look at the patients and say we need to

get them in the treatment room and not in the courtroom. I have looked carefully at this and I can see that the Hastert bill is a perfect solution for this, or maybe not perfect but it is a perfect start. It is something we need to look at. If we do not do this, we are going to have patients who will not have choices because they won't have doctors, and that is serious.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

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

Mrs. CAPPS. Mr. Speaker, on behalf of the patients of the central coast of California and all across America, I rise to say that enough is enough. I have been an elected official for only four months but I have been a nurse for over 30 years. As a nurse I know firsthand the importance of accessible, quality, patient-centered care.

We must pass a bill which is more than a band-aid, which will ensure patients' rights and consumer protection against the abuses of HMOs. For common sense, comprehensive managed care reform, we must guarantee that critical decisions will remain in the hands of doctors and nurses, not insurance companies. We must guarantee access to specialists, so that people can really choose their own doctors. We must guarantee an end to financial incentives to limit medical care. We must guarantee emergency room care so people are not turned away from the hospital door. We must guarantee tough enforcement to hold insurance company bureaucrats responsible for their cost-cutting actions.

The American people deserve a bill with these guarantees, not a Republican bill, not a Democrat bill but a people's bill. The Ganske-Dingell proposal protects patients with the force of law. This bipartisan bill will allow people to choose their own doctor, end oppressive gag rules so patients can have access to all critical treatment options, and perhaps most importantly give patients legal recourse when insurance companies deny important medical coverage.

Basic patients' rights can mean the difference between life and death. If patients can sue their doctors for poor care, they should be able to sue the insurance bureaucrats who pull the strings and are behind these cost-cutting decisions.

As one of three nurses in Congress, it is my duty to speak out. The leadership bill has huge loopholes which do nothing to prohibit HMOs from denying care. Our health care system needs serious medicine, not a political placebo.

Mr. Speaker, we still have time to act. With 32 days left in Congress, if we do nothing else, we must guarantee real patients' rights for the American people. Let us pass comprehensive, bipartisan managed care reform today.

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. NORWOOD) who worked on the task force and certainly was the creator of a lot of the thoughtful positions that are included in our plan.

Mr. NORWOOD. Mr. Speaker, it seems to me that it has been years in my life till we get to this day. I have wanted this to happen a long time. I am saddened deeply by what I hear and see happening in this room today. I had hoped that all of us would recognize the importance of protecting human beings' lives, the importance of correcting the malfunctioned ERISA laws of 1974 and could come together and actually offer good patient protections that the people of this country so deserve. But I hear over and over again demagoguery, politicization, misrepresentation, total untruths, just simply getting it wrong and not telling it right, and I am saddened by that.

The Dingell-Ganske bill has good patient protections in it. I do not question that. I know that it does. It is imperfect, however. The Republican bill has excellent patient protections in it, though it, too, is also imperfect.

I want to speak to my friend from Texas who says, oh, all of a sudden the Democrats have realized we need to protect patients. We bring this up today because we are Democrats.

I would remind my friend from Texas that you are the same group that tried to put everybody in the country in managed care 4 years ago, with no thought to any particular patient protections. I have for at least two terms of Congress as a Republican tried to protect patients, and I am delighted that you have joined with us at this late date.

Mr. Speaker, I have spent the last year and a half calling for support to end the ERISA preemption of State medical malpractice law. I pled with the President to add ERISA liability to his advisory committee report in November 1997. He did not. I requested that the President call for ERISA liability reform in his State of the Union address in January of 1998. He did not. I argued day after day with the Republican Working Group to add ERISA liability reform to this bill. They would not. There is a reason for that. It is a big enough reason that we can end up this year with no law, no patient protections over this subject. As much as I am for it, I am for a law this year that will get as many patient protections as we possibly can meet. The task force met me more than halfway with a new proposal that I frankly like very much. It is about liability and it is about suing an HMO. If I could only have one of the two liability provisions, I believe today that I would take our own. I ask you to stop this politicization of this bill and let us work together and pass patient protections.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, I rise today in strong support of the Ganske-Dingell Patients' Bill of Rights, and in equally strong opposition to the Hastert bill. Nothing in the Republican bill would have protected the rights of young Brice Randa from Colorado. Here is a picture of the Randa family, Allen and Jodi with their children Taylor on the left and Brice on the right. Brice died just two months after this picture was taken.

Brice was diagnosed with Lissencephaly, a terrible disease that made Brice's short life limited to breathing tubes, stomach wraps and motor seizures, a disease which eventually killed him. Although it was inevitable, Brice's death is heartbreaking for more than one reason. The tragedy lies in the fact that this family spent the few precious months they had with their son negotiating with the HMOs instead of taking care of their precious little boy. The 16 months the Randas had with Brice were consumed with lawyers filing paperwork and appealing decisions made by their HMO.

The Randas' doctor wrote the HMO begging, ''The family is overwhelmed. We petition for 4 hours per day extra assistance,'' and the HMO denied this.

Under the Republican bill, a health plan can define medical necessity any way it wants, giving families like the Randas no protection from insurance company bureaucrats deciding what medical care is appropriate. Moreover, under the GOP's rules, if the Randas did want an external review of the decision denying the 4 hours a day of care for Brice, they would have to pony up $100 from their pocket just to have the case heard by somebody who would have to follow guidelines set by the very HMO that denied the care in the first place. And if Brice had needed emergency care, the HMO would have had 72 hours to consider an appeal of an emergency care decision. Frankly, this GOP scheme is worse than the status quo. It stabs at the heart of what the debate over HMO reform is really about. On the other hand, the Ganske-Dingell bill ensures that the medical profession will define medically necessary care.

Vote for our alternative. Vote ''no'' on the Hastert bill.

Mr. HASTERT. Mr. Speaker, I yield myself 10 seconds. I just want to remind the gentlewoman from Colorado that if it is emergency care, our patients are in the emergency room immediately, not 72 hours. She is wrong and she misrepresented the facts.

Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. HAYWORTH).

Mr. HAYWORTH. I thank my colleague from Illinois and I thank the gentlewoman from Colorado, because she unintentionally demonstrates why we should oppose the Dingell bill and support the reasonable, rational, compassionate Patient Protection Act.

You see, Mr. Speaker, we are faced with a choice today. Do we support a true patient bill of rights, or do we support a lawyer's right to bill? I rise with

colleagues from both sides of the aisle who say they do not want decisions made by bureaucrats, whether they are Washington bureaucrats or insurance company bureaucrats. Health care decisions should be made by physicians and health care professionals consulting with their patients. That is the element that we preserve, uphold and amplify in the Patient Protection Act. Sadly, endless litigation and lawsuit after lawsuit is provided for in the Dingell substitute. That is what we have to remember; true compassion, not courtroom drama.

□ 1230

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Speaker, I rise today in opposition to H.R. 2450, what the Republicans have called the Patient Protection Act, but is better termed the Republican Patient Election Year Posturing Act.

H.R. 4250 is full of hollow promises and empty protections. Republicans call this a managed care reform bill, but in reality it is far from it.

For starters, the Election Year Posturing Act does little to address the serious problems of our current health delivery system and does a lot to maintain the status quo.

Let me detail what the Republican bill does not provide. It does not put medical decisions back in the hands of doctors and, instead, keeps it in the hands of insurance company accountants and their executives, people who we call the bean counters.

It does not give patients access to specialty care where they need it. We heard from our Republican colleague the gentleman from Florida (Mr. WELDON), a doctor, previously indicating he was on a talk show, and a woman indicated she was in the same Federal health plan as all of us. He asked, ''why did you not choose a different one to get the doctor of your choice?'' She said to him, and hopefully I am quoting this right, she could not afford it.

So the bottom line is we cannot afford it. We get substandard care. I think that is wrong on the part of the Republicans. It does not give patients access to specialty care. It does not provide women undergoing a mastectomy from being pushed out of the hospitals just hours after surgery and does not require insurers to cover reconstruction surgery after mastectomy. It does not allow a woman to choose a gynecologist or other specialist as a primary care doctor.

Let me also indicate that we heard from a trial attorney Republican supporting the Republican bill. He indicated that if one is misdiagnosed and does not get subsequent needed treatment, we are going to give them $500 a day. Oh, well, we will give you $1,000 a day.

But if that is one's mother, and that misdiagnosis or lack of coverage and treatment, like a bone marrow transplant, or needed chemotherapy, is denied, it might be to the insurance company's advantage to give them the $1,000 a day versus having the right to sue the provider and the health care bean counter.

Mr. Speaker, I ask the Members to support the Dingell-Ganske bill.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from South Carolina (Mr. GRAHAM).

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

For any lawyer out there, listen up close. The $500 a day is to ensure prompt payment. The bill ensures treatment. That is the whole point of this bill. If one has a medically urgent situation, one can go to court within minutes of being said no to and get a temporary restraining order ordering the treatment to be given.

Also, the physician and hospital can provide one the treatment and subrogate to one's interest and have an external review of the HMO decision within 6 days. That is when the $500 per day kicks in, to get them to pay.

During the initial waiting period, one is getting the treatment. That is the point. The $500 a day is to ensure payment. Under our bill, one gets treatment from day one, from minute one, because one has avenues to compel them to treat them.

But what about the $500 claim? As a lawyer, one comes in to my office with a $500 claim, no matter how meritorious it is, I am going to say that is very nice, but I have got to make a living and feed my family. I cannot chase $500.

Under the Democratic bill, if we have a small claim, we are not entitled to external review until the significant threshold is passed. Under the Republican bill, if they nickel and dime us for $100, $200, $500, and that is what happens every day. They nickel and dime us out there. We allow people to go to external appeal no matter how small the claim is if they put up from $25 to $100. The filing fee in South Carolina for tort actions is $35.

So they get an external appeals process and a small claim, then the $500 a day kicks in plus attorneys' fees, plus the benefit. I will take the case then, because I can get paid, and there is a $500 clock running for the small claims.

So HMOs will not nickel and dime people. That is where the abuse is at. And my colleagues do nothing about that. This really makes them honest. We get the treatment up front. The penalties are significant. We get people what they need, which is health care, not a jury award 4 years later when they are dead.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, I rise in support of the Ganske-Dingell bill and in opposition of the Republican bill.

For the last 2 years, I have been working on legislation to end the practice of drive-through mastectomies. The bill simply ensures that breast cancer patients are allowed 48 hours in the hospital to recover from this physically and emotionally devastating surgery. It does not seem like much to ask, and yet the Republican leadership has refused to schedule hearings on this important legislation.

The Democratic Patients' Bill of Rights ends the practice of drive-through mastectomies. The House Republican leadership bill ignores this problem. What is worse, their legislation will actually strip away existing State protections.

My State of Connecticut has led the fight to end outpatient mastectomies. The Connecticut legislature has already acted to outlaw this outrageous practice. But the Republican bill would repeal those hard-fought patient protections.

The Republican bill will not put medical decisions back in the hands of doctors and patients. It makes current problems worse. It eliminates consumer safeguards. In the case of breast cancer patients, this bill is a slap in the face.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Nevada (Mr. ENSIGN).

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

Mr. ENSIGN. Mr. Speaker, I rise in support of the Republican bill today for several reasons. First of all, we have to listen to the other side. These are the people who are now saying that they want the doctors to choose their health care and the type of choices in those health care plans. But these are the same people who 4 years ago or 5 years ago were saying, ''Do you know what? We want everybody to be in nationalized health care, and we want bureaucrats to make those decisions.'' Look beneath the surface.

The Republican plan contains medical malpractice and medical savings accounts, two things that I strongly support. In the final bill, they probably will not be able to be included because the President has said he would veto the bill over those two provisions, unfortunately, because they would help bring costs down. But we could still have good patient protections in this bill if it is enacted even if we have to drop those provisions.

In the State of Nevada, we got together, Republicans and Democrats alike, and enacted patient protections similar to what are in the Patients' Bill of Rights that we have on the floor today. This was authored, by the way, by a Nevada Democrat State legislator. We ought to do the same thing here. Put common sense together; put party politics aside.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from Connecticut (Mrs. KENNELLY).

Mrs. KENNELLY of Connecticut. Mr. Speaker, the 161 million Americans in

managed care today deserve to know that their health care comes first.

For 18 years, I have represented Hartford, Connecticut, the insurance capital of the world. So I know how managed care came into being. Health insurance premiums were rising at double-digit rates, 17 percent in 1988, 21 percent the following year, 17 percent again in 1990.

The industry responded to rein in the costs, and it worked. But it so often happens in reform, once a balance is reached, some people do not know when to stop. So now profits became the prize.

Yes, we have stable prices, but they have come at a terrible cost. That is what we are addressing today, the cost of our confidence that we will get the health care that we need, that we deserve, and that we pay for.

Specialist treatment, continuity of care, emergency room treatments are not options. They are not frills, as some managed care companies seem to believe. When patients are denied adequate care by arbitrary decision-makers, they must have recourse.

Mr. Speaker, we must put patients first again in this bill. H.R. 3605 offers real relief at modest cost, and I urge my colleagues to do this today.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentlewoman from Kentucky (Mrs. NORTHUP).

Mrs. NORTHUP. Mr. Speaker, we all know that, in this fast-emerging change in health care that there have been abuses by HMOs, and we are proud to be here today to deal with those and to address those and make sure that there is the important level of care that every American deserves. We are going to deal with that today.

But we should not let this be an excuse for huge new Federal controls of the delivery of health care. That is what people that believe in a big bureaucracy dealing with health care support. We should not also make this an excuse to give the trial attorneys a huge new cut of our medical premiums. Medical money needs to go to medical care and not to trial attorneys.

I am proud that I am not on the trial attorneys' side and not on their team. It is no wonder that the team that is on their side is supporting this substitute here today.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman from Michigan (Mr. DINGELL) has 16½ minutes remaining. The gentleman from Illinois (Mr. HASTERT) has 17¾ minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Speaker, today I stand on behalf of Kathryn Carberry in my State of Rhode Island. She was released too quickly from the hospital because her insurance company denied her treatment for a breast operation that she had and continued treatment for that.

I also stand on behalf of Deborah Kushner's little boy who was nearly killed because her HMO denied treatment in an emergency room.

The Republican leadership have refused any committee debate with full and free testimony because they are afraid of these stories. Now they come up with a bill that is a product of the HMO industry itself.

We have waited for managed care reform, so why should we settle for the HMO's own plan. This bill leaves out so many crucial provisions, it is almost laughable. Where is the provision against drive-through mastectomies that could have saved Ms. Carberry's life. It is not in there. Where is the prudent layperson for Mrs. Kushner's son? It is not in there. Where is the provision to hold accountable these HMOs? It is not in there.

Every other product in this country can be held liable but managed care organizations. It is time we put a stop to managed care organizations who are practicing medicine without a medical license.

Mr. HASTERT. Mr. Speaker, I yield myself 5 seconds. I would just like to recommend to the gentleman from Rhode Island that he read the right bill.

Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BALLENGER).

Mr. BALLENGER. Mr. Speaker, I support the Patient Protection Act. While the bill is not perfect, it is an important step in ensuring access to health care insurance for many people who are currently without it.

As a small business officer of a company which self-insures its 200 employees, the unlimited liability of the Dingell bill is frightening. We insure all of our employees currently, but if big government Dingell bill were to become law, we would be forced to give our employees the money and let them buy their own insurance at, obviously, a higher cost. Many businesses would have to do the same.

The Dingell bill encourages patients to sue after a denial of coverage occurs rather than bringing a quick appeals process that would help the patient get coverage for care in a timely fashion.

Also, the Congressional Budget Office has estimated that the Dingell bill will increase the cost of health care and not make it more affordable. On behalf of the American people who need affordable care, oppose this substitute.

In the United States today, there are more than 42 million Americans without health insurance—many of whom are employed, or have a family member employed, by a small business that cannot afford to offer health care coverage for its employees.

The Patient Protection Act addresses the lack of coverage of these individuals in several ways, including the creation of association health plans which will be governed by uniform standards. These plans would allow small businesses, trade associations, labor unions and professional associations to pool together to obtain the same economies of scale, purchasing clout and administrative efficiencies, that employees of large employers benefit from. Association health plans will have the freedom and flexibility to design more affordable benefit options. This will allow small businesses to offer their workers access to the same benefit choices regardless of where they live. At the same time, these plans must meet strict new solvency standards to protect patients' interests and ensure that their benefits are paid.

I want to mention just very briefly that I appreciate that authors of this bill attempt to deal with the issue of confidentiality of medical information. It's a complicated issue, and one that has to be dealt with carefully. I do have some concerns with what is in the bill, in terms of its potential risk to employers and the lack of clarity, particularly with regard to two areas in my committee's jurisdiction, workers compensation and occupational safety and health. I hope that these are issues that we can address during the conference to ensure that the medical confidentiality provisions work well, and do not inadvertently create problems in these areas.

Accessible, affordable, quality health care is very important to all Americans. I have been contacted by many constituents who are demanding that we act in their interest. So, with their letters and concerns in mind, I support this important piece of legislation and urge my colleagues to do the same.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. GREEN).

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

Mr. GREEN. Mr. Speaker, for many months, a lot of Members have been working for this debate today. What is frustrating is the debate we have now.

I rise in support of the Dingell-Ganske amendment. But instead of a real debate and a committee process we have, the Republican leadership is forcing this weak fig leaf bill through which will do little to give the American people what they really need for their health insurance.

In fact, it will hurt State laws now in effect. In my home State of Texas, this Republican bill would override State law on mammogram screening, Alzheimer's treatment, and prostate cancer screening, and many more.

On page 187 of their bill, because some of us had a chance to skim their bill that was released last night, line 19 exempts these State protections. So maybe they ought to read their bill before they defend it.

I think it is ironic they talk about this being a trial lawyer bill, Mr. Speaker, and I ask unanimous consent to place in the RECORD a letter from the American Medical Association, who typically does not support the trial lawyers. It was sent to me yesterday, talking about the reasons that the Republican bill is so bad and the Dingell-Ganske amendment is so good.

The letter referred to is as follows:

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, July 23, 1998.

Hon. GENE GREEN,
House of Representatives, Rayburn House Office Building, Washington, DC.

DEAR CONGRESSMAN GREEN: The American Medical Association (AMA) recognizes that

changes may be offered to H.R. 4250, the House Republican ''Patient Protection Act of 1998,'' when it is brought to the House floor, to begin to address some of the serious concerns with the legislation as introduced. We urge Members of Congress to take the time to fully explore whether any such amendments correct the problems outlined below. As you may know the AMA has carefully reviewed and lent its full support to H.R. 3605, the ''Patients' Bill of Rights Act of 1998.'' We believe that H.R. 3605 provides comprehensive and meaningful patient protections that should be enacted before Congress adjourns this fall.

On behalf of the 300,000 physician members of the AMA and the millions of patients we serve, we strongly urge you to oppose H.R. 4250, as introduced, and to vote in favor of the Ganske-Dingell substitute (text of H.R. 3605). In our view, only H.R. 3605 would provide meaningful patient protections to address existing abuses in managed health care.

There are ten reasons to vote against H.R. 4250 and to vote for H.R. 3605.

Reason #10: ''The Devil is in the Details''—Here are the facts.

H.R. 4250 claims to offer ''similar'' protections to those extended in H.R. 3605, but the legislative language of H.R. 4250, at nearly every turn, clearly favors health plans and insurance companies at the expense of patients. These problems are much more than just ''technical drafting matters.'' In fact, Members of Congress have not had time to fully understand critical differences in the two bills since last Friday's introduction of the House Republican bill. By contrast, H.R. 3605 was drafted and introduced earlier this year, with ample time for public examination; its provisions ensure that patients would receive medically necessary covered services. H.R. 4250 would continue to allow insurance companies and health plans to put their financial bottom-line ahead of patient care.

Reason #9: H.R. 4250 would allow health insurance companies to decide what is medically necessary; H.R. 3605 would restore physician medical decision-making.

By retaining the power to define what is and what is not medically necessary, under H.R. 4250, health plans—not physicians—would continue to decide all patient health care decisions, Linda Peeno, MD, a former HMO medical director, described this retained control ''as a health plan's smart bomb capability'' in testimony before the House Commerce Committee. Consequently, the external appeals process proposed by H.R. 4250 would be of little or no value if the health plan were always allowed to define what is medically necessary or appropriate. By contrast, H.R. 3605, promotes good medical practice by specifically prohibiting health plans from practicing medicine by substituting their decisions for the patient-specific medical judgments of the treating physician.

Reason #8: The internal and external review process in H.R. 4250 does not require health plans to use physicians with the appropriate medical specialty training to review treatment denials. H.R. 3605 is clear that only ''clinical peers''—physicians with similar specialty training will review other physicians' medical decisions.

As an example, only cancer specialists should review cancer treatment. Reviewers must have the right specialty training to decide life and death issues. Only H.R. 3605 would provide this critical patient protection.

Reason #7: H.R. 4250 would require patients to pay for the privilege of an external review of treatment denial; H.R. 3605 imposes no such fees on patients seeking to exercise their rights.

Patients should not have to pay to have a treatment denial reviewed.

Reason #6: H.R. 4250 does not contain several key physician choice provisions that are included in H.R. 3605.

H.R. 4250 does not include a provision found in H.R. 3605 that would allow a patient in the midst of serious illness or pregnancy to continue a relationship with a physician who leaves or is forced to leave a health plan network. The House Republican bill also does not provide patients with critical ongoing access to specialists for chronic conditions (such as asthma, diabetes, etc). H.R. 4250 also does not require plans to disclose to prospective enrollees the adequacy of the physician network to serve a given patient population. H.R. 2605 provides both access to necessary specialty care and disclosure of the plan's physician mix to patients.

Reason #5: H. R. 4250 would provide a huge loophole for plans to circumvent the point of service provisions.

Under the terms of H.R. 4250, employers would not have to offer employees point of service coverage if they could prove that the plan's premiums would increase by 1%. The AMA has always said that patients may choose to bear reasonable additional costs to obtain a point of service option that would ensure greater choice of physicians. This opt-out provision of H.R. 4250 could effectively ''gut'' the concept of a point of service option for many plan participants.

Reason #4: H.R. 4250 would delay the effective date of patient protections for up to two years after the date of enactment. H.R. 3605 would provide for nearly immediate implementation of most patient protections.

The evidence is overwhelming that patients need and are demanding protections now. The delayed effective date in H.R. 4250 is an opportunity for more legislative mischief by health plans seeking passage of ''gutting'' amendments before patient protections are actually offered to patients. H.R. 3605 would generally extend all patient protections soon after enactment.

Reason #3: H.R. 4250 does not adequately protect the broadest possible range of ''medical communications,'' nor would it ensure all necessary emergency care. It even cuts back on the Balanced Budget Act's antigag clause/practices and prudent layperson provisions that cover Medicare patients.

On anti-gag practices, H.R. 4250 does not include the words ''otherwise restrict'' medical communications. The omission of these key words would allow health plans to continue to gag physicians. The ''prudent layperson'' provision for emergency services in H.R. 4250 does not include ''severe pain'' in the definition of what a reasonable person would think requires immediate treatment.

Reason #2: H.R. 4250 creates a new federal preemption of state patient protections laws for association health plans and would override many of the patient protections laws already enacted by some 43 states.

Association health plans would be exempt from state patient protection requirements. H.R. 4250 also lacks express language recognizing the authority of state legislators to regulate the health care delivery practices of such entities for state residents.

Reason #1: H.R. 4250 does not hold health plans properly accountable for making medical treatment decisions that result in patient injury or death.

The managed care liability issue is about basic fairness and holding health plans accountable for their conduct. No other industry in America enjoys the special legal protections currently extended to health plans. Members of Congress have spoken out against special legal protections for tobacco companies. Why should health plans continue to be given special liability protections? The AMA continues to lobby for tort reforms, but we have never advocated that patients should be denied adequate compensation for true medical negligence. The damages and penalties in H.R. 4250 fall far short of providing patients with proper compensation for preventable injuries and death.

Again, we urge you to vote for a House floor procedure rule that will allow a vote on H.R. 3605, and to vote for passage of H.R. 3605.

Respectfully,

E. RATCLIFFE ANDERSON, JR., MD.

□ 1245

PARLIAMENTARY INQUIRY

Mr. DINGELL. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman will state it.

Mr. DINGELL. Mr. Speaker, who has the right to close debate on this bill?

The SPEAKER. As stated on page 567 of the House Rules and Manual, the Chair will assume that the manager of a measure is representing the committee of jurisdiction, even where the measure called up is unreported.

House Resolution 509 specifically named Mr. HASTERT as the manager of this bill; Mr. HASTERT called up the measure; and Mr. HASTERT is a member of the committee having primary jurisdiction over the bill. As such, the gentleman from Illinois has the right to close.

Mr. HASTERT. Mr. Speaker, I yield three minutes to the gentleman from California (Mr. THOMAS), Chairman of the Subcommittee on Health Care of the Committee on Ways and Means.

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

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

Mr. Speaker, one of the things we have to make sure we do not do is revise history. I think it might be useful just to remember where the prudent layperson language in the Republican provision and in the Democrat provision came from. It came from the changes that were made in the Medicare program.

I think when you examine the gag rule provision, it is in the Democratic bill, it is in the Republican bill, it came from the Medicare revisions. If you recall, I said, prior to the election, the Democrats were accusing the Republicans of trying to destroy Medicare. After the election we sat down and put together a prudent package to preserve and protect Medicare. We included a number of provisions that were applicable only to Medicare because it was a bill dealing with Medicare. That was in 1997.

We then began in the Subcommittee on Health a series of hearings about the problems that were out in the current marketplace because of the distortion of the rapid movement to managed care. We began examining the Medicare changes to find what we could include in the package.

You have heard repeatedly that somehow the Republican plan was

thrown together in a couple of days. That is pre-election rhetoric. It simply is not the truth.

We include significant patient protections; they include some patient protections.

We include the opportunity to get health care, make it more affordable, make it more accessible. Do not believe me, believe the Congressional Budget Office. They looked at their bill. They evaluated it. They priced it out. They said if the Democrat's bill were law, premiums would cost more. Health care costs would go up.

The Congressional Budget Office looked at our bill, they examined it, they priced it. The nonpartisan fiscal analyst said if the Republican bill became law, health care costs, premiums, would go down.

In addition to that, a provision that they had said is a poison pill, it would kill the bill, the medical malpractice provision that is in the Republican bill, it is not in the Democratic bill, that that measure alone, reforming medical malpractice, would save, directly save the Federal Government and the Medicare and Medicaid program, $1.5 billion a year over a 10 year period; $1.5 billion.

Where is that money going to come from? It is going to come from money that does not go to trial lawyers. Why do they call it a poison pill? Frankly, given the way their bill is structured, it is the trial lawyers who are going to be the main beneficiaries of those premiums going up. CBO says their plan increases premiums. CBO says our plan reduces premiums.

Yes, it is important to address the changes in the health care market today about patient protections. It is also important to make sure that health care is affordable for more Americans. Our plan does it; their's does not.

Mr. DINGELL. Mr. Speaker, I yield one minute to the distinguished gentleman from Michigan (Mr. LEVIN).

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

Mr. LEVIN. Mr. Chairman, let me give you a real live example of the major differences between these two bills. Twenty-five years ago one of my constituents was diagnosed with multiple sclerosis. A battery of medications have been developed in recent years that can often slow the course this disease, but it is expensive. His doctor prescribed the medication, but then the HMO said, ''You need another opinion.''

The day after he went to that second doctor, he received a letter from the HMO stating no way would they pay for the drug. So my constituent called that second neurologist and he said he had not even spoken to the HMO.

Then the HMO said the reason my constituent was denied access to the drug was that he was at stage seven of MS, and there was no published research about the use of this drug on stage seven MS. So even though two doctors believed that he would benefit from the medication, they were overruled by the HMO.

Ganske-Dingell, the Patients' Bill of Rights Act, would help avoid situations like this. Vote for Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield three minutes to the gentlewoman from Connecticut (Mrs. JOHNSON) a member of the Subcommittee on Health of the Committee on Ways and Means, and distinguished for her work on health care for many, many years.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman from Illinois for yielding me time, who has done such an outstanding job in leading this task force and developing this bill.

This is indeed an historic day for the U.S. House of Representatives. We are going to pass legislation that forcefully protects patients' needs, puts physicians back in charge of medical decisions, holds insurance companies accountable for quality care and gives millions of uninsured Americans access to affordable health coverage. We have heard the many concerns of the American people and are acting to address them directly and realistically.

Key to the reforms in this bill is the strong internal and external appeals mechanism that guarantees physicians will control medical decisions. Both the internal and external appeals process, in both of those processes, the physician must review the decision. It is physician-controlled and physician-directed, both within the plan and in the independent external review process. This guarantees that physicians, not HMO bureaucrats, will control medical decisions.

Both the internal and external appeal decisions are governed by strict time frames within which decisions must be made. Patients will no longer be kept in limbo while bureaucrats delay. Rather, physicians will make timely decisions about lifesaving medical treatments. This will inject fairness and objectivity into our medical system.

Accountability is key to this legislation. I have worked with the bill's sponsors to insert an important provision that will force public accountability of the insurance companies on this very issue, because we will now report publicly the results of these appeals processes. In other words, if the plan denies a patient care and that decision is overturned on external appeal, people will know it. They can change plans. They will not buy that plan. The market will deliver a far more devastating verdict to that plan than the courts could over many years.

The external and internal appeals, because they are physician-controlled, they are patient-oriented, will bring timely decisions and access to specialty care, in the right way, to the people without raising costs, but improving quality of care.

Coupled together, the provisions in this bill are what we need to restore fairness and quality to our health care system. This is a good bill that not only provides the consumer protections the American people have been looking for, but it expands access to all those that are too often ignored, the uninsured in America, and prevents an increase in costs that would merely drive people out of the system.

I urge support of this legislation.

Mr. DINGELL. Mr. Speaker, I yield one minute to the distinguished gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, let me thank my friend from Michigan for yielding me this time and congratulate him on his leadership.

Mr. Speaker, we have a clear choice. If you want to provide protection for your constituents for full access to emergency care with symptoms with severe pain; if you want to provide your constituents with a choice of doctors within their HMOs, access to specialists like cancer specialists, women adequate care for mastectomies and the right for reconstructive surgery, that will provide continuing care if the HMO drops a doctor so you can continue to see that doctor until you get to a new doctor; if you want to provide your constituents with clinical trials and experimental treatment which may be the only way to save their life; if you want them to have the latest drugs that your doctor thinks are needed; if you want to make sure that an HMO has enough doctors and locations so your constituents can get to see the doctor; if you want to provide all these protections to your constituents, then you must vote for the Ganske-Dingell substitute, because the Republican bill does not provide those protections to your constituents and does not provide for adequate enforcement.

The choice is clear. I urge my colleagues to support the amendment.

Mr. HASTERT. Mr. Speaker, I would inquire as to the remaining time.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman from Illinois (Mr. HASTERT) has 10¾ minutes remaining and the gentleman from Michigan (Mr. DINGELL) has 12½ minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, today this House has a very basic decision to make: Are we going to pass effective and enforceable legislation to ensure a patient bill of rights for people in this country? Are we going to agree to the Ganske-Dingell proposal which is going to give people the rights they need to deal with arbitrary and unfair treatment by big insurance companies and HMOs? Or are we going to rush through a Republican leadership bill that is designed to do just one thing, fool people into thinking that something is being done to help them just long enough to get through the next election? Because that is exactly the issue before us.

Are we going to pass legislation that requires HMOs to have an adequate

number and variety of health care providers so that people can get the services they need and are paying for? The Ganske-Dingell bill does that. The Republican leadership bill does not.

Are we going to be sure that people can get to a specialist if they need one? Ganske-Dingell says yes. The Republican bill does not.

Are we going to let insurance companies make the decisions about what medical patients need? Ganske-Dingell says decisions belong to the patients and their doctors. The Republican bill does not. That is why the doctors support the Ganske-Dingell legislation.

Today this House has a very basic decision to make: are we going to pass effective and enforceable legislation to ensure a patient bill of rights for people in this country?

Are we going to agree to the Ganske-Dingell proposal which is going to give people the rights they need to deal with arbitrary and unfair treatment by big insurance companies and HMO's?

Or are we going to rush through a Republican leadership bill that is designed to do just one thing: fool people into thinking that something is being done to help them just long enough to get through the next election.

Because that is exactly the issue before us.

Are we going to pass legislation that requires HMO's to have an adequate number and variety of health care providers so that people can get the services they need—and are paying for? The Ganske-Dingell bill does that. The Republican leadership bill does not.

Are we going to be sure that people can get to a specialist if they need one? Ganske-Dingell says yes. The Republican bill does not.

Are we going to let insurance companies make the decisions about what medical care patients need? Ganske-Dingell says that decision belongs to the doctor and the patient. The Republican bill does not. It actually increases the power of insurance companies to decide what is medically necessary. Since when did insurance bureaucrats become qualified to be doctors?

Are we going to override the protections the States have enacted to assure people health benefits and give them some consumer protections? Ganske-Dingell builds on and strengthens them. The Republican leadership bill actually takes away the protections that are there.

And are we going to make sure that people have an effective way to enforce the rights we are giving them, or not? Ganske-Dingell says if you can't enforce it, you don't have it. The Republican leadership bill sneaks in language that makes sure the insurance companies decision about what is medically necessary is not going to be challenged.

We owe the American people legislation that works to protect their rights. We need to level the field between big insurance and their desire to profits, and patients who depend on their insurance and HMOs for their health care. We owe people a way to make sure they get the medical services they need from their HMO or any other health plan.

This debate should be about patients, not profits.

The Republican leadership bill is on this floor today only for one reason: after months of opposition and working hand in hand with big insurance to kill any patient bill of rights, they noticed the polls told them the American people were demanding action.

So Mr. GINGRICH and his allies have responded with a cynical bill that is designed to look like it's doing something when it is not.

They've made sure that this bill didn't get looked at by the Committees or the public. They've made sure that we vote on this before anyone has a chance to know what it really does.

They claimed to have privacy protections—but actually they made it OK to sell medical records. When they were caught, they changed it.

They claimed to make sure emergency care would be covered if a prudent person would think it was necessary. But they actually weakened the protections we already have in law for Medicare beneficiaries. They said severe pain wouldn't be a reason to go. They said the HMO could make you foot most of the bill if you didn't go to their facility. In other words, they gutted the protections.

Well they got caught again, so they changed it.

How many things are in this bill that haven't been found yet? It's a cynical way to deal with people's lives and health care.

Does anyone believe that a Republican leadership that has urged insurance companies to spend money to defeat these bills is actually going to write a good one? Does anyone believe that after they've fought it every step of the way, they've suddenly seen the light?

Let's adopt the bill that works. Let's adopt the bill that has been endorsed by the doctors and the nurses and the patients. Let's adopt the Ganske-Dingell bill.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL).

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

Mr. PASCRELL. Mr. Speaker, a question was asked a few seconds about whose side are we on.

The average CEO from an HMO makes $6 million a year. It goes up to $20 million a year. You are asking us whose side we are on?

A woman in my district recently summed up the problems with our current managed care system in a conversation with me. She asked if there was a way she could get into Medicare early because she thought she could receive better care under her Medicare than under her current health insurance program.

All across my State of New Jersey, patients are being denied their basic rights, and I think that is what this argument and debate is all about. New Jerseyans who benefit from some of the strongest patient protections in the country would lose under the original bill.

Benefits and services such as bone marrow transplants, diabetic supplies, mammogram and prostrate screenings and minimum maternity stays would all be in jeopardy for thousands of patients in our State. Let us do the right thing today.

Mr. HASTERT. Mr. Speaker, I yield 4½ minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, as we close down this debate and come toward the end of what, for me, has been a long time coming, I want you to know I am not only saddened by the debate but I am exhilarated by this debate also because it is with great pleasure I see each side of the aisle trying to outdo the other on patient protections, and Lord knows that has been a long time coming.

It is often asked of me why would a conservative Republican like myself, why would you be involved in something like this? Why would you want to deal with national standards? I think that is a reasonable question, and I think it is a fair question.

The answer is pretty clear. What I want to do is take health care out of the ERISA laws that should never have been put in the ERISA laws, that never was about health care but always about your pension plans, but we cannot do that.

□ 1300

But we cannot do that. The other option is to do nothing, and we all know that is wrong, and the other option then is to set some national standards, and that is where I am, and that is where we are in this debate today.

We have today one of the reasons I might mention that I am involved in this is that we have today the best medical care, best trained physicians, best technology in the world, but it does no good to have any of that if we are denied our care. We all can agree, I believe, on that.

I have been in Congress 3½ years. There is a lot I do not know, but I will tell my colleagues one thing I do know something about. I know something about treating patients. I have been doing that all of my adult life. In fact, I have been doing that longer than any of my colleagues have been in Congress, except maybe the gentleman from Michigan (Mr. DINGELL). Generally speaking, that is all I know, And I have in every sense since I have come to this town tried to say that there are serious problems out there that are occurring that we must address. Thank God we are. It is a contest of who is addressing them best, perhaps.

Mr. Speaker, I remember seeing patients back when there really was a doctor-patient relationship, back when there was a free market, before the 1973 HMO Act, before the 1974 ERISA Act. Things are not better today for patients. Maybe our skills are better, maybe our technology is better, but people have been denied the benefits that are in their plan. I thank my colleagues for joining with us, I thank them for joining with us to try to address that, and we are going in the end to address that, I believe, in a very correct manner.

One of the other reasons I have been so interested in this is that in 1994 I did not like Clinton care. Do my colleagues want to know why? Clinton care was a program to deny patients' choice of

doctor and of hospital. It was a program that would deny them care and rationed care, and it was a program designed to use untrained and less trained people to take care of patients. Guess what? They won. That is exactly what we have today. The big difference is Mr. Clinton would have used Federal bureaucrats; today we use corporate bureaucrats. I promise my colleagues, a patient that has been denied care and their child has died does not care whether it was a corporate bureaucrat or whether it was a Federal bureaucrat.

Mr. Speaker, we have before us today, I say to my colleagues, two bills, and we are debating actively on who has done the best job. These bills are fighting to see who can protect patients most. I think that is wonderful.

Let me just simply close by saying that there are many things that are similar. There are many very good protections in the Republican bill, and I certainly do not oppose the liability part, except I am scared that it will kill the bill for this Congress and we will have no protections.

Vote against the motion to recommit, vote for this bill, and work with us to make it all better.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from New York (Mr. SCHUMER).

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

Mr. SCHUMER. Mr. Speaker, I want to thank the gentleman for yielding me this time. I want to say that the American people are clamoring for real reform of HMOs. If we pretend to give them reform, if we offer a phoney solution, they will not be fooled. The Dingell-Ganske substitute will make a true difference to millions of families. Let us go the real way. Let us really help people and not just make it appear we are.

Let us support Dingell-Ganske and make a difference for the millions who are suffering under the yoke of unfair HMOs.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. DUNN), a member of our leadership.

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

I rise today to say to American families who are worried about their health care coverage, we understand your fears and your anxieties, and help is on the way.

H.R. 4250, the Republican plan to make health care more accessible and strengthen patient protection, is a sensible approach to the problems facing Americans, especially working women.

Mr. Speaker, 80 percent of all the health care decisions in this country today are made by women. As a result, women view health care as a consumer issue, not a political issue. That is why the Republican plan addresses the need to expand access to health care for those who cannot afford it, or are uninsured by their employers. H.R. 4250 makes some important reforms that will allow small businesses, an area of our economy increasingly dominated by women, to ban together to purchase health care coverage.

One of the biggest obstacles to health coverage for small business women and their employees is cost. By allowing these small businesses to join together and pool their resources, they will be able to purchase health care at the same discounted rates enjoyed now by big business.

In addition, our Patient Protection Act will give our Nation's women direct access to their OB–GYN. These physicians are extremely important to the lives of every woman and they should not be considered specialists. We should demand that the essential care that they give be accessible without having to jump through bureaucratic hoops.

The Republican plan will also help our Nation's mothers get easier access to pediatricians for the care of their children. Once again, the care given to our Nation's youth is critical to fostering a healthy childhood and it must be available without delay.

Whether it be expanding access to health care for America's small business women or ensuring that mothers and children have the care that they deserve when they need it, the Republican health care plan is right for our Nation's families.

Mr. Speaker, I urge my colleagues to support H.R. 4250 and help give families the peace of mind they so richly deserve.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I thank the gentleman for the leadership he has shown on this issue.

Let me tell my colleagues a little bit about this issue. I look at these two bills and I see mirror images. The Hastert bill takes us a step backwards, at least in Oregon, in protecting patients, and the Ganske-Dingell bill moves that agenda forward.

I want to tell my colleagues how backwards this takes us. In Oregon, our State has already adopted model patient protections. Make no mistake: I would like to see us move forward on patient protection. This, in fact, moves Oregonians backwards. It repeals protections Oregonians already have been guaranteed by the State. Cervical cancer, mammogram screenings, minimum maternity care, mastectomy stays, breast reconstruction, alcoholism and drug abuse treatment, well child care.

In the last session of the Oregon legislature they worked in a bipartisan fashion, held extensive hearings, took the data and opinions of everyone concerned, and what they got was a model piece of legislation. They had hearings on it. What a contrast to this.

Please support the Ganske-Dingell bill.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman from Illinois (Mr. HASTERT) has 9 minutes remaining; the gentleman from Michigan (Mr. DINGELL) has 4 and a quarter minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 15 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, let us try to get this straight. The Federal law known as ERISA is what preempts State laws. It is not this bill; it is the ERISA law that preempts State laws.

Mr. DINGELL. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. PELOSI).

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

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding and for his tremendous leadership in providing access to quality health care for all Americans.

I rise in strong opposition to the Republican bill and in strong support of the Ganske-Dingell bill.

Mr. Speaker, I rise in strong support of the Patients' Bill of Rights, the substitute to the fatally flawed Republican HMO protection bill. The manner in which this legislation is being rushed through by the leadership should tell us clearly that they want to avoid real scrutiny, and given their bill, that is understandable.

With the health care system transforming around us, the most important decision we have to make in writing health care reform legislation is: What interests are we going to protect? Do we stand with patients trying to access quality care and needed specialty services? Or do we craft legislation which gives cover to the industry and considers patients second?

The Democratic Patients' Bill of Rights is true patient protection that will make a difference in the lives of every American.

The contrasts between the Republican and Democratic plan are many and stark. I want to focus on three issues which are very important to constituents in my district.

First, OB/GYN services are among the most personal, and important, health care services. This area of health care goes to the heart of the treasured doctor-patient relationship. When that relationship is full of trust and honesty, it can lead to better diagnosis, treatment, and comfort in the medical care setting.

The Democratic plan gives women direct access to OB/GYN services, without limitations that can stand in the way of receiving services, such as limits on the number of visits to the doctor. The Republican plan does not guarantee this coverage for all health insurance consumers.

Second, I am often approached by people in my district who depend on access to clinical trials. People with AIDS, breast cancer, and other health problems know that the cure for their diseases has not been found yet.

Their hope is their ability to participate with others in the search for medical answers. The Democratic plan promotes access to clinical trials that may provide people access to new, life-saving therapies. The Republican plan fails to do this.

Third, the Dingell-Ganske substitute, but not the Republican bill, permits individuals to sue the health plans under State law for personal injury or wrongful death.

We need health care legislation that puts patients, not HMOs, first. And we need enforcement mechanisms that make those protections real. The Republican plan falls far short on both counts. It is cover for the health industry and for Republicans, not tangible protection for consumers.

I urge my colleagues to support real protection for patients by voting for the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Rhode Island (Mr. WEYGAND).

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

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

I was just very interested, being a former small business owner, when the gentleman just came up a little while ago and mentioned that this bill does not preclude many of the State requirements that the gentlewoman from Oregon (Ms. HOOLEY) just mentioned.

Let me tell my colleagues what this bill does. It shifts small businesses who, like myself, belong to an association health care plan. It took all of the care of my employees and puts it now into ERISA.

This is what it is going to do for those people in the State of Rhode Island. It is going to remove the requirement that there be a well child care program, mammography screening, minimum maternity stays, minimum mastectomy stays, breast cancer reconstruction, cervical cancer screening, diabetic supplies, alcoholism treatment, drug abuse treatment, home health care, off-label drug use, newborn sickle cell testing and blood lead screening, removes patient rights from small business owners and employees of small businesses. This bill does that. The Ganske-Dingell bill does not. Please support the Ganske-Dingell bill.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. SHADEGG).

Mr. SHADEGG. Mr. Speaker, I thank the gentleman for yielding me this time. I would like to engage in a colloquy with the gentleman from California (Mr. THOMAS), the chairman of the Subcommittee on Health from the Committee on Commerce.

It is my understanding that the gentleman, along with most of our Republican colleagues and leaders, would agree with me that the biggest problem with health care today is that the Tax Code encourages employers, and not individuals, to be the purchasers of health care. Indeed, employers have a tax incentive to offer health care benefits for their employees, and individuals do not have that same benefit, so they are discouraged from purchasing their own health care.

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

Mr. SHADEGG. I yield to the gentleman from California.

Mr. THOMAS. Mr. Speaker, I would inform the gentleman that the Subcommittee on Health is a subcommittee of the Committee on Ways and Means.

In looking at the Tax Code, we are very concerned about what has happened. Clearly, there are some advantages to managed care and HMOs in dealing with treating the patient, but I think it is fairly obvious that most employers turned to a controlled cost structure, as well. The employed had no ability to control the rising costs, 18½ percent a year in 1988. What they did was determine, I will take a health care that gives me a fixed dollar amount per employee.

Mr. SHADEGG. Mr. Speaker, I know the gentleman would agree with me that this legislation today, the Republican legislation before us today, takes important steps toward solving these problems, but that there is also agreement on the part of the gentleman and on the part of our Republican leadership that the best long-term solution would be to adopt reforms which make it possible, and indeed, encourage, individuals, whether they are employees of a company or the self-employed, or for that matter unemployed, to purchase their own health insurance without having to go through their employer and get the same tax advantage as their employer currently gets under the law.

Mr. THOMAS. Mr. Speaker, if the gentleman will continue to yield, I could not agree with the gentleman more. The current system is fatally flawed. What we are doing is simply working on the edges. The only way to fundamentally deal with the problems in our health insurance area is to empower consumers, empower them with the wherewithal to purchase the insurance, and just as importantly, empower them with the knowledge to make choices. They have neither of those in today's current system. It needs fundamental reform beginning with the Tax Code, and with the collection of data, to make those changes possible.

Mr. SHADEGG. Mr. Speaker, I understand there is a commitment on the part of the Members to move that as soon as possible.

Mr. THOMAS. Mr. Speaker, I would tell the gentleman that I have no interest in playing on the margin; I want to go to the heart of the problem and change it.

Mr. SHADEGG. Mr. Speaker, I thank the gentleman very much.

The SPEAKER pro tempore. The gentleman from Illinois (Mr. HASTERT) has 2 minutes remaining and has the right to close; the gentleman from Michigan (Mr. DINGELL) has 8 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from New York (Mr. ENGEL).

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

Mr. ENGEL. Mr. Speaker, I rise in strong support of the Ganske-Dingell bill and in opposition to the Republican bill.

The Democratic Patients' Bill of Rights takes health care decisions away from insurance company bureaucrats and gives them back to doctors and patients.

The Republican bill is a sham—it will actually turn the clock back on health care consumers and is another empty political promise from this GOP Congress.

The Republican bill covers too few people, provides too few patient protections and contains unnecessary and irrelevant provisions.

The Democratic bill:

First, returns health care decisions to health care professionals and their patients. The Republican bill does not.

Second, the Democratic plan guarantees patients the right to see a specialist when they need to do so. The Republican bill does not.

Third, the Democratic bill guarantees an end to financial incentives to limit medical care. The Republican bill does not.

Fourth, the Democratic bill guarantees tough enforcement that will hold insurance companies responsible for their actions. The Republican bill does not.

Fifth, the Democratic bill guarantees emergency care. The Republic bill does not.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Illinois (Mr. POSHARD).

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

Mr. POSHARD. Mr. Speaker, I rise in strong support of the Ganske-Dingell bill.

□ 1315

Mr. DINGELL. Mr. Speaker, I yield such time as she may consume to the distinguished gentlewoman from Texas (Ms. JACKSON-LEE).

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in strong support of the Ganske-Dingell bill that does not hurt Texas.

Mr. Speaker, thank you for the opportunity to speak on this important issue today. Mr. Speaker, I am deeply concerned that after spending the last full year blocking any type of adequate health care reform the legislation that is on the floor today is an unacceptable proposal to Americans' very real health care reform concerns. Once again, Mr. Speaker, the House Republican leadership has allowed the insurance industry and its powerful lobbyists to make the rules!

H.R. 4250 may give the appearance of reform, but there is no substance to this bill. There is no provision for specialty care, no provision for needed drugs and clinical trials, and no effective mechanism to hold plans responsible when plan abuse inevitably kills or injures someone.

Instead of protecting patients who desperately need help, the bill here on the floor protects the insurance industry! H.R. 4250 has serious and apparent flaws and I urge my colleagues to oppose this bill.

This bill does not provide enforceable guarantees to protect consumers from bureaucratic abuses. It does not allow patients to seek recourse for denial of care which may result in

injury or death. In addition, the Republican bill which would be more aptly named as the Patient Propaganda Act, Insurance Industry Protection Act or the Profit Protection Act does not guarantee patients access to needed care outside of their managed care plan, does not guarantee the right of patients to see a specialist and does not guarantee access to all necessary prescription drugs. Unfortunately, this bill does nothing to prohibit or prevent HMOs from offering bonuses to doctors for denying necessary care. By contrast the Patients' Bill of Rights Act allows patients access to specialists, and protects the doctor-patient relationship.

The Democratic Patients' Bill of Rights, in contrast is supported by over 300 health related organizations including the Children's Defense Fund, the National Partnership for Women and Families, the National Association of Children's Hospitals, the American Medical Association, and the National Breast Cancer Association. In addition, the American Public Health Association who represents more than 50,000 public health professionals, believes that H.R. 4250 provides inadequate protection of personal health data and may lead to undesirable uses of private information.

H.R. 4250 will allow health insurance companies, not doctors to decide what is medically necessary. In testimony before the House Commerce Committee, Dr. Linda Peeno, a former HMO medical director described the control that health insurance companies would have over our health as ''a health plan's smart bomb capability.'' External appeals will be of no value if the health plan itself is always allowed to decide and define what is medically necessary or appropriate. By contrast, our democratic bill specifically prohibits health plans from practicing medicine by substituting their decisions for the doctors.

And what about the gag rule? H.R. 4250 does not adequately protect the broadest possible range of ''medical communications'' and it would not ensure necessary emergency care! Because H.R. 4250 does not include the words ''otherwise restrict'' medical communications, because of this important omission, health plans can continue to silence physicians. Imagine, even with severe pain, there is no requirement for an insurance plan to allow treatment! In fact, this bill still does not deal with Americans' concerns with gag clauses, yet the bipartisan Ganske-Dingell bill extends the prohibition on gag clauses to subcontracts—in other words, assuring that health care professionals in all types of managed care will be protected and that patients will be protected.

Because we are about women's health concerns, the Dingell-Ganske bill prohibits drive-through mastectomies and requires coverage for reconstructive surgery after a mastectomy. H.R. 4250 does not even include anything close to this type of protection for women. As an advocate of women's rights, I am concerned that the Republican plan does not allow women to choose their obstetrician or gynecologist as a primary care physician, and it also does not allow a woman undergoing an active cause of treatment in her last trimester of pregnancy to continue with her doctor if her employer changes plans.

As a concerned parent and Chair of the Congressional Children's Caucus, I wonder about the children that would not receive adequate care under the Republican bill, in that it does not guarantee access to pediatric specialists.

I urge my colleagues to oppose the Republican plan. We must provide our country's citizens with adequate health care. Our President strongly endorses this plan, and as an article in the July 3, New York Times states, doctors and advocates for consumer groups prefer the Patients' Bill of Rights over the Republican plan, and the New York Times itself said that the Democratic bill seems to be far more prescriptive.

One of the letters I received recently is from a Texas woman, a senior citizen who has worked a lifetime in the medical profession. She told me that she had worked during an era when a doctor saved a gravely ill child—sutured bleeding patients—sat at the bedside of someone's dying loved one knowing there was nothing further he could do except to be there—and then see those same physicians feeling badly in accepting fresh garden vegetables or a dozen eggs with a pound of butter as a payment for his services.

She spoke of a time when doctors were able to act for the benefits of their patients alone, when insurance companies could not deny sick and dying patients their only hope for treatment and cure, based only on greed and profit. The Democratic Patients' Bill of Rights is the only plan guaranteeing that doctors and patients make medical decisions, not insurance bureaucrats!

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to my good friend, the gentleman from Pennsylvania (Mr. DOYLE).

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

Mr. DOYLE. Mr. Speaker, I urge my colleagues to vote for Dingell-Ganske.

Mr. Speaker, I rise to urge my colleagues to vote for real patient protection legislation, in the form of the Dingell-Ganske Patients' Bill of Rights.

The Dingell-Ganske bill is a bipartisan effort to put healthcare decisions back into the hands of doctors and nurses, not insurance companies. It would guarantee emergency care and access to specialists, and retain for doctors the right to speak freely with patients about their medical treatment.

Contrary to the claims of the insurance industry, these important patient protections can be guaranteed without radically increasing costs. We need to continue to get the news out about the recent Congressional Budget Office study, showing that the average policyholder will pay only an additional two dollars a month for these protections.

The Republican leadership bill would leave treatment decisions in the hands of the insurance companies and would not guarantee the right to see a specialist. This is not real reform at all.

I'm sorry to say that the Republican leadership bill still bears the faint aroma of something drafted by industry lobbyists behind closed doors. Even after last-minute changes last night, the Republican bill would still work to actually tear down existing patient protections. In my home state of Pennsylvania, and around the country, existing state patient protection laws would be preempted by this Republican leadership bill.

For example, H.R. 4250, the Republican leadership bill, would override Pennsylvania's medical records confidentiality law. There would be nothing to stop your health plan from sharing your medical information with other organizations, such as your employer. Should an employer have unfettered access, or any access at all, to every employee's health information? I don't think so. On this and a number of other issues, H.R. 4250 is more than just a sop to the issue of HMO reform, it's a bad bill, and we must vote to reject it.

Today, we have a choice between real reform, or a watered-down, half-hearted motion designed simply to provide political cover to the Republican party. I urge my colleagues on both sides of the aisle to support the bipartisan Patients' Bill of Rights. Thank you, and I yield the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. MENENDEZ).

Mr. MENENDEZ. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me this time.

Mr. Speaker, when Republicans seek to avoid reform, they raise the specter of Big Government. Yet it is the Republican majority's lack of governmental intervention that has let the abuses take place over the years of their majority in the HMOs across the country. It is only when Democrats clamored for patient protection that they came forth with the fig leaf they produced today.

One mother in my district came to me because her child had been denied necessary rehabilitative treatment after surgery, and now that child will live with the damaging effects of this denial for the rest of his life. The Republicans' bill gives that family no relief, no enforcement mechanism. That is not family values.

Today HMOs have all of the protection and none of the responsibility. We want to give patients protection. We want to make sure HMOs are responsible for their actions. We want to preserve what is trusted by Americans, their relationship with their doctor. We want to give them those choices. We want to make sure that a doctor is making those decisions.

Mr. Speaker, that is why I join the gentleman from Iowa (Mr. GANSKE), a Republican, in supporting the Ganske-Dingell bill.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Indiana (Mr. VISCLOSKY).

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

Mr. VISCLOSKY. Mr. Speaker, I rise in support of the Ganske-Dingell substitute.

Mr. Speaker, I rise this morning as a cosponsor of the bipartisan Patients' Bill of Rights and a believer in the notion that doctors should make decisions about their patients' medical treatments, not insurance companies. Today's managed care plans are run by insurance industry bureaucrats whose first

concern is the bottom line for insurance companies, not quality care for patients. These insurance industry bureaucrats seek to maximize profits for insurance companies by restricting treatment to patients and preventing doctors from providing proper care.

In addressing this situation, the bipartisan bill, which is the basis of the Dingell/Ganske substitute, offers its protections to patients, who need to know that their insurance companies are not interfering with their access to quality health care. This bill is dramatically different than the Republican bill which seeks only to protect the insurance industry.

Currently, 125 million Americans are enrolled through their employers in self-insured health plans, in which the insurance companies cannot be held liable for their decisions to restrict medical treatment, even if those decisions directly result in the death or maiming of the patient. The Congress should eliminate this legal protection for insurance companies, so that insurance companies can be held legally accountable for their decisions, just like everyone else. The bipartisan bill would offer Americans the legal protections of their individual states in holding insurance companies accountable for their decisions. The Republican bill on the other hand, would go the other way by restricting patients' legal rights and increasing the number of patients who are not protected by state malpractice laws from insurance companies.

Americans need to know that they have access to adequate internal and external appeals processes if their insurance company denies them coverage for a treatment. While the bipartisan bill provides for an external review that is truly independent and bases the definition of medical necessity on ''generally accepted principles of professional medical practice,'' the Republican bill would allow the insurance company to determine what is considered medically necessary and who performs the external review.

Americans need to know that they have access to emergency care when it is necessary, and we should encourage people to go to the emergency room when they experience severe chest pain—a sign of a possible heart attack. But the Republican bill fails to guarantee payment for care in such cases, leaving the health of Americans at risk. That's why the President of the American College of Emergency Physicians has said that the Republican bill ''will not bring peace of mind to anyone seeking emergency care when they need it.''

Americans need to know that their insurance companies are not restricting the range of treatments that their doctors are allowed to discuss, and are not offering financial incentives to doctors to limit patient care. While the bipartisan bill provides strong protections to patients in both of these circumstances, the Republican anti-gag provision is riddled with loopholes, and their bill doesn't even address the problem of financial incentives designed to limit care.

Americans need to know that they will have access to a specialist when it is needed and not become a victim of managed care bureaucrats. The bipartisan bill provides this protection to patients; the Republican bill does not.

With a set of consumer protections so weak as to be almost meaningless, the Republican bill is a cynical attempt to include erroneous provisions that have absolutely nothing to do with the problems of managed care such as provisions that would allow companies unrestricted access to your personal, confidential medical information and that would allow wealthy Americans to set up tax shelters through medical savings accounts.

Mr. Speaker, the American people deserve strong protections from the insurance bureaucrats who seek to do nothing more than maximize profits by restricting care. Please join me in voting for real protections for patients and against further protections for insurance companies, and vote for the bipartisan substitute and against the Republican bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Georgia (Mr. LEWIS).

Mr. LEWIS of Georgia. Mr. Speaker, we need a real Patients' Bill of Rights. I know because I have heard from the people in my district.

A mother told me her daughter had a mastectomy. The mother begged, pleaded to keep her daughter in the hospital for just one night. She needed to be there, but the insurance company sent her home.

I have heard from a doctor, a doctor who had to fight the insurance company to get coverage to treat his cancer.

Mr. Speaker, too many patients are paying more and are getting less. Under the present system, too many patients are getting a raw deal. They need a fair deal. They need a good deal. They need a better deal.

The differences are clear. Democrats are concerned about protecting patients. Republicans are concerned with protecting big business and insurance companies. The system is broken. It needs help. It needs a doctor. The Republicans are only offering a Band-Aid.

We need a bill to let doctors make medical decisions. The Democratic bill makes sense. If we can choose who fixes our car when it is broken, then we should be able to choose who would care for us when we are sick.

If insurance companies want to tell us that we cannot see a doctor, that we cannot get treatment, then they must be held accountable. The doctors and nurses on Main Street should make the decisions about our health care, not the insurance company and wheelers and dealers on Wall Street.

The Democratic bill protects patients. The Republican bill does not. Mr. Speaker, we need a real patient's protection act and we need it now. Not tomorrow, not next week, not next year, but now.

Mr. Speaker, we should vote for a real patient protection bill and we need it now. Vote for the Ganske-Dingell bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Michigan (Mr. BONIOR).

Mr. BONIOR. Mr. Speaker, after ignoring the public outcry for months, the Republicans have rushed to the floor with a midnight deal that does nothing to end HMO abuses. We might as well call the Republican bill the Insurance Company Protection Act, because that is all it does. It does not protect patients.

These are the same insurance companies that have spent millions on TV ads to kill HMO reform and the same insurance companies that cut corners with people's lives. When insurance companies play doctor, and that is what they are doing, people get hurt, people die.

Under the Republican bill, many HMOs can still limit what doctors can tell their patients. Under the Republican bill, HMOs can still restrict patients' access to emergency rooms. If patients have a heart attack and the ambulance speeds to a hospital close by but outside their network, they can get stuck with a $4,000, $5,000, $6,000 emergency room bill. It is enough to give them another heart attack.

Under the Republican bill, patients have little access to specialists or freedom to choose their own doctor. Under the Republican bill, HMOs can release private medical records without the patient's permission.

Under the Republican bill, it even gives HMOs the authority to define ''medical necessity.'' And if an HMO denies necessary medical care, the HMO cannot be sued for damages. That is not reform. That is reprehensible. But that is what the Republicans propose. They are telling our constituents: Take two aspirins and call us after the election.

The President has made it very clear, he will veto this sham reform. I urge my colleagues to stand firm today. Support the Dingell-Ganske bill for real HMO reform and patient protections.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Illinois (Mr. DAVIS).

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

Mr. DAVIS of Illinois. Mr. Speaker, I rise in favor of the Dingell-Ganske bill.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Missouri (Mr. GEPHARDT) the minority leader, for purposes of concluding debate.

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

Mr. GEPHARDT. Mr. Speaker, the bill that the Republican leadership has brought to the floor is what happens when they bring a bill that they really do not believe in, when they bring a bill that is really designed to be political cover to address an area they really genuinely do not believe needs to be treated with legislation.

It is a fake. It is a fig leaf. It is a sham. It is a subterfuge. It is a charade. It is cosmetic. It is ineffective. And it will not work to solve the real problems and the real concerns that the American people have in this area.

If Republicans really believed in their bill and thought that it had merit, they would have had extensive hearings in the committee and allowed doctors and nurses, senior citizens and

patients, consumers, health care company officials and others to come and testify and tell us in the Congress their feelings, pro and con, about the bill.

If they really believed in their bill and what it did, they would not have been writing it at midnight last night, changing it, trying to shove things into it to try to attract the last few votes on their side to be able to pass the bill. They would have proudly stood for their bill as an effective answer.

Mr. Speaker, I just ask Members today to ask themselves one simple question: Where are the doctors and nurses on this piece of legislation? Which piece of legislation do they support, the people who, on a daily basis, give their lives and their careers to help get people well?

Mr. Speaker, they are for the Patients' Bill of Rights, the patient protection act written by the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE). They are against this sham, this political fig leaf that has been put up on the other side.

Why is that the case? Let me give just three quick, simple reasons. First, the Republican bill does not guarantee that if our doctor says we need to see a specialist, that we will actually be able to see that specialist. Just imagine if a patient has cancer and their doctor says they need to see an oncologist. If the Republican bill passes, there will be no guarantee in the law that patient will be able to see that oncologist.

Secondly, the idea of what is medically necessary will still, under the Republican bill, be up to bureaucrats in insurance companies who have their eyes on the bottom line, the profit line, and not on what is good medical care.

Finally, no enforcement. No enforcement. This is a bill with rhetoric but without a remedy. What we need in this area is to be able to know that if the medical necessity is not observed, if the guarantee of the plan is not observed, that patients have some place to go to get a remedy.

What physicians say to me is, ''I am accountable for my health care decisions every day, every minute of every day. But now we have some bureaucrat at the end of an 800-number who can make medical decisions that are just as important as my decisions, and they are not in any way accountable to anybody for the decisions they make.'' That is the heart of this bill, and that is why the Democratic bill is the only good bill before us today.

Let me end with this. Members are voting today on the rights and the ability of flesh and blood human beings in their district. Make no mistake about this, they care about this bill. This really counts in their lives. When Americans need the Bill of Rights, they need it.

Mr. Speaker, I sat with my son when he was sick in the hospital and talked to other parents of kids who had cancer and they would say, ''My policy did not cover, my policy did not work on the treatment, the experimental treatment that my son or daughter needed.'' Let me tell my colleagues that when one is sitting in that hospital room and they have a loved one in front of them who is dying because they cannot get the treatment that they have paid for, they will want this Patients' Bill of Rights and they will want it now.

Mr. Speaker, I urge my colleagues to vote against this fig leaf. Vote for a good bill.

Mr. HASTERT. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. MICA).

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

Mr. MICA. Mr. Speaker, I rise in support of the Republican alternative and against the Democrat, more regulatory, bureaucratic, and more litigious approach.

Mr. HASTERT. Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia (Mr. LINDER).

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

Mr. LINDER. Mr. Speaker, I rise in favor of the Republican alternative.

Mr. HASTERT. Mr. Speaker, I yield the balance of my time to the gentleman from Georgia (Mr. GINGRICH), Speaker of the House.

Mr. GINGRICH. Mr. Speaker, let me thank my colleagues and let me thank the gentleman from Illinois (Mr. HASTERT) and everyone who served on the Health Task Force for developing the Patients' Protection Act.

Let me remind everyone that this is not a new process for us. We founded the Health Reform Task Force in 1991. We developed a series of reforms which included Medical Savings Accounts, which included preventive care for diabetes, for prostate cancer, for colorectal cancer, for breast cancer.

We have moved a series of initiatives on child health. We moved a series of initiatives to expand access to health insurance for small business. And now we are back working in the same general direction which is really to do three things: To make sure that every citizen has access to health care; to make sure that it is the most modern and best health care in the world; and to lower its costs.

Let us be clear about the choices here. The Dingell bill is a well-meaning bill, if one is a trial lawyer.

□ 1330

The Dingell bill is terrific for trial lawyers. The Dingell bill is about trial lawyer enrichment. We are better on every count. We save money. The Dingell bill costs money. So we make it easier to buy health insurance and expand the coverage. We have provisions so that more people can get covered by health insurance.

The Dingell bill will actually take a million and a half people out of health insurance and put them on the taxpayer. So they have less health insurance for fewer people at greater cost.

Our bill says if someone gets sick and they have a reasonable layman's standard, they go to the emergency room and they are automatically covered. It then says if that individual is not in an emergency situation, but that individual does not agree, they can get, within 72 hours, an internal review. And if they do not agree with that, they can get, within 72 hours, an external review. They do not have to go to a trial lawyer.

And the review, by the way, is done by appropriate medical professionals of comparable specialties. So medical people make medical choices in our bill. Trial lawyers make litigation choices in the Dingell bill.

This is not a complicated issue. This is an issue of the trial lawyers seeking to enrich themselves at the expense of everybody else in this country by having more lawsuits over a longer period of time and a more jammed courtroom. We have a proposal which says more patients have more rights by appealing against the HMO, appealing against the insurance company, and appealing directly to an independent council of medical professionals.

Now, let us say the medical professionals decide, yes, the patient deserves the coverage, and the HMO says we are not going to do it. At that point, under our plan, that individual goes to court with a presumption that the HMO is guilty. The judge is now looking at an independent medical panel having said, yes, the patient should get this treatment. So we give the American people better treatment, faster, with medical specialties, at lower cost.

But we do one thing that our good friends cannot stand: We do not make the trial lawyers richer. We also have malpractice reform, which is what every doctor has told us for 20 years they want.

So I would say the vote on Dingell is very simple: If we want better patient protection, vote ''no''. If we want lower cost, vote ''no''. If we want more people covered by health insurance, vote ''no''. If we want medical doctors making medical decisions, vote ''no''. But if Members really think they owe it to the trial lawyers to give them a new chance to get richer, vote ''yes''.

Mr. SERRANO. Mr. Speaker, I rise in strong support of H.R. 3605, the Dingell-Ganske Patients' Bill of Rights, and in equally strong opposition to H.R. 4250, the pale shadow of reform offered by the Republican leadership.

The American people have called on us to rein in the managed care companies that are putting profits ahead of people, denying and delaying care and causing real harm. We have heard from patients with terrible stories of injury and death caused by the decisions of arrogant, unfeeling insurance company bureaucrats intent on their corporate bottom line. We have heard from doctors who have been forced to beg for permission to treat their patients according to their professional judgment. We have heard from nurses who daily see

and deal with the results of denial and delay. We have even heard from former HMO employees about what they had to do—until they couldn't stomach it any more—to keep their jobs.

While it is gratifying that Republican leaders have finally listened to the American people and scheduled floor debate on managed care reform, this is a holly exercise. Their useless bill, which is likely to pass, will be vetoed. We know that already. So this is not serious attempt to accomplish meaningful reform, it is an attempt to give Republican candidates cover on an issue that is critical to millions of Americans, to permit Republicans to claim they have done something about health care.

In stark contrast, the Dingell-Ganske bill would provide meaningful, enforceable patient protections and quality health care. It would let doctors and patients make medical decisions and end financial incentives to limit medical care. It would guarantee access to specialists outside the HMO, to emergency services, to the full range of prescription drugs, and to clinical trials. It would end excessive use of cost-cutting devices such as outpatient mastectomies and drive-by deliveries. Most important, it would be enforceable.

The Interreligious Health Care Working Group supports legislation that includes ''patient access to information; choice of providers and plans; access to emergency services; participation in treatment decisions; respect and nondiscrimination; confidentiality of health information; and complaint and appeal procedures'' as well as credible means of enforcing those rights. H.R. 3605 meets this standard. H.R. 4250 does not.

The Consumer Federation of America supports legislation that includes ''holding managed care companies accountable; requiring an external grievance and appeals system; comprehensive information disclosure; quality assurance programs; and protection of the doctor-patient relationship in a manner that allows advocacy on behalf of patients and prohibits improper physician incentive plans.'' H.R. 3605 meets this standard. H.R. 4205 does not.

Similarly, the American Federation of Teachers, Families USA, the Lutheran Office for Governmental Affairs, Consumers Union, and others that have outlined principles for addressing problems in the managed care industry find H.R. 4250 sadly lacking in both protections and enforcement. They all support H.R. 3605.

The American Medical Association—the AMA, Mr. Speaker—lists 10 reasons to vote against the Republican leadership's bill and for the Patients' Bill of Rights. I won't list them all, but I should mention a couple of key issues. AMA Reason No. 9 is ''H.R. 4250 would allow health insurance companies to decide what is medically necessary * * *'' AMA Reasion No. 7 is ''H.R. 4250 would require patients to pay for the privilege of an external review of treatment denial; H.R. 3605 imposes on such fees * * *'' AMA Reason No. 4 is ''H.R. 4250 would delay the effective date of patient protection for up to 2 years * * * H.R. 3605 would peovide for nearly immediate implementation * * *''. Finally, and perhaps most importantly, AMA Reason No. 1 is ''H.R. 4250 does not hold health plans properly accountable for making medical treatment decisions that result in patient injury or death.''

Of course, Mr. Speaker, the Republican leadership doesn't stop at offending the American people by offering only a hollow promise of reform, it throws in posion pills that have been considered and rejected before. Exempting Association Health Plans (AHAs) and Multiple Employer Welfare Arrangements (MEWAs) from state law would deny millions of Americans coverage under many of the patient protection laws already enacted by 43 states. That includes my own state of New York, which has been a pioneer in establishing patient protections. Expanding the availability of medical savings accounts (MSAs) would give tax breaks to the healthy and wealthy while increasing costs of health insurance for the sicker and poorer.

It is obvious that this is a political exercise. The Republican leadership's bill was introduced only last week and has not been examined in a single hearing or subjected to amendment by any committee. It hasn't been scored by the Congressional Budget Office. As the AMA writes, ''In fact, Members of Congress have not had time to fully understand critical differences in the two bills since last Friday's introduction of the House Republican bill''. Not surprisingly, then, the bill has been a work in progress, subjected to numerous changes—changes that sound like improvements but are largely cosmetic—in attempts to attract enough votes to pass the bill without actually accomplishing anything that would annoy the Republicans' friends in the insurance industry.

I urge my colleagues to support meaningful, enforceable reform, not posturing. Support the Dingell-Ganske Patients' Bill of Rights and reject the Republican leadership's Managed Care Reform Lite.

Mr. TURNER. Mr. Speaker, Democrats initiated the effort in this Congress to protect patients and their doctors from interference by insurance company bureaucrats. The Dingell-Ganske bill provides these protections and eliminates the complete exemption from accountability that many HMOs enjoy today under the Federal ERISA law.

The Republican bill, on the other hand, is an effort to preserve the insurance companies' shield of protection from accountability for their mistakes. It creates a Federal bureaucracy in the Department of Labor and a complex appeals process diagrammed here on this chart to my right. Look at this. And endless maze of bureaucratic nightmare is created by the Republican bill.

Consider the example of Phyllis Cannon. In September of 1991, Ms. Cannon was diagnosed with leukemia. On August 10 of 1992, her doctor sought approval from her HMO for a bone marrow treatment. 43 days later, her doctor pleaded for authorization to treat her life-threatening condition and it was again denied. By the time the HMO finally agreed to authorize treatment, it was too late and Phyllis Cannon died.

Could she have gone through this maze under the Republican bill and done any better? I think not. And if she had made it through the maze under the Republican bill, after her death she would have been entitled to only $500 per day. Under the Republican bill, the total recovery for her family would have amounted to only $20,000.

Is this what we call protecting patients? Vote against this Republican bill. Vote for the Ganske-Dingell bill and prevent this kind of endless bureaucratic interference with medical decisions from happening to the patients of this country.

Mr. THOMPSON. Mr. Speaker, I rise today as the Representative from Mississippi's 2d Congressional District in support of H.R. 3605, the bipartisan Dingell-Ganske Patients' Bill of Rights. This bill guarantees that decisions will remain in the hands of doctors and nurses, not insurance companies; that people will have access to specialists; that there will be protection for women after mastectomy (minimum hospital stay); and the ability to hold plans accountable when abusive practices kills or injure patients.

I oppose the Republican HMO health care bill. Mr. Speaker, I am in support and committed to passing major managed care legislation. However, I do not support the Republican bill that covers too few people, provides limited patient protections, and contains unnecessary and irrelevant provisions. It undermines existing state consumer protections, leaves patients and small businesses with fewer protections than they already have. The Republican bill is being pushed through the House with almost no debate and virtually no amendments allowed in an attempt to stop the only real bipartisan managed care reform bill—the Dingell-Ganske Patients' Bill of Rights—from passing. Mr. Speaker, the Republicans are playing politics with the lives of Americans. Let's stop this ridiculous rhetoric and pass some meaningful legislation.

As I close, I would like to once again express my support for H.R. 3605 and thank Representative DINGELL and Representative GANSKE for their work in bringing this legislation forth to protect the interests of patients. I urge my colleagues to support this bill.

Mr. COYNE. Mr. Speaker, I rise in support of H.R. 3605, the bipartisan Patients' Bill of Rights. Today we have a tremendous opportunity to protect our constituents' right to receive quality health care.

More than half of all Americans are not offered a choice of health care providers by their employer. Under current law, many consumers have little recourse if their HMOs or insurance companies do not protect their most basic health care rights. I believe Congress must act to guarantee these rights.

I am proud to be an original cosponsor of the bipartisan Ganske-Dingell bill (H.R. 3605). It would ban ''gag rules'' and contracts in which doctors are paid less if they refer to needed specialists or suggest expensive treatment, guarantee access to specialty and emergency care, protected medical confidentiality, and give patients access to a free, timely appeals process if their HMOs deny them benefits. If patients are harmed by decisions made by their HMOs, they will be allowed to take the HMO to court and recover damages. H.R. 3605 also provides for speedy implementation. Americans need relief from badly managed care now, not 2 years from now.

On the other hand, H.R. 4250, the Republican alternative, is a step in the wrong direction. It actually weakens the protections patients have under current law. The association health plan proposal would increase the number of patients who are not allowed to sue their health plans if they are harmed or killed by decisions made by the plan. The bill also undermines current laws which protect medical confidentiality, allowing almost any insurance company official access to a wide range of personal medical records. By expanding medical savings accounts, they encourage

wealthy, healthy people to ''opt out'' of the current health insurance coverage insurance system, increasing the price of health insurance for everyone else. Finally, the Republican bill would maintain the status quo in which insurance companies, not doctors, decide what is ''medically necessary,'' and health plans can continue giving doctors financial incentives to deny necessary care.

I urge my colleagues to join me in supporting H.R. 3605, the Patients' Bill of Rights. We owe it to our constituents to use this opportunity to enact real reform.

Mr. BENTSEN. Mr. Speaker, I rise today to express my strong support for H.R. 3605, the bipartisan Patients' Bill of Rights, that is sponsored by Representatives DINGELL and GANSKE. Today, we will consider two different approaches to reform managed health care plans. I am a strong supporter and co-sponsor of H.R. 3605 because I believe that this bill provides essential consumer protections to all Americans. I urge my colleagues to reject the Republican leadership sponsored legislation, H.R. 4250, and vote for the real Patients' Bill of Rights.

Today, there are more than 160 million Americans enrolled in managed care plans, such as health maintenance organizations (HMOs). Of these enrollees, approximately 125 million Americans are enrolled in managed care health plans that are governed by federal law, the Employee Retirement and Insurance Security Act (ERISA). Under ERISA, these Americans cannot seek legal remedy if their health plans denies or delays access to care. In a time when many Americans believe that their health plans are arbitrarily denying care and services, the Dingell-Ganske substitute bill would ensure that health plans must provide an appeals process to their decisions. Under the Dingell-Ganske bill, patients would be guaranteed the right to seek both an internal and external appeals process with a deadline for decisions to be made. If both of these appeals are denied, consumers would have the right to hold their plans accountable for their decisions through a legal case in our court system. In my state of Texas, where a new law has recently been approved to provide this legal right for consumers under state-based health plans. This legislation would simply ensure that ERISA-based health plans are held accountable by consumers.

The Dingell-Ganske bill provides critical reforms that patients need. It guarantees that decisions will remain in the hands of doctors and nurses, not insurance companies. It guarantees access to specialists and ensures that doctors and nurses can talk freely with patients without interference from their health plans. The Dingell-Ganske bill also prohibits the use of financial incentives to limit medical care. The Dingell-Ganske bill also ensures that patients can seek care in emergency rooms without prior approval and when they are suffering severe pain.

I would like to highlight one main difference between these bills. The Dingell-Ganske substitute includes an important provision to ensure that all Americans can enroll in cutting-edge clinical trials if they need them. As the sponsor of legislation to ensure that Medicare beneficiaries can enroll in clinical trials, I believe we must guarantee this right to ensure that patients have access to the best, most-advanced care. As the Representative for the Texas Medical Center, where many of these clinical trials are conducted, I believe that this guarantee must be included as any consumer-protection legislation. The Dingell-Ganske substitute would require managed care plans to pay for the routine costs associated with clinical trials. The Republican majority legislation does not include this critical provision.

Finally, I would like to highlight one other critical point about the Patients' Bill of Rights. I believe the Patients' Bill of Rights is a cost-effective, reasonable approach to provide uniform federal standards for managed care health plans. I believe that consumers are willing to pay for these protections. The Congressional Budget Office has estimated that the Patients' Bill of Rights would add a total of $2 per month for these protections. Let me repeat that, for $2 per month, patients can be guaranteed real protections. I believe that consumers believe that this small price is worth its guarantees to ensure that consumers receive the health care services they need and deserve.

I urge my colleagues to reject the Republican leadership bill and vote for the Patients' Bill of Rights.

Mr. COSTELLO. Mr. Speaker, I rise today in strong support of the Dingell Patients' Bill of Rights. The Republican plan tries to give the appearance of reform without actually doing so. The Republican plan does not limit HMOs' and insurance companies' use of improper financial incentives to limit needed care, does not give access to specialists, does not allow women to choose their obstetrician or gynecologist as a primary care doctor and what is most important, the Republican bill provides no effective mechanism to hold HMOs accountable when a patient is killed or injured.

The American people have waited long enough to be granted the ability to sue HMO's when a patient or family member is injured or killed due to the negligence of their health plan. They deserve the right to take legal action. HMO's should not be exempted from legal liability. Most industries in the U.S. today have responsibility to provide safe products and safe work places and can be subjected to legal recourse if they intentionally harm an individual. HMO's are no different; we must pass legislation to make them responsible for their actions!

The Republicans use of scare tactics claiming that the Democratic bill will escalate the cost of managed care plans is bogus. Last week, the Republicans' own Congressional Budget Office (CBO) released an analysis of the Patients' Bill of Rights discrediting Republican claims. The CBO estimates that the Democratic proposal costs only $2 more a month for patients with managed care plans. The CBO also estimates that the Democratic provision allowing patients to sue their health plans will increase premiums by just 1.2%. That is a small price to pay to make sure HMO's understand they will face legal liability.

The Democratic bill has been endorsed by the American Medical Association, American Nurses Association, American Cancer Society, and the American Trial Lawyers Association. It's time we hold health plans accountable for their actions and give the American public back their right to quality health care. I strongly urge my colleagues to support the Ganske-Dingell substitute.

Ms. MCCARTHY of Missouri. Mr. Speaker, I rise today to speak in favor of H.R. 3605, the Dingell-Ganske Patients' Bill of Rights, of which I am a co-sponsor. I urge my colleagues on both sides of the aisle to join me in support of this bipartisan bill. This bill guarantees that medical decisions will be made by doctors and their patients, not by insurance companies. It ensures that doctors can inform patients of all of the treatment options available to them so that patients can make educated choices regarding their health care. It guarantees that a patient who goes to an emergency room with severe pain will be treated.

The Patients' Bill of Rights also extends important protections to women. This bill allows women direct access to obstetric and gynecological care, and it allows women to designate their own gynecologist as their primary care provider. This provision allows a woman to continue to be treated by a doctor with whom she has become comfortable and who knows her personal medical history.

Further, the Dingell-Ganske bill provides patient protection at an affordable price. The Congressional Budget Office has reported that most individuals would only pay about $2 more per month in premiums as a result of the Patients' Bill of Rights. The peace of mind and security that will result from this bill are well worth this small amount.

Last year, my home state of Missouri enacted legislation that ensure a patient's right to emergency room care, to choose a doctor, and to know about all of the options available to them for treatment, regardless of the cost. In addition, the Missouri law provides for well-child care, mammography screening, drug abuse and alcohol treatment, bone marrow transplants, and breast reconstruction.

With this legislation, Missouri took great strides to guarantee access to specialists and provide more rights for patients. If the Gingrich-Hastert bill is enacted, Missouri's law will be over-ridden, and the rights of the people of my state will be taken away. We must not let this happen. Instead, we should recognize successful efforts like Missouri's at the state level to guarantee patients basic rights and follow this lead by passing the Dingell-Ganske bill.

We must guarantee that insurance companies are held accountable for their actions when they deny patients the health care they need. We must guarantee that when patients need to go to the emergency room, they can go without worrying whether their insurance will allow them to be treated for their medical emergency. We must guarantee that doctors and not insurance companies are making the decisions about what is medically necessary for their patients.

In my district, at the Children's Mercy Hospital, social workers are fighting the current system to ensure that patients receive the care they need. For example, one little boy with an amputated arm needed a special kind of prosthesis. His insurance company deemed the special arm not medically necessary and refused to pay. The social worker at Children's Mercy was able to secure outside charitable funding for this little boy to get the arm he needed, but not all hospitals are able to provide this service, and frankly, they shouldn't have to.

Join with me in supporting H.R. 3605 and grant America's patients the basic medical rights they deserve.

Mr. OWENS. Mr. Speaker, I rise to oppose H.R. 4250, the Republican so-called Patient

Protection Act and to voice my enthusiastic support for H.R. 3605, the Patients' Bill of Rights Act. H.R. 4250 was conceived in the back room of the Speaker's special 15-member Task Force on Health Care and unveiled just last week. Although the bill was referred to several committees, in a transparently desperate political maneuver, the Republican leadership has put the bill on a fast-track basis and side stepped the traditional deliberative process. I am pleased, however, that many of the provisions that are included in several Democratic bills, including my own bill (H.R. 1191, the Patient and Health Care Professional Protection Act), have been included in today's Patient Protection Act. Yet, this bill, H.R. 4250, falls disgracefully short on ''protections'' for patients and health care workers. The authors of H.R. 4250 took great care to ensure the protection of the owners of the commerce of health care—managed care companies. At a time when the health care industry is completely re-engineering itself and a record 160 million Americans have fallen susceptible to the cost-saving strategies characterized by too many managed care plans, we must not support this phony ''Patients' Bill of Rights.'' We wish to note also that irrational Medicaid rate reductions by state Governors are also jeopardizing the health of patients.

Disappointingly, most of the new Federal protections in H.R. 4250, would cover merely 48 million Americans in self-insured, employer-sponsored health plans that fall under the purview of ERISA (the Employee Retirement Income Security Act of 1974). However, there are more than 160 million Americans who have private health insurance. Congress must act to ensure the protection of a broader range of health care consumers, including Medicaid recipients.

In addition, H.R. 4250 contains a bogus grievance mechanism for patients who my have disputes with their HMOs. Under the bill, a so-called internal and external appeals process would be established, Upon first glance, it appears that H.R. 4250 adequately provides for a fair process whereby patients can appeal any denials of care. However, upon a closer look at the bill language, it is clear that the so-called external process is not very independent of the HMO with whom the patient is in dispute. H.R. 4250 would stack the cards in favor of the HMO from the onset. An independent medical expert would be required to examine the dispute on the merits of whether or not the HMO followed its own rules. The independent medical expert would not be authorized to determine that the medical procedure is indeed, necessary. To add insult to injury, the bill would permit health plans to charge up to $100 to a patient who pursues the external appeals route.

Unlike the Democratic substitute (H.R. 3605 sponsored by Representatives DINGELL and GANSKE), H.R. 4250 would not allow patients to sue their health plans. (Currently ERISA does not permit patients in employer-sponsored plans to sue their health plans.) Republicans have demonized the right to sue as some kind of payoff to the trial lawyers of America. On the contrary, the right to sue is an appropriate remedy which allows for maximum enforcement against health plans, especially when great injury or death results from their cost-cutting decisions. Any true patient protection bill and patient advocacy language would arm the patient with this basic tool of American civil rights.

Moreover, H.R. 4250 contains no protection for the very individuals who are on the front lines of the health care delivery system—nurses, doctors, and other health care professionals. The bill does not have whistleblower protections for health care workers who are in the best position to witness and report patient safety concerns. The Service Employees International Union, the organization that represents the largest number of health care professionals in the country (1.3 million members) states, ''In a recent national survey of health care professionals, nearly 1 out of 4 reported that 'employees are penalized for, or afraid to speak up about problems in their workplace' '' Yet, H.R. 4250 ignores this fact by not protecting workers from discharge, demotion, or harassment when they decide to stand up for patient care.

It should be noted that my bill, H.R. 1191 which was originally introduced in the 104th Congress and reintroduced on March 20, 1997, addresses these issues and accomplishes the following: Provides strong whistleblower protection for nurses and doctors; ensures that managed care plans mandate that adequate staffing guidelines are implemented in every hospital across the country (This would stop the current practice of replacing registered nurses and licensed practical nurses with unlicensed aides.); mandates the compilation of public, uniform, national patient-outcome data collection and analysis; assures than no patient is denied care for non-medical reasons; establishes a Federal mechanism for the emergency investigation of egregious hospital cases involving death or life-threatening situations; and establishes well-funded, consumer-dominated, non-governmental genuine health care advocacy groups in each state.

Finally, H.R. 4250 would prematurely expand access to medical savings accounts (MSA). MSAs are tax-exempt savings accounts which may be used to pay for medical expenses. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) authorized a limited number of MSAs (750,000) under a demonstration program beginning on January 1, 1997. Many Members and consumer groups were vehemently opposed to the demonstration program, citing that MSAs work for those that are more healthy and more rich. The vast expansion of MSAs under H.R. 4250 is reckless and extreme given that the impact of the 1997 demonstration program has yet to be studied.

Health care is big business. Spending for health care totals approximately $1 trillion every year in the United States. Competition within the health care industry is fierce, and Congress has the unequivocal role in assuring that cutting costs and increasing one's profits are not priorities at the expense of patient care quality and safety. When I recently convened an extensive health care empowerment conference in my district, my constituents demanded reform. The 11th Congressional District Advisory Committee and the HMO Consumer Advisory Committee called for the formation of an ''HMO Certification Council'' to give a seal of approval to managed care plans. The conference participants stated their desire for greater access to doctors. The conference participants also called for the passage of state legislation that would hold managed care companies accountable and permit wronged patients to sue these companies. And when a group of nurses visited me two years ago and conducted a rally at the Capitol, they demanded protection for themselves and their colleagues and freedom to advocate on behalf of their patients. I urge my colleagues to carry out the will of the American people, and not the wishes of greedy American businesses. Vote ''no'' on H.R. 4250, and vote ''yes'' on H.R. 3605, the Democratic Dingell-Ganske substitute.

Mr. PAYNE. Mr. Speaker, I rise in support of the Patients' Bill of Rights, the Dingell-Ganske substitute. I do so because the substitute lives up to its name. Improving health care quality is what this debate is supposed to be about and that is what the Patients' Bill of Rights does.

This measure enjoys broad bipartisan support from the AFL–CIO to the American Medical Association. Unlike H.R. 4250, the Patients' Bill of Rights allows states to continue on their current course of expanding health care coverage to the uninsured and improving health care quality.

The bill ensures that treatment discussions stay between the doctor and their patient. It also requires that health plans have an adequate number and variety of health providers. This provision is especially important to me because African Americans and other minorities are consistently discriminated against in the treatment and provisions of care.

The Patients' Bill of Rights has critical safeguards to protect patients and providers from discrimination. Mr. Speaker, I urge my colleagues to protect the public health and support the Patients' Bill of Rights. Vote yes on the Dingell-Ganske substitute.

Mr. SANDLIN. Mr. Speaker, I rise in strong support of the Dingell-Ganske substitute and in opposition to H.R. 4250, the so-called Patient Protection Act. That bill does not protect patients. In fact, several provisions of their bill would harm patients. H.R. 4250 was rushed to the floor with no hearings, no markup, and not even so much as a CBO cost estimate until minutes ago.

One of the most critical differences in the two alternatives before us is who makes decisions. As we increase access to health care, we must not allow unqualified parties to make critical decisions about patient treatment. Patients need to feel confident that their doctors are giving them all necessary information and not restricting information because of requirements issued by a health insurance provider. Patients should make critical decisions about their health care with the advice of their doctor. These decisions should not be overridden or limited by insurance company bureaucrats. The Patients' Bill of Rights allows patients to make their critical care decisions.

As a strong supporter of local control, I support the Dingell-Ganske substitute because, unlike H.R. 4250, it will not override protections already enacted by the states. In my home state of Texas, the following protections would be overridden by H.R. 4250: well-child care; mammography screening; minimum maternity stays; breast reconstruction; diabetic supplies; prostate cancer screening; home health care; mental health care; alcoholism treatment; drug abuse treatment; Alzheimer's disease; formula for PKU; TMJ disorders; and bone mass measurement. The federal government should not be in the business of overriding state legislatures' decisions about consumer protections.

Recently, I received a letter from two Republican members of the Texas legislature

who were instrumental in the passage of recent Texas laws that provide strong consumer protections. I quote from that letter:

In 1995 managed care reform opponents called the patient protection act a billion-dollar health care tax, and in 1997 they claimed health care costs would skyrocket upwards of 30 percent. However, multiple independent studies, including an actuarial analysis by Milliman and Robertson, of Scott and White's HMO, show costs have increased by about 34 cents per member per month.

H.R. 4250, the House GOP bill, would weaken Texas' independent review provisions. Apparently, H.R. 4250's independent review is not binding compared to the Texas law that requires managed care organizations to provide care deemed appropriate by the independent review organization.

We also are concerned that H.R. 4250 weakens current Texas law regarding emergency care and gag clauses. As we understand it, the bill waters down Texas' prudent lay person by allowing a health plan to override the treatment decision by the emergency department physician. The gag clause provision does not protect health care providers from retaliation when they act as advocates for their patients.

One of the most important provisions of this legislation ensures that a new Texas law will not be overturned. That provision declares that the Employee Retirement Income Security Act of 1974 does not prevent a patient from suing his or her HMO in state court for personal injury or wrongful death damages. This provision makes insurance companies accountable for their actions. The laws in this country make every other industry accountable for their actions. If automobile manufacturers produce an inferior product that harms people, they are accountable for that damage. Doctors are accountable for the medical decisions they make that harm their patients. Why then are insurance companies not accountable for the decisions they make that harm the health of patients?

Allegations that the Dingell-Ganske substitute would make employers liable are simply not true. Clearly, employers cannot be held liable for the decisions of insurance companies and/or the decisions of others. The Dingell-Ganske substitute does not create a new right of action. It simply removes the provision of ERISA that protects insurance companies from being sued. It specifically states that employers cannot be held liable unless they exercise discretionary authority to make a decision on a claim for benefits covered under the plan. During the course of the last six months, I have met with many representatives of the business community. I have repeatedly asked them to bring me language that they believe would prevent employers from being sued and assured them that I would work with Mr. DINGELL and Mr. GANSKE to address their concerns. Not one of those people has taken me up on my offer. That is because there is no employer liability in the bill. Their answer instead is to oppose the entire bill and support H.R. 4250, and threaten Members who support Dingell-Ganske.

One of the most disturbing provisions of H.R. 4250 will severely undermine the patient's right to private medical records. This bill allows for the release and use of confidential health information without the patient's consent. Once that information is released, it can be sold without the patient's consent or knowledge. And once again, H.R. 4250 would preempt state laws that already have strong medical privacy protections. That's wrong and this Congress should not be subjecting the American people to such an outrageous position.

Mr. Speaker, I urge my colleagues to support the Dingell-Ganske substitute and oppose the disingenuous attempt by supporters of H.R. 4250 to pull the wool over the eyes of the American people.

Mr. MORAN of Virginia. Mr. Speaker, there must be certain provisions included in patients rights legislation in order to ensure true protections. For all health plans, there should be an outside review appeals mechanism. Patients should have the right to appeal adverse coverage decisions made by their health plans. Women should be able to choose their OBGYNs as their primary care physician, and chronically ill patients should not have to get referral from a primary care physician every time they need to see the specialist who treats their chronic illness. States should be able to protect consumers from breaches to consumer privacy. The Ganske-Dingell substitute provides these vital protections and more.

Although I have concerns about a provision in the bill which deals with the certification of class action law suits, I feel that the true protections the Ganske-Dingell substitute would provide are of greater benefit to health care consumers, our constituents, than my concerns could justify opposing the substitute. I am hopeful that the authors of this legislation would consider working to address these concerns in conference, but with the assurance of the patient protections guaranteed in the Ganske-Dingell substitute I am pleased to support its passage.

Ms. CHRISTIAN-GREEN. Mr. Speaker, as a physician, it is very important to me that we pass meaningful managed care reform, and that means passing the Ganske-Dingell bill.

Anyone who has heard me speak on health care issues has heard my concern about those Americans who are under or un-insured, because they are denied access to medical care.

Well Mr. Speaker, what the current managed care system has done is made a bad system worse.

Now even people who have insurance under managed care are being denied access to needed and appropriate medical care.

Mr. Speaker this has to change and the Ganske-Dingell bill—the Patients' Bill of Rights is the bill which will provide that access.

Further Mr. Speaker, if a health plan makes a decision about patient care and something goes wrong, it must be liable. To do anything less is patently unfair.

Mr. Speaker and colleagues, lets fix the mangled care system. Pass the Ganske-Dingell bipartisan bill.

Mr. CONYERS. Mr. Speaker, I rise today to oppose the Republican attack on the health care of millions of Americans. The Republican bill, which had no public hearings, no committee markup, and no CBO estimate of its costs is a slapdash, thrown together, cynical attempt to satisfy the American people's hunger for real managed care reform.

This Republican bill is a lie. It is titled the Patient Protection Act, but it has nothing to do with patient protection. This bill is all about protecting insurance companies from angry and injured patients who have been denied care because, in the view of their insurance company, their treatment was not ''medically necessary.'' Why are the Republicans trying to keep insurance companies from being held accountable for their mistakes? No other industry has the right to the same immunity from suit that insurance companies have, and no other industry should have that immunity. The thousands of men, women, and children across this country who have been hurt by an insurance company decision are crying out for justice, and we as their representatives should provide them with a way to achieve that justice.

The Dingell bill provides them with this justice. This bill will ensure that the next time an insurance bureaucrat has to decide whether a child he has never seen needs life saving treatment, he will think twice, instead of denying the treatment out of hand.

We need to reform the insurance industry, and make insurance companies care about the health of the patients that they cover. Our bill does this. Don't vote for the Republican's cynical lie. I urge my colleagues to support the Dingell bill, and provide Americans with the health justice they need and deserve.

Ms. LEE. Mr. Speaker, I rise in strong support of H.R. 3605, The Patients' Bill of Rights. Today we see appalling, devastating problems with HMO's. Instead of concern for patients, too many HMO's focus on making money at the expense of quality health care. They have denied medical procedures that they decide ''unnecessary'', even though patients' lives may have depended on them. They have refused to pay for medical procedures for children with terrible deformities, calling the operations ''cosmetic''. They have even taken away a doctor's right to authorize crucial procedures, dangerously yielding the most important decision-making responsibilities to a bureaucrat in an office building 3,000 miles away.

The Patients' Bill of Rights is a comprehensive bill which makes certain that health care providers do what is in the best interests of their customers, not their profits. It guarantees basic rights for all patients, placing health, well-being, and safety above all else, and valuing the patient-doctor relationship. Among the most important aspects of the bill is that it allows doctors, not insurance companies, to make crucial decisions regarding the health of patients. Another important safeguard in the bill guarantees that individuals are covered for *all* emergency services. No one should have to worry about insurance coverage for life-saving emergency care.

Furthermore, and very significant, the Patients' Bill of Rights calls for internal and external appeals processes to adequately address patients' grievances. These processes are crucial because they ensure that insurance companies are held accountable for providing quality care to people, or required to pay the consequence.

In contrast, H.R. 4250, the Republican version of a healthcare bill, is a vague and inadequate measure that fails to address many of the vital problems in the healthcare industry. Failing to focus on the needs of patients, it favors the multibillion-dollar insurance industry. Under H.R. 4250, insurance companies will not be held accountable for decisions that cause injury to a patient. Crucial health decisions will continue to be made by the patient's insurance company rather than the doctor. The Republican plan does not put patients first, but rather, serves insurance companies' interests at the cost of quality health care.

Furthermore, whereas the Patients' Bill of Rights expands healthcare to include provisions for patients who are seriously ill or require the expertise of the specialist, such as victims of HIV and cancer, the Republican plan puts at risk even the most basic and necessary measures. In my home state of California, current benefits such as mammography and cervical cancer screening, prenatal care, and mental health care could be overridden by H.R. 4250. It is unthinkable to me that these essential, preventative measures are threatened in this legislation. This would be a drastic step backward in caring for our people, and a further example of cutting cost at the expense of patient care.

Mr. Speaker, I have heard some of my colleagues on the other side of the aisle connect our current U.S. health care system to capitalism, stating that capitalism produces excellence in health care. This misguided mentality is frightening to me. Capitalism affords excellent healthcare only to the select few who are able to pay the most for it, and leaves all others without. This principle of the profit-making, market system is a devastating policy for health care. Health care is not a luxury to be afforded to the highest bidder. Providing health care is not about striving to make the greatest amount of money.

Health care is a basic right that all Americans deserve, yet the United States is the only Western industrialized country that does not have a national health program. In a wealthy nation such as ours, it is incredible to me that there are so many who lack access to this fundamental necessity. The Republican plan will serve only to increase the rift between those who have access to health care and those who are left behind, neglected and trapped without adequate care.

I urge your opposition of H.R. 4250 and support of H.R. 3605, the Patients' Bill of Rights.

Mr. ALLEN. Mr. Speaker, I rise in support of the Ganske-Dingell substitute to H.R. 4250, the Republican HMO health care bill.

We have an opportunity in this Congress to enact real reform in our health care system. Months ago, Democrats introduced the Patients' Bill of Rights Act to protect patients against HMO abuses. Now that we are a few months away from an election, the Republicans have decided that they need their own version of a managed care ''reform'' bill.

This republican bill is being rushed to the House floor without the benefit of even one public hearing or any committee mark-up. As of 1 a.m. this morning, this bill was still being drafted.

While the Republican leadership has been willing to spend more than a year and millions of dollars on committee investigations, they are not willing to allow even one hearing on legislation which could significantly affect Americans' lives.

Health care financing is in transition. Private and public purchasers of health care are turning to managed care.

The shift to managed care has raised concerns about the implications for health care quality. I believe that managed care must be more than managed cost.

Last month I held community health care forums in my district. This was an opportunity for my constituents to come and share their experiences. I wanted to hear from them about health care costs, quality and access for Maine children and families.

I did not hear the managed care horror stories to the extent that many of my colleagues have heard. Maine has been slow to move to managed care. People did, however, express their fears about this system.

I heard from a mother who works an extra job to pay for an indemnity health insurance policy for her daughter who has a severe disability. It was clear that purchasing this health plan was a financial hardship for this family. This mother was too fearful to move to a managed care plan which may be less expensive because it could limit the care that her daughter needs.

Others also shared their concerns about managed care. Could some of the same horror stories that they hear about on the national news happen to them?

My constituents are not alone in their fears about managed care. There is a crisis of confidence in American health care:

Eighty percent of all consumers believe that insurance plans often compromise the quality of care to save money.

The worst problems are often reported by those who need good care the most—those with chronic conditions who experienced an illness serious enough to require hospitalization. More than one half of this group reported problems with their health insurance.

36 percent said that their condition worsened as a result of the insurance problem.

35 percent said the problem led to an additional condition,

And 17 percent developed permanent disabilities. Problems ranged from delays in care to failure to refer to a specialist to problems with payment, billing, and coverage.

As I mentioned, Maine has not moved to managed care as rapidly as other areas. Furthermore, strong patient protections have been enacted at the state level. However, because of federal preemptions to state protections, at least 250,000 people in Maine are left unprotected. My constituents recognize that we need a national solution to a national problem.

The Republican legislation only applies to Americans in self insured plans. They ignore two-thirds of Americans with private health insurance. This means that Americans with individual policies, state and local government employees and people whose employers purchase coverage through an HMO or insurance policy are left unprotected. 113 million Americans are left out in the cold by the Republican bill.

The Republican bill is clearly designed for political cover rather than real patient protections. For example, the Republican bill does not:

Provide patients with access to clinical trials;

Permit doctors to prescribe prescription drugs that are not on an HMO's predetermined list;

Provide ongoing access to specialty care;

Protect health care workers who report quality problems;

Provide choice of doctors within a plan; or

Hold managed care plans accountable when a patient is injured by a plan's decision to withhold or limit care.

By contrast, the Patients' Bill of Rights Act does provide all of these protections.

In addition to empty promises, the Republican bill is laced with poison pills such as healthmarts and malpractice limits.

I plan to hold more community health care forums in my district during the August in district work period. It is my sincere hope that I will be able to assure my constituents that they do not need to fear the health care system in this country.

The American people have been clear. They want real protections. They do not want a watered down bill. They want the Ganske-Dingell substitute, the Patients' Bill of Rights Act.

Ms. KILPATRICK. Mr. Speaker, I rise today in strong, unequivocal and clear support of H.R. 3605, the Democratic Patient Protection Act, and oppose H.R. 4250, the Republican Politician Protection Act. The Republican Politician Protection Act provides too few patient protections, undermines existing state consumer protections, has not had a single hearing or mark-up, and contains unnecessary and irrelevant provisions. It is time that we, the Congress, stopped playing games with the health care of our constituents and get down to the real business of providing both doctors and patients with the protections that they need and deserve. I recently had a meeting with the Michigan State Medical Society, an organization made up of doctors in the State of Michigan, and they wholeheartedly endorse the Democratic Patient Protection Act, among more than 50 consumer protection, labor union, and health care organizations.

Let me take a minute to explain to you three key differences between the Democratic Patient Protection Act and the Republican Politician Protection Act:

The Republican Politician Protection Act allows medical insurance companies to give your confidential medical records to another agency—another insurance company, mortgage company, credit bureau, pharmacy, or health care bureaucrat—without your consent. This means that anyone—a person applying for a mortgage, someone looking to peer through your medical history before you start a job, a person looking for negative health information against a potential candidate for Congress—could have access to your medical records. The Democratic Patient Protection Act protects the confidentiality of your medical records. No one would be allowed to review or transfer your records without your express and written consent.

The Politician Protection Act usurps and supersedes state consumer protections. Mr. Speaker, before I was elected to this august body, I served for 18 years as a state legislator in the great State of Michigan. I abhorred and detested those rules, laws and regulations that superseded our rules, laws and regulations that were democratically arrived at and after many hearings, debate, and votes. Ostensibly, the Republican Party is one of respecting the rights of states to make the best decisions for themselves—or has posited themselves as such. The Republican Politician Protection Act would not allow states to decide for themselves the best consumer protections for their citizens. The Democratic Patient Protection Act does not usurp state law.

The Republican Politician Protection Act does not allow patients to sue their health insurance plans for wrongdoing. The Republican Politician protection act allows persons to sue for fiduciary damages, but not for pain and suffering or punitive damages. What does this mean? Well, it means that if your doctor in a managed care plan recommends that you have an additional mammogram, but the plan refuses to pay for it and the patient dies as a result, the family could sue for the cost of the

mammogram. The Democratic Patient Protection Act will ensure that patients can sue for compensatory and punitive damages, and let a jury—the same juries who register to vote and send us to Congress—decide the merits of these issues.

Adoption of the Democratic Patient Protection Act would be only a first step toward solving our health care crisis. We still need to address the more than 4 million families, women, children and adults over the past decade who do not have any health insurance. Guess who is footing the bill when these uninsured women, children and adults show up at the hospitals of our nation? That's right, you and I. Access to quality health care, before catastrophic diseases attack, has been proven to prolong the length and quality of life of Americans. The challenge of serving those persons who do not have access to health care is one of the many unfinished tasks facing us as a Congress and as a nation as we consider the reform of our health care system.

If you think that you don't know someone who is medically underserved, think again. The usual person who is defined as ''medically underserved'' is poor, elderly, has no health care, and does not have access to primary care physicians. In our land of plenty, over 43 million people are medically underserved, and only 24 percent of those persons are served through community health centers. What happens to more than three quarters of these people who do not have access to health care is simply this: immunizations are not given, and babies fall ill to preventable diseases; elderly citizens do not get their high blood pressure or diabetes cared for, and end up in the hospital, or women do not get a life-saving mammogram. Not having any health care, in our land of plenty, is almost criminal.

Taxpayers want, and need, long-range solutions to the challenge of access to affordable, quality health care. Taxpayers deserve an investment of resources and commitment to the goal of health care for all. It is the job and duty of Congress to address this issue now. The doors of health care must remain open to protect the public health, prevent disease, improve our quality of life and save scarce taxpayer dollars. Congress can, and must, improve access to health care for all. The Democratic Patient Protection Act is a strong, aggressive step toward the much needed reform of our health insurance system, but it is only a first step. I urge all of my colleagues to reject the Republican Politician Protection Act and vote for the Democratic Patient Protection Act.

The SPEAKER pro tempore (Mr. KOLBE). The question is on the amendment in the nature of a substitute offered by the gentleman from Michigan (Mr. DINGELL).

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

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

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

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 212, nays 217, not voting 6, as follows:

[Roll No. 336]

YEAS—212

Abercrombie
Ackerman
Allen
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bilbray
Bishop
Blagojevich
Blumenauer
Boehlert
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Capps
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Fazio
Filner
Forbes
Fox
Frank (MA)
Frost
Furse
Ganske
Gejdenson
Gephardt
Goode
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hooley
Horn
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson (WI)
Johnson, E. B.
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
LaTourette
Leach
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manton
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHale
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran (VA)
Morella
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roukema
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schumer
Scott
Serrano
Sherman
Sisisky
Skaggs
Skelton
Slaughter
Smith, Adam
Snyder
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson
Thurman
Tierney
Torres
Towns
Traficant
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Wexler
Weygand
Wise
Woolsey
Wynn

NAYS—217

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilirakis
Bliley
Blunt
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Crapo
Cubin
Cunningham
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
Lazio
Lewis (CA)
Lewis (KY)
Linder
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryun
Salmon
Sanford
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NOT VOTING—6

Ford
Gonzalez
Hinojosa
Markey
Yates
Young (FL)

☐ 1352

Messrs. WHITE and EHLERS changed their vote from ''yea'' to ''nay.''

Ms. BROWN of Florida, Mr. SCHUMER and Mr. BOYD changed their vote from ''nay'' to ''yea.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

PERSONAL EXPLANATION

Mr. HINOJOSA. Mr. Speaker, during rollcall vote No. 336, The Dingell Substitute to H.R. 4250, I was unavoidably detained. Had I been present, I would have voted ''yes.''

The SPEAKER pro tempore (Mr. KOLBE). Pursuant to House Resolution 509, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. BERRY

Mr. BERRY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman from Arkansas opposed to the bill?

Mr. BERRY. Yes, Mr. Speaker, in its current form.

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

The Clerk read as follows:

Mr. Berry moves to recommit the bill H.R. 4250 to the Committee on Ways and Means and to the Committee on Education and the Workforce with instructions to report back the same to the House forthwith with the following amendments to the portions of the same within their respective jurisdiction:

Page 38, beginning on line 9, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 39, beginning on line 16, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 48, beginning on line 17, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 53, beginning on line 17, strike ''meets, under the facts and circumstances at the time of the determination, the plan's requirement for medical appropriateness or necessity'' and insert ''is, under the facts and circumstances at the time of the determination, medically necessary and appropriate''.

Page 60, line 17, strike all that follows the first period.

Page 60, after line 17, insert the following new subparagraph:

''(V) MEDICAL NECESSITY AND APPROPRIATENESS.—The term 'medically necessary and appropriate' means, with respect to an item or service, an item or service determined by the treating physician (who furnishes items and services under a contract or other arrangement with the group health plan or with a health insurance issuer providing health insurance coverage in connection with such a plan), after consultation with a participant or beneficiary, to be required, according to generally accepted principles of good medical practice, for the diagnosis or direct care and treatment of an illness or injury of the participant or beneficiary.''.

Page 227, strike line 1 and all that follows through page 233, line 3, and insert the following (and conform the table of contents accordingly):

Subtitle C—Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 3201. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—The table contained in subparagraph (B) of section 162(l)(1) of the Internal Revenue Code of 1986 is amended to read as follows:

In the case of taxable years beginning in calendar year:	The applicable percentage is:
1999, 2000, and 2001 ..	60 percent
2002	70 percent
2003 or thereafter ...	100 percent.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1998.

Mr. BERRY (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

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

Mr. HASTERT. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

The Clerk will continue to read.

The Clerk continued reading the motion to recommit.

Mr. HASTERT. Mr. Speaker, I reserve all points of order.

The SPEAKER pro tempore. The gentleman reserves a point of order.

The gentleman from Arkansas (Mr. BERRY) is recognized for 5 minutes.

Mr. BERRY. Mr. Speaker, my motion makes the following two important changes: It strikes the Medical Savings Account provision from the Republican bill, saving billions of dollars a year.

The money saved in the MSA will be used to accelerate the health insurance deduction for the self-employed. This helps small businessmen by increasing the deduction for expenditures on health insurance to 60 percent in the next 3 years, 70 percent in the year 2002, and 100 percent thereafter.

The current deduction is 45 percent and will not increase to 100 percent until the year 2006.

It amends the Republican bill by putting the decision of ''medical necessity'' back in the hands of doctors. The new language allows for the doctor and the patient, not the insurance companies, to determine the proper care and treatment for the patient.

□ 1400

It also makes sure the care they receive is consistent with good medical practice, not insurance profits. The Republican version leaves this decision up to the insurance companies. The Republican bill would create a system where the insurance company would win every time. The deck is stacked against the patients before they even get in to see their doctor.

The bill would allow insurers to develop their own definitions and methods for determining medical necessity, which would make it virtually impossible for enrollees to challenge the plan's decision. A plan could define medical necessity to essentially be nothing more than the care defined under whatever treatment guidelines and utilization protocols the plan adopts, even if the guidelines and protocols are not backed up by any clinical evidence or good professional practice. Plans would always win under this scenario. The Republican bill would allow insurers to overturn physicians' treatment decisions on the basis of completely arbitrary standards that are not based on any credible medical evidence.

I do not think that that is the kind of care that we want for our families, our children, our parents or our friends. But that is just what this Republican bill would allow.

I yield to the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I thank the gentleman for yielding to me. I would observe that here we are discussing the fundamental difference between the two bills. If you want to provide protection for the doctor-patient relationship, vote for the motion to recommit, because the motion to recommit assures that it will be medical necessity decided by the doctor that determines the course of treatment of a patient of an HMO, not some curious, insurance-oriented approach which would be decided by the Republican plan.

One of my friends who is one of the outstanding physicians and surgeons in the 16th District called me to tell me about something that happened to him recently. He was made an examiner of medical claims. He was fired by the HMO. The reason was that he was making medical decisions, not insurance decisions. That is exactly the issue which is before us.

If you want the doctor to decide what you and your family and your constituents are going to receive in the way of medical care, vote for the motion to recommit. If you want to have an unelected, unaccountable health care bureaucrat appointed by a health insurance company or an HMO, then vote against it. And what you will be doing, you will be vesting in the HMO the power to make a medical decision instead of seeing to it that that medical decision is made by the doctor in concert with his patient. Medical necessity should be decided by a doctor who is trusted by the patient, not by an unknown voice on the telephone who is neither doctor nor accountable, a health care bureaucrat. That is the point of this amendment.

If you believe in the doctor-patient relationship and if you believe it is worth protecting, then vote ''aye'' on the motion to recommit. That is what is at stake, the doctor-patient relationship, and the doctor making a decision with regard to what constitutes medical necessity and what constitutes the need of the patient. To vote ''no'' on this motion to recommit is to assure that medical necessity is decided by an anonymous voice on the telephone belonging to no one with a relationship to the patient.

POINT OF ORDER

The SPEAKER pro tempore (Mr. KOLBE). Does the gentleman from Illinois insist on a point of order?

Mr. HASTERT. Mr. Speaker, I insist on a point of order.

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

Mr. HASTERT. I yield to the gentleman from California (Mr. THOMAS).

The SPEAKER pro tempore. The Chair will recognize the gentleman from California (Mr. THOMAS) on the point of order.

Mr. THOMAS. Mr. Speaker, contained among the numerous provisions in the motion to recommit is striking the medical savings accounts. Notwithstanding the gentleman's representation that this will save billions of dollars a year, the Congressional Budget Office says that simply is not so. In fact, it will save less than $1 billion a year. That is the point on which the point of order turns, because the gentleman's addition of the acceleration of the self-employed deduction in fact scores more than $1 billion and therefore is subject to a 303 Congressional Budget Act point of order. It in fact increases the budget before the final

budget is adopted in a given fiscal year. It applies clearly in this particular instance. A point of order, therefore, lies against the gentleman and I would urge the Chair to sustain the 303(a) Congressional Budget Act point of order.

The SPEAKER pro tempore. The gentleman from California has made a point of order.

Does the gentleman from Arkansas (Mr. BERRY) wish to be heard on the point of order?

Does the gentleman from Maryland (Mr. CARDIN) wish to be heard on the point of order?

Mr. CARDIN. Yes, I do, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from Maryland is recognized on the point of order.

Mr. CARDIN. If I understand the gentleman from California's point is that the striking of the medical savings account provision would not save as much money as accelerating the self-employed insurance deduction by 4 years.

Mr. Speaker, I would like to include in the RECORD a document that has been received from the Joint Committee on Taxation that shows that striking the medical savings account provision will save $4.1 billion, the self-employed health insurance deduction would cost $3.4 billion, for a net revenue savings to the treasury of $687 million.

The SPEAKER pro tempore. The gentleman from Maryland may insert the documents after the point of order but not during debate on the point of order.

Is there any other Member who wishes to be heard on the point of order?

Mr. CARDIN. Mr. Speaker, on that point, if I am correct, the point of order is being raised as it relates to having——

The SPEAKER pro tempore. That is correct. The Chair must rely on what is being said to the Chair and so insertion into the RECORD during the debate on the point of order is not in order at this time.

Mr. CARDIN. I would just quote into the record the document from the Joint Committee on Taxation dated July 23, 1998, and would be glad to make it available to the Parliamentarian.

The SPEAKER pro tempore. Does any other Member wish to be heard?

Mr. THOMAS. Mr. Speaker, on the point just registered, this is the House and not the Senate. The Senate just read 10-year numbers, the House operates on 5-year numbers, and the point of order still stands.

Mr. CARDIN. Mr. Speaker, let me put into the record the 5-year numbers. The 5-year numbers on striking the medical savings account provision would save $1.3 billion, the self-employed would cost $1.2 billion, for a net savings to the treasury of $56 million.

The SPEAKER pro tempore. Is there any other Member who wishes to be heard on the point of order? If not, the Chair is prepared to rule.

Mr. THOMAS. Mr. Speaker, the gentleman is reading from a document that I do not believe is current. Would he cite the number and the date?

Mr. CARDIN. If the gentleman would yield, it is dated July 23, 1998.

Mr. THOMAS. I tell the gentleman the numbers I just read come from a Joint Tax Committee publication July 24, 1998. But the gentleman is not bad being only one day behind.

Mr. CARDIN. Mr. Speaker, I have the July 25 numbers.

The SPEAKER pro tempore. Does the gentleman from Illinois insist upon his point of order?

Mr. HASTERT. Mr. Speaker, I insist on my point of order.

The SPEAKER pro tempore. Does any other Member wish to be heard on the point of order? Is there anybody else who wishes to be heard on the point of order? If not, the Chair is prepared to rule.

The amendment proposed in the motion to recommit would strike one of the revenue provisions from the bill. The amendment also would insert an alternate revenue change. In this latter respect, the amendment ''provides an increase or decrease in revenues'' within the meaning of section 303 of the Budget Act.

Because this revenue change would occur during fiscal year 1999, a year for which a budget resolution has yet to be finalized, the amendment violates section 303(a)(2) of the Act.

The point of order is sustained.

Mr. CARDIN. Mr. Speaker, this is not the point raised in the objection by the Member. I do not know how the Chair can on its own use as a basis for an appeal that was not raised and we did not have a chance to argue the point on. That is blatantly against the rules of the House, and I appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is, Shall the decision of the Chair stand as the judgment of the House?

MOTION TO TABLE OFFERED BY MR. ARMEY

Mr. ARMEY. Mr. Speaker, I move to table the appeal.

The SPEAKER pro tempore. The question is on the motion to table offered by the gentleman from Texas (Mr. ARMEY).

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

RECORDED VOTE

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

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 222, noes 204, not voting 9, as follows:

[Roll No. 337]

AYES—222

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Crapo
Cubin
Cunningham
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Fox
Franks (NJ)
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gilman
Gingrich
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Morella
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryun
Salmon
Sanford
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NOES—204

Abercrombie
Ackerman
Allen
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Capps
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Fazio
Filner
Forbes
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Goode
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Hinojosa
Holden
Hooley
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson (WI)
Johnson, E. B.
Kanjorski

Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manton
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHale
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran (VA)
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schumer
Scott
Serrano
Sherman
Sisisky
Skaggs
Skelton
Slaughter
Smith, Adam
Snyder
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson
Thurman
Tierney
Torres
Towns
Traficant
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Wexler
Weygand
Wise
Woolsey
Wynn

NOT VOTING—9

Ford
Gillmor
Gonzalez
Johnson (CT)
Linder
Markey
Weldon (PA)
Yates
Young (FL)

□ 1428

So the motion to table was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MOTION TO RECOMMIT OFFERED BY MR. BERRY

Mr. BERRY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore (Mr. KOLBE). Is the gentleman still opposed to bill?

Mr. BERRY. Mr. Speaker, in its current form, I am.

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

The Clerk read as follows:

Mr. BERRY moves to recommit the bill H.R. 4250 to the Committee on Education and the Workforce with instructions to report back the same to the House forthwith with the following amendments:

Page 38, beginning on line 9, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 39, beginning on line 16, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 48, beginning on line 17, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 53, beginning on line 17, strike ''meets, under the facts and circumstances at the time of the determination, the plan's requirement for medical appropriateness or necessity'' and insert ''is, under the facts and circumstances at the time of the determination, medically necessary and appropriate''.

Page 60, line 17, strike all that follows the first period.

Page 60, after line 17, insert the following new subparagraph:

''(V) MEDICAL NECESSITY AND APPROPRIATENESS.—The term 'medically necessary and appropriate' means, with respect to an item or service, an item or service determined by the treating physician (who furnishes items and services under a contract or other arrangement with the group health plan or with a health insurance issuer providing health insurance coverage in connection with such a plan), after consultation with a participant or beneficiary, to be required, according to generally accepted principles of good medical practice, for the diagnosis or direct care and treatment of an illness or injury of the participant or beneficiary.''.

Mr. BERRY (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

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

Mr. HASTERT. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

The Clerk will continue reading the motion.

The Clerk continued reading the motion.

Mr. HASTERT. Mr. Speaker, I reserve a point of order against the motion.

The SPEAKER pro tempore. The gentleman from Arkansas (Mr. BERRY) is recognized for five minutes on his motion to recommit.

Mr. BERRY. Mr. Speaker, my motion to recommit is the same as the last motion, but deals solely with the definition of ''medical necessity.'' The motion to recommit will allow the doctor to determine what care is medically necessary. The doctor, not the insurance company, not a Federal bureaucrat, not a state bureaucrat, but the doctor, the person who went to medical school for many years to learn how to take care of you, would make that decision.

The motion to recommit would make sure that the health care that they receive from their managed care company is consistent with good medical practice, not accounting profit principles.

The motion to recommit will make sure that the decisions insurance companies are making regarding what it is or is not to be provided are supported by credible medical evidence. The motion to recommit puts medical care where it belongs, in the hands of doctors, not in the hands of Republican special interest friends.

The SPEAKER pro tempore. Does the gentleman from Illinois (Mr. HASTERT) insist on his point of order?

Mr. HASTERT. Mr. Speaker, I withdraw my point of order.

The SPEAKER pro tempore. Does the gentleman from Illinois (Mr. HASTERT) wish to be heard on the motion to recommit?

Mr. HASTERT. I do.

The SPEAKER pro tempore. Is the gentleman opposed to the motion?

Mr. HASTERT. I am opposed to the motion.

The SPEAKER pro tempore. The gentleman from Illinois (Mr. HASTERT) is recognized for five minutes.

Mr. HASTERT. Mr. Speaker, I yield to the gentleman from Georgia (Mr. GINGRICH), the Speaker of the House.

Mr. GINGRICH. Mr. Speaker, let me recapture for everybody we were are at here, because I think you have to put in context this interesting and inventive motion to recommit.

First of all, under the Patient Protection Act that will come to final passage, anybody who has a practical layman's feeling that they need emergency care, has a presumption they need it, automatically, you walk in, you say ''I have heart pain,'' or ''I have a chest pain,'' and you are covered.

When you walk in, under the Patient Protection Act, a medical doctor on the site looking at the patient makes a decision, do you need further treatment? For example, if it turns out you over-ate and in fact need bicarbonate, you probably do not get an MRI. But if they think you have a severe heart problem or they think you might have cancer, you immediately have an opportunity for whatever emergency room treatment is necessary on a medical basis defined by the medical doctor.

If you find out you have a longer-term problem, under the Patient Protection Act, if you happen to belong to an HMO that does not agree you should be treated, you immediately have an appeal internally, and within 72 hours they have to say ''yes,'' or ''no, you should get this.''

If you do not agree when they say no, you have an immediate external appeal to a medically appropriate group of specialists who fit the same topic, and they, within 72 hours, have to say yes, in fact you have pancreatic cancer, you deserve and need chemotherapy, period.

At that point, if the HMO is truly stupid, it can say they are not going to give it to you anyway, in which case you can go to court carrying with you the medical doctors who have already said you are right.

Now, that is what we do, notice at every stage; medical doctor, medical doctor, medical doctor.

But there is one hook, as I read this quite inventive proposal. I believe, and I am not a lawyer, I am just a historian, and for everybody who is grateful for a nonlawyer as Speaker, I understand it has been a rare event, but, anyway, as I understand this, from the brief few minutes we have had to look at it, this would in essence eliminate the concept of insurance coverage.

This would allow you, as worded, to walk in and have a doctor say, ''You know, I know you never paid for this insurance, I know you are not covered for this at all, but I am now going to do the following 12 medically necessary things.'' A terrific idea. It bankrupts every insurance company in America, it eliminates the employer-based system, it guarantees you go to government health care, and, literally, I do not know why you guys wrote it this way, this has no meaning in the real

world, except that you would be required to get everything open-ended as long as you found a doctor somewhere who said you should get it.

Now, this is in fact one of the nuttiest expansions of the right to charge for health care I have ever seen, and I am sure it is just because they got their earlier motion, which was clever and well-crafted, ruled out of order and they had to rush something to the floor.

I would encourage all of you, unless you want to bankrupt the whole country, just simply vote no. The details will come out later when they have a chance to rewrite it.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

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

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 205, nays 221, not voting 9, as follows:

[Roll No. 338]

YEAS—205

Abercrombie
Ackerman
Allen
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Capps
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Fazio
Filner
Forbes
Fox
Frank (MA)
Frost
Furse
Ganske
Gejdenson
Gephardt
Goode
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamilton
Hastings (FL)
Hefner
Hilliard
Hinchey
Hinojosa
Holden
Hooley
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (WI)
Johnson, E. B.
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manton
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHale
McIntyre
McKinney
McNulty
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran (VA)
Morella
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roukema
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schumer
Scott
Serrano
Sherman
Sisisky
Skaggs
Skelton
Slaughter
Smith, Adam
Snyder
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson
Thurman
Tierney
Torres
Towns
Traficant
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Wexler
Weygand
Wise
Woolsey
Wynn

NAYS—221

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Crapo
Cubin
Cunningham
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Harman
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryun
Salmon
Sanford
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NOT VOTING—9

Ford
Gonzalez
John
Klug
Linder
Markey
Meehan
Yates
Young (FL)

□ 1455

Mr. BLAGOJEVICH changed his vote from ''nay'' to ''yea.''

So the motion to table the appeal of the ruling of the Chair was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore (Mr. KOLBE). The question is on the passage of the bill.

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

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

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 216, nays 210, not voting 9, as follows:

[Roll No. 339]

YEAS—216

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bono
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Cubin
Cunningham
Danner
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Fox
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryun
Salmon
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Traficant
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NAYS—210

Abercrombie	Gephardt	Nadler
Ackerman	Gordon	Neal
Allen	Green	Oberstar
Andrews	Gutierrez	Obey
Baesler	Hall (OH)	Olver
Baldacci	Hall (TX)	Ortiz
Barcia	Hamilton	Owens
Barr	Harman	Pallone
Barrett (WI)	Hastings (FL)	Pascrell
Becerra	Hefner	Pastor
Bentsen	Hilliard	Paul
Berman	Hinchey	Payne
Berry	Hinojosa	Pelosi
Bishop	Holden	Peterson (MN)
Blagojevich	Hooley	Pickett
Blumenauer	Hoyer	Pomeroy
Bonilla	Jackson (IL)	Poshard
Bonior	Jackson-Lee (TX)	Price (NC)
Borski	Jefferson	Rahall
Boswell	Johnson (WI)	Rangel
Boucher	Johnson, E. B.	Reyes
Boyd	Kanjorski	Rivers
Brady (PA)	Kaptur	Roemer
Brady (TX)	Kennedy (MA)	Rothman
Brown (CA)	Kennedy (RI)	Roukema
Brown (FL)	Kennelly	Roybal-Allard
Brown (OH)	Kildee	Rush
Campbell	Kilpatrick	Sabo
Capps	Kind (WI)	Sanchez
Cardin	Kleczka	Sanders
Carson	Klink	Sandlin
Chenoweth	Kucinich	Sanford
Clay	LaFalce	Sawyer
Clayton	Lampson	Schumer
Clement	Lantos	Scott
Clyburn	Lee	Serrano
Condit	Levin	Sherman
Conyers	Lewis (GA)	Sisisky
Costello	Lipinski	Skaggs
Coyne	Lofgren	Skelton
Cramer	Lowey	Slaughter
Crapo	Luther	Smith, Adam
Cummings	Maloney (CT)	Snyder
Davis (FL)	Maloney (NY)	Spratt
Davis (IL)	Manton	Stabenow
DeFazio	Martinez	Stark
DeGette	Mascara	Stenholm
Delahunt	Matsui	Stokes
DeLauro	McCarthy (MO)	Strickland
Deutsch	McCarthy (NY)	Stupak
Dicks	McDermott	Tanner
Dingell	McGovern	Tauscher
Dixon	McHale	Taylor (MS)
Doggett	McIntyre	Thompson
Dooley	McKinney	Thurman
Doyle	McNulty	Tierney
Edwards	Meehan	Torres
Engel	Meek (FL)	Towns
Eshoo	Meeks (NY)	Turner
Etheridge	Menendez	Velazquez
Evans	Millender-McDonald	Vento
Farr	Miller (CA)	Visclosky
Fattah	Minge	Waters
Fazio	Mink	Watt (NC)
Filner	Moakley	Waxman
Forbes	Mollohan	Wexler
Frank (MA)	Moran (VA)	Weygand
Frost	Morella	Wise
Furse	Murtha	Woolsey
Ganske		Wynn
Gejdenson		

NOT VOTING—9

Ford	Klug	Rodriguez
Gonzalez	Linder	Yates
John	Markey	Young (FL)

□ 1512

Mr. PAUL changed his vote from ''present'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

COMMUNICATION FROM THE HONORABLE MICHAEL P. FORBES, MEMBER OF CONGRESS

The SPEAKER pro tempore laid before the House the following communication from the Honorable MICHAEL P. FORBES, Member of Congress:

HOUSE OF REPRESENTATIVES,
Washington, DC, July 23, 1998.

Hon. NEWT GINGRICH,
Marietta, GA,

DEAR MR. SPEAKER: This is to formally notify you pursuant to Rule L (50) of the Rules of the House that I have been served with a subpoena issued by the United States District Court for the Eastern District of New York.

After consultation with the General Counsel, I will make the determinations required by Rule L.

Sincerely,

MICHAEL P. FORBES,
Member of Congress.

LEGISLATIVE PROGRAM

(Mrs. KENNELLY of Connecticut asked and was given permission to address the House for 1 minute.)

Mrs. KENNELLY of Connecticut. Mr. Speaker, I ask for this time to inquire of the gentleman from California (Mr. THOMAS) about next week's schedule.

Mr. THOMAS. Mr. Speaker, will the gentlewoman yield?

Mrs. KENNELLY of Connecticut. I yield to the gentleman from California.

Mr. THOMAS. Mr. Speaker, I am pleased to announce that we have concluded legislative business for this week. The House will next meet on Monday, July 27, at 10:30 a.m. for morning hour, and at 12 noon for legislative business. We do not expect any recorded votes before 5 p.m.

On Monday, July 27, we will consider a number of bills under suspension of the rules, a list of which will be distributed to Members' offices this afternoon.

After suspensions, Mr. Speaker, the House will continue consideration of H.R. 2183, the Bipartisan Campaign Integrity Act of 1997. We hope to, as we did last Monday, make extensive progress on the Shays-Meehan amendment in the nature of a substitute on Monday, and we also hope to return to campaign finance again at some point during the week.

On Tuesday, July 28, and the balance of the week, the House will consider the following legislation: H.R. 629, the Texas Low-Level Radioactive Waste Conference Report. We will finish H.R. 4194, the Veterans Administration, HUD and Independent Agencies Appropriations; H.R. 4276, Commerce, Justice Appropriations Act; the Transportation Appropriations Act; H.J. Res. 120, a Vietnam Trade Resolution; and House Resolution 507, a Resolution Providing Special Investigative Authority for the Committee on Education and the Workforce.

□ 1515

Mr. Speaker, Members should be prepared to work late next week on these appropriation bills. If we can do that, we hope to conclude legislative business for the week by 2 p.m. on Friday, July 31.

Mrs. KENNELLY of Connecticut. Mr. Speaker, I wish to further ask of the gentleman, we have heard in some places that there might not be votes until after 7 o'clock on Monday. Is there any truth to that?

Mr. THOMAS. Mr. Speaker, I believe if Members are not participating in the legislation, they should have a relatively high comfort level that there would be no votes on Monday prior to 7 p.m.

Mrs. KENNELLY of Connecticut. I thank the gentleman very much. How late does the gentleman expect the last vote to be on Monday?

Mr. THOMAS. As we did last Monday night, we are hopeful, under the unanimous consent agreement on Shays-Meehan, that we could go as late as possible, to cover as many amendments as possible, so that the rest of the week would have enough time to move to a conclusion. It will be a decision made by the participants.

As the gentlewoman knows, they went very late last Monday. Our goal would be to go as late as we could, to cover as many of the amendments as we could, on Monday night, but it would be achieved under some mutual agreement.

Obviously, if they go extremely late, Members would expect that any votes that would be ordered would be rolled.

Mrs. KENNELLY of Connecticut. Is it still the intention of the leadership on the majority side to finish the Shays-Meehan bill by the August recess?

Mr. THOMAS. I would tell the gentlewoman that is why we are going to take a major chunk of time on Monday and, as I stated, reserve another piece of time, so that, in fact, the leadership's commitment that the Shays-Meehan amendment be concluded prior to the House's August break, that is our goal, that is our commitment, and we will meet it.

Mrs. KENNELLY of Connecticut. Mr. Speaker, I thank the gentleman very much.

Mr. SKAGGS. Mr. Speaker, will the gentlewoman yield?

Mrs. KENNELLY of Connecticut. I yield to the gentleman from Colorado.

Mr. SKAGGS. Mr. Speaker, I thank the gentlewoman for yielding to me. I wanted to use this opportunity to advise colleagues of a social event for this body that will occur next Tuesday evening from 6 to 8 p.m. in the Cannon Caucus Room. It is our more or less regular summer House picnic for both Members and spouses and children.

So I hope since we will be in the middle of some appropriations work on Tuesday, it will be a nice opportunity to get together on a bipartisan basis, get to know our colleagues and our families a little bit. Conveniently located over in the Cannon Caucus Room, very reasonably priced.

Members may contact either my office or the office of the gentleman from Illinois (Mr. LAHOOD) or the Members and Family Room to make reservations.

Mrs. KENNELLY of Connecticut. Mr. Speaker, reclaiming my time, I was asking about final passage on campaign finance reform, and the gentleman from California (Mr. THOMAS)

did mention Shays-Meehan. I realize he insinuated that that might be acted upon. What about final passage?

Mr. THOMAS. Well, if the gentlewoman will continue to yield, our commitment was to the Shays-Meehan, which had the most amendments attached to it. Obviously, once that is dispensed with, in terms of the amendments, that is the only amendment that we have under unanimous consent agreement. Our hope is that we will have reached a level of comity that we could move through the rest of those substitutes relatively quickly. But since we do not have a unanimous consent agreement on the amendments or the structure, it is extremely difficult to pin it down. But our goal is to complete it.

We now have a clear assignment on Shays-Meehan, and to the degree we can meet that next week, we will have a much better understanding of what we need to do to agree to finish it. Obviously, my personal commitment is to get it done before we leave in its entirety.

Mrs. KENNELLY of Connecticut. Mr. Speaker, I thank the gentleman.

CONSIDERING MEMBER AS FIRST SPONSOR OF H.R. 1542

Mrs. BONO. Mr. Speaker, I ask unanimous consent that I may hereafter be considered as the first sponsor H.R. 1542, a bill originally introduced by Representative Bono of California, for the purposes of adding cosponsors and requesting reprintings pursuant to clause 4 of rule XXII.

The SPEAKER pro tempore (Mr. PEASE). Is there objection to the request of the gentlewoman from California?

There was no objection.

CONSIDERING MEMBER AS FIRST SPONSOR OF H.R. 2882

Mrs. BONO. Mr. Speaker, I ask unanimous consent that I may hereafter be considered as the first sponsor of H.R. 2882, a bill originally introduced by Representative Bono of California, for the purposes of adding cosponsors and requesting reprintings pursuant to clause 4 of rule XXII.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

ADJOURNMENT TO MONDAY, JULY 27, 1998

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 10:30 a.m. on Monday next for morning hour debates.

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

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY NEXT

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday next.

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

There was no objection.

PERSONAL EXPLANATION

Mr. FILNER. Mr. Speaker, on July 16 and July 17 last week I had to be in my Congressional District on official business and missed rollcall votes 288 through 296. Had I been present I would have voted in the following way:

Number 288, aye; number 289, no; number 290, aye; number 291, no; number 292, no; number 293, no; number 294, aye; number 295, aye; and number 296, no.

APPOINTMENT AS MEMBER OF NATIONAL BIPARTISAN COMMISSION ON FUTURE OF MEDICARE

The SPEAKER pro tempore. Pursuant to the provisions of section 4021(c) of Public Law 105–33, the Chair announces the Speaker's appointment of the following Member on the part of the House to the National Bipartisan Commission on the Future of Medicare to fill the existing vacancy thereon:

Mrs. Colleen Conway-Welch, Tennessee.

TRIBUTE TO ROBERT F. LANGFORD

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

Mr. HINOJOSA. Mr. Speaker, it is a great honor to stand before my colleagues today to pay homage to a man who has benefitted us all. Mr. Robert Langford, the senior vice president of production operations of Owens' Country Sausage has retired after 35 years of service.

Robert, a graduate of both Texas A&M University and Southern Methodist University was hired by Jerry Owens in 1963. Mr. Owens recognized Robert's talents and quickly promoted him to manager of engineering. In 1972, he became the general manager and was continually advanced through the ranks until he reached his present position, the senior vice president of production operations. Due in large part to his work and innovations, Robert led the Owens Corporation to gain the number one market share position in the Southwest, which it still enjoys to this day.

These accomplishments are quite impressive, yet they are only one aspect of Robert F. Langford's life. Robert also worked extensively with the Southwest Meat Association. He was the president of SMA from 1978 to 1980 and composed its bylaws and mission statement. But Robert was not content to merely serve the SMA. He wanted to serve his community as well. To realize this goal, Robert became one of the three founders of the Southwest Meat Association's Education Foundation as well as its chairman from 1982 to 1998. The Education Foundation provides scholarships to deserving students who display an interest and aptitude for a career in the meat industry. He believes education is a must.

Robert's commitment to promoting education in the community is shared by his wife Kathy, who dedicated 35 years of her life to teaching her young children. Kathy has zealously supported Robert every step of the way and she shares in all his numerous triumphs.

Robert F. Langford served his country in the United States Air Force as a fighter pilot for five years. He has served his community as the Chairman of the Fellowship of Deacons for Park Cities Baptist Church, and he has served us all by improving our quality of life through his work.

He has earned my admiration as a talented businessman and inventor. He has gained my respect as a dedicated family man and community leader. And he has won my friendship as a kindhearted and generous person.

I wish for Robert, his wife Kathy, and their children and grandchildren, all the blessings that are mine to give. From the bottom of my heart.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain further 1-minute requests.

TAX SURPLUS DOES NOT BELONG TO CONGRESS

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

Mr. GIBBONS. Mr. Speaker, the Democrats have known for a long time that a government that robs from Peter to pay Paul can always depend upon the support of Paul.

Our liberal colleagues want to rob the hard working taxpayers of America by taking their tax surplus and giving it to Washington bureaucrats.

Not so fast! That tax surplus does not belong to Congress, does not belong to the administration, and does not belong to the bureaucrats. Rather, it belongs to the taxpayers.

We must cut taxes so that families can take that much-needed vacation, spend some time with their kids, or even put some money aside for their education.

Now, recently, President Clinton labeled this idea of giving back the taxpayer some money the wrong course for America. Well, Mr. Speaker, the American people just are not going to accept the Democrats' liberal spin on this at this time.

The Republican Congress is determined to track down the mistakes of 60 years of liberals robbing from Peter to pay Paul. Republicans are determined to save the ship before it sinks from the weight and burdens of excess taxes.

Mr. Speaker, I yield back to the American public any much-needed tax break.

ATTORNEY GENERAL HAS NO CHOICE BUT TO APPOINT INDEPENDENT COUNSEL

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

Mr. STEARNS. Mr. Speaker, yesterday the lead editorial in The New York Times came out strongly against the Attorney General and her continued refusal to admit to the obvious. The law requires that an independent counsel be named to investigate allegations of illegal campaign money from Communist China into the Democratic Party in the 1996 election.

FBI Director Louie Freeh has pleaded with the Attorney General to do so. And now Charles Labella, the person who was hand picked by Janet Reno to lead the investigation of these charges, has told the Attorney General that she simply has no choice.

The New York Times in this editorial states, ''Ms. Reno can give her usual runaround about being hard-headed, but she cannot hide from the meaning of this development.''

Ms. Reno has ignored the advice of the FBI Director and her own handpicked investigator for too long. She is a lot like the character in Hogan's Heroes, that great TV series, Sergeant Schultz. When Colonel Hogan would say something to him about nefarious affairs, Sergeant Schultz would say, ''I know nothing, I see nothing, I hear nothing.''

Ms. Reno, it is time to appoint an independent prosecutor for campaign finance.

REGARDING THE 2000 CENSUS

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

Mr. WELDON of Florida. Mr. Speaker, I would like to respond to the errant comments of my colleagues, ill-informed colleagues on the other side of the aisle, regarding the year 2000 census.

Let me suggest that the very same Democrats who self-righteously assure us that the Commerce Department under President Clinton will be immune from politics, if given the opportunity to conduct the census by sampling, would be the very same people who would be screaming, ''Don't play politics with the census'', if a Republican President were trying to do the same thing.

In fact, there is not a single Democrat who would be supporting sampling if the sampling computer magic were not being conducted by the political appointees of the Commerce Department. And let us not forget that the administration that my colleagues suggest is a paragon of integrity is the same administration that used the IRS to smear Billy Dale and the White House travel office employees, the same administration that politicized the Immigration and Naturalization Service in 1996 to illegally approve citizenship for criminal aliens, and, of course, it is the same administration that has done such a good job regarding missile technology secrets from the Communist Chinese.

□ 1530

AMERICAN PEOPLE DESERVE AND EXPECT AN EXPLANATION

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

Mr. GUTKNECHT. Mr. Speaker, of all the scandals coming out of this White House, one scandal above all is perhaps the most disturbing. This scandal is more disturbing than the 900 FBI files on Republicans that somehow showed up in the White House; more disturbing than the use of private investigators to smear political opponents; more disturbing than the use of the IRS and the FBI to smear Billy Dale and the Travel Office employees; more disturbing than the allegations of perjury and obstruction of justice; and even more disturbing than the vast left-wing coverup of all of the above.

I am talking about the shocking revelation that the White House has helped the Communist Chinese Government with its missile program. We do not know if this administration gave a waver to Loral Corporation because the chairman, Bernard Schwartz, was the Democrat's top donor in 1996 or not. But whether this administration did it for the money or not, the scandal is still almost beyond comprehension.

At best, the administration inadvertently helped the Communist Chinese Government to develop its Long March missiles. The American people expect and deserve an explanation.

AMERICA NEEDS TO ADDRESS CRISIS IN AGRICULTURE

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

Mr. THUNE. Mr. Speaker, agriculture in the northern plains is in great crisis. Farmers are having to sell below the cost of production. People across America need to understand that there is a close connection between a healthy agricultural economy and a strong America.

We need to address the crisis in agriculture, but we need to do it without the partisan carping that is coming out of the Democrats in Congress. The level of the rhetoric that is coming out of the Democratic leadership in the Congress is shameful.

We need to work together to solve the cash-flow problems in agriculture, to more aggressively open markets overseas, and to improve the crop insurance program. Farmers do not care whether the Democrats or the Republicans get the credit. They only know that they need to stay in business.

I challenge my colleagues on the other side of the aisle to work with us cooperatively to find solutions to the crisis in agriculture. Let us quit playing politics with agriculture's future. Let us work together.

IRANIANS TEST INTERMEDIATE RANGE BALLISTIC MISSILE

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

Mr. HUNTER. Mr. Speaker, when just a couple of days ago the Iranians tested an intermediate range ballistic missile, one that has the range to strike Israel, our administration was once more embarrassed, because they had predicted a number of times that the Iranians could not achieve this capability until sometime late next year.

Well, the Iranians were a year ahead of schedule. Only one person predicted they would be able to do it much earlier in this body, and that was the gentleman from Pennsylvania (Mr. WELDON). He is working on a piece of missile defense legislation. The gentleman from New Jersey (Mr. SAXTON) is putting in legislation a number of us are cosponsoring which directs the President to conduct an emergency program to build a defense against the systems the Iranians are developing right now.

Mr. Speaker, now is the time for the President to act. With the same urgency with which our enemies are building the ballistic missiles, we must act with the same urgency to build defenses against those missiles.

TODAY UTAH CELEBRATES ITS PIONEER HERITAGE

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

Mr. CANNON. Mr. Speaker, 151 years ago today, Brigham Young led the first Mormon pioneers into the valley of the Great Salt Lake.

The next spring, malnourished Mormon settlers began planting corn, beans, wheat, and potatoes. But as soon as they sprouted, the shoots were attacked by hordes of crickets.

Dr. Priddy Meeks recorded in his journal that ''the crickets came so thick it made the earth black in places, and it did look like they would take away what little we had growing * * * and we a thousand miles away from supplies.''

Out of desperation, men, women and children poured into the fields to scare

the crickets away. They dug ditches around the field. They used fire. But it was all in vain.

Just as all seemed lost and starvation likely, help came from above in the form of thousands of seagulls. Eyewitness reports tell of the birds descending on the fields, gobbling up the crickets and sparing the precious crops.

Today, Utah celebrates its pioneer heritage. Many of the celebrations will center around Seagull Monument in downtown Salt Lake City, erected in honor of the event I have just described.

I encourage my colleagues to join me today in honoring the courageous spirit and the sacrifices of the Mormon pioneers.

A FOURTH INVESTIGATION OF THE INVESTIGATOR: D.C. BAR COUNSEL PROBES LEAKS BY INDEPENDENT COUNSEL STARR

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan, Mr. CONYERS, is recognized for 5 minutes.

Mr. CONYERS. Mr. Speaker, by my count, Independent Counsel Kenneth Starr is now the subject of four separate investigations into whether he and his staff improperly leaked confidential information to the media. The first is being conducted by Chief Judge Norma Holloway Johnson of the federal court in the District of Columbia. The second involves Attorney General Janet Reno's referral of the issue to the Justice Department's Office of Professional Responsibility. The third is being conducted by Mr. Starr himself in response to complaints lodged by the President's lawyers. And the fourth, as reported in the media today, is in the hands of the District of Columbia Bar Counsel.

Back in early February, the President's lawyer, Mr. Kendall, wrote the Independent Counsel that the ''leaking by your office has reached an intolerable point.'' In response to that letter, the Independent Counsel struck an indignant tone. He called the letter from the President's lawyer ''strange and inappropriate,'' and accused Mr. Kendall of elevating ''mere suspicion to specific accusation without any facts other than the press's often-misleading attributions of sources.''

The Independent Counsel's response to Mr. Kendall added that: ''[i]n light of the unclear press attributions in some examples cited in your letter, I have undertaken an investigation to determine whether, despite my persistent admonitions, someone in this Office may be culpable. I have no factual basis—as you likewise do not have—even to suspect anyone at this juncture. I am undertaking this investigation with deep regret, because I know how demoralizing it is to a staff of highly professional and experienced federal prosecutors. You do an extreme disservice to these men and women—and to the legal profession and the public—by your unsupported charges.''

Mr. Starr has never reported the results of his ''investigation.'' But in light of his later admissions that he and his deputy, Mr. Bennett, routinely talk to the press on an off-the-record basis, I assume he did not have to look far to find the source of these leaks. Judge Johnson, the Attorney General, and now the District of Columbia Bar Counsel, have all treated this issue far more seriously than the Independent Counsel. In fact, media reports say that Judge Johnson has ordered Mr. Starr to show cause why he should not be held in contempt for his inappropriate release of information.

The Independent Counsel's indifference to this issue is very troubling. To date, Mr. Starr has defended his actions with the technical claim that rules regarding grand jury secrecy apply only after information is presented to a grand jury. I do not agree with that claim, and I do not believe that D.C. Circuit law allows the kind of off-the-record conversations that happened here. We will see whether Mr. Starr can survive the scrutiny of these outside investigators.

EXCHANGE OF SPECIAL ORDER TIME

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise to ask unanimous consent to claim the time of the gentleman from Michigan (Mr. CONYERS).

The SPEAKER pro tempore (Mr. PEASE). Is there objection to the request of the gentlewoman from Texas?

There was no objection.

EXPANSION OF MEDICAL AND PATIENT RIGHTS FOR ALL AMERICANS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, with all of the pandemonium that transpired just a few short minutes ago, I imagine that some of my colleagues might have gathered from the discourse that many of us do not come to the floor of the House with passion and concern and personal stories. And, so, I thought it was extremely important that we cleared the dust and put a face on the debate that we had today.

Sadly, we lost that debate, those of us who care about the expansion of medical rights and patient rights for all Americans. This morning as I rose, I was determined not to share my personal story, for the people send us to this Congress to stand and to represent their interests, but I do think it is important for the people to realize that we are human, too.

I have had a personal story and personal loss. For, recognizing that all of us care about our loved ones, I experienced the denial of service in the care of my father. So this is not a frivolous and baseless debate for me, but I thought it was more important to share with my colleagues the story of the Chiang family.

This young couple, with a husband and wife, left a position and the father was the sole breadwinner, and the mother was determined to keep a certain HMO so that her son could continue to go to that same pediatrician. They kept that HMO, and the son had the pediatrician, but the mother became ill.

She had constant pain in her stomach. She went to the HMO doctor, and continuously he said, ''We will put you on a certain diet.'' But the pain became so debilitating she went back again because she thought it was something that had to do with her ability to give birth again.

She went back and further service was denied, until finally, some three months later, she was sent to a specialist and it was then determined that that mother, 34 years old, had colon cancer. And subsequent to that late determination, after the denial of service, that 34-year-old died.

Today I read to my colleagues a letter from Lula Somers, a senior citizen who has been in the medical profession for many, many years from Pasadena, Texas, the community that I come from. She said, ''This letter is directed to you from a working senior citizen who has served a lifetime in the medical profession and who is deeply concerned about the direction we are heading. Dedicated healing physicians are having their once regarded highest standard of ethics and devotion be dictated to by people who have not the first clue of the onerous problem being cast upon innocent citizens.''

She said she worked at a time when doctors saved a gravely ill child, sutured bleeding patients, sat at the bedside of someone dying, and maybe wound up with vegetables or eggs from someone's farm.

We may not be able to go to that, my colleagues, but the Patients' Bill of Rights the Democrats and bipartisan Republicans were supporting realizes that we must stand with the physicians and the providers of health care like nurses and nurses assistants and the patients.

The bill we pass today will hurt my State of Texas. It will probably hurt my colleagues'. Texas already has provisions for well-child care, mammography screening, minimum maternity care, breast reconstruction, diabetes supplies, alcohol abuse treatment, drug abuse treatment. The bill we pass today will overcome all of that, supercede that. Mental health care and bone mass measurement. All of that Texas had. Now with this Federal bill that the Republicans will pass, we do not have it.

Just think for a moment if they have a heart attack and go straight to the nearest hospital but the hospital does not participate in their plan. The Republican bill will allow their plan to force them right out of the hospital. That is what we passed today.

If their plan denied them an X-ray for a broken arm because the plan did not think the X-rays were medically necessary, they could not appeal on the basis of merit. They can only appeal on the basis of what the plan says is a necessary medical condition. It takes away that decision of the physician and their pain and the need for service and puts it in the hands of some accountant in an office far, far away.

If they are a woman and they want direct access to their nurse midwife,

their plan does not have to give it to them. They can only require them to see a physician. So many women want nurse midwives and have found that to be a comfortable way to give birth.

If they are terminally ill and their only hope is an approved clinical trial, the Republican bill would not allow it. So many of my constituents have said, ''I beg of you to allow me to participate in a clinical trial. I will go anywhere, do anything to save my life or that of my loved one.''

If they are about to deliver their baby at a hospital and their health plan drops their doctor, the Republican bill allows their plan to make them get a new doctor at the very time that they are in need. And if they are scheduled for a cancer operation and their health plan drops their doctor, under the Republican plan they have to find a new doctor.

My colleagues, what we did today was a travesty. I hope that we will be able to repair that and pass a bill, Mr. Speaker, that really responds to the life and the death of Mrs. Chiang.

UNIVERSITY OF MISSISSIPPI CONCERT SINGERS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Mississippi (Mr. WICKER) is recognized for 5 minutes.

Mr. WICKER. Mr. Speaker, I rise today to share with my colleagues the wonderful news that the University of Mississippi Concert Singers won top honors last week at the World Choral Competition in Rome, Italy.

The group from Ole Miss, led by Dr. Jerry Jordan, is the first American choir ever to have qualified for this exclusive international competition and, of course, the first to win the top prize. Today, they are considered the best amateur choir on the face of the Earth.

To reach the Super Bowl of choral competitions in Italy, groups from around the world first had to qualify for and then win 1 of 6 international events. On their way to the finals, the Ole Miss singers won the grand prize in May of 1997 in a competition in Bulgaria. Then last week, the group outperformed choirs from Sweden, Hungary, Estonia and Taiwan, all of which had won international choral events in past years.

The Ole Miss concert singers are no strangers to performing on the international stage. During Dr. Jordan's 18 years at Ole Miss, his choral groups have toured on nine occasions; they have participated in international competition three times; and, in 1994, earned their only other trip to the grand event.

The Collegiate Choir Program at the University of Mississippi is recognized among the best in the Nation. Dr. Jerry Jordan is one of the country's most accomplished directors. He has conducted the American Symphony Orchestra at Lincoln Center in New York and is a regular conductor at Carnegie Hall.

Dr. Jordan's leadership and the exceptional talents of these students produced an unprecedented result in Rome. The judges said the group performed an extremely difficult and diverse program and did so flawlessly. The 50-member group sang seven songs in five different languages over the span of its allotted 30-minute program.

Mr. Speaker, there are at least five alumni from the University of Mississippi in the House of Representatives. And at this point, I am pleased to yield 1 minute to the distinguished gentleman from Mississippi my colleague (Mr. PICKERING).

Mr. PICKERING. Mr. Speaker, I thank the gentleman from Mississippi (Mr. WICKER) for yielding.

I rise with him to recognize the Mississippi Concert Singers and their accomplishment. They come from the University of Mississippi, the same place where the new director of the National Endowment for Humanities, Dr. William Ferris, the author of the Encyclopedia of Southern Culture.

In Mississippi, where we have the tradition of being the birthplace of blues, of rock and roll, and in my district, Meridian, the birthplace of country music with the grandfather of country music, Jimmy Rogers.

And today we celebrate our additional contribution to our State's culture and our Nation's culture to the world, the Mississippi Choral Singers, and the great achievement that they have won by being the first American choir to win this preeminent distinction and competition in Rome.

So I rise with the gentleman from Mississippi (Mr. WICKER) and to acknowledge and to appreciate this great accomplishment.

Mr. WICKER. Mr. Speaker, reclaiming my time, I thank my colleague for his remarks. And one final word, Mr. Speaker.

This outstanding group of performers from the University of Mississippi has earned an honor reserved for a select few. They have earned the right to be called the best in the world, and they have made all Americans proud. I salute them today.

□ 1545

EXCHANGE OF SPECIAL ORDER TIME

Mr. LAMPSON. Mr. Speaker, I ask unanimous consent to claim the time of the gentleman from New York (Mr. ENGEL).

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Is there objection to the request of the gentleman from Texas?

There was no objection.

MISSING AND EXPLOITED CHILDREN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. LAMPSON) is recognized for 5 minutes.

Mr. LAMPSON. Mr. Speaker, as a father, one of my biggest fears over the years has been discovering perhaps that one of my daughters would be missing.

Sadly, last November, one of my constituents was living mine and every parent's nightmare when she frantically called the Texas City Texas Police Department after her ten year old daughter did not arrive home from school.

Recently, my district has been stricken with a stream of missing children. This issue has become my highest priority as well as that of the police departments in my area to try to put an end to this. The chief of police for Texas City, Texas, Jerry Purdon, last year visited the National Center for Missing and Exploited Children and underwent training on developing a program for responding to a missing child alert.

One of the key elements in the department's new program was the actual response time, which they felt had been a key factor in previous failures. In this Texas City case, the department was able to flood the area with both police and informed neighbors to search for any sign of the missing child.

Hours went by until a man appeared in the middle of the neighborhood with the missing girl, stating that he had found her under some stairs. She was immediately rushed to the hospital while the man was questioned by the police.

Suspicious from the start, they were able to obtain a full confession. This man, who knew the girl, picked her up from school and returned to his home with her and after sexually abusing her he admitted that he intended to kill her and dispose of the body. In his words, he was prevented from carrying out his plan because, quote, every time I looked out my front window I saw a police car and every time I looked out the back, I saw a neighbor who knew what was happening, unquote.

Thanks to the quick response and organization of Chief Purdon and his officers, that little girl was returned to her family. I stand here proud of their efforts and would like to applaud each and every one who helped save the little girl. It is with forceful reactions to crimes like this that we hope to end the disappearances of our children and prevent all parents from experiencing this nightmare.

TRIBUTE TO HORACE ELLIS JONES

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia (Mr. COLLINS) is recognized for 5 minutes.

Mr. COLLINS. Mr. Speaker, I rise to honor an individual, no not a Georgian by birth but is the essence of a Georgia gentleman.

Horace Ellis Jones is the grandfather of one of my legislative staff members. Today I pay tribute to Mr. Jones through the eyes of his grandson.

Born on February 7, 1916, in Spring City, Pennsylvania, to Russell and Mary Ellis Jones, Horace Ellis Jones spent his childhood days growing up in the suburbs of Philadelphia.

He was known for his wide grin smile and his charming demeanor. He was very active in the Boy Scouts, earning the distinction of an Eagle Scout.

After attending Spring City High School and Stanton Military Academy in Virginia, Mr. Jones decided on Duke University and became a true Blue Devil. A couple of days before he was to leave for Durham, Mr. Ellis dropped by a local cafe just outside of Pottstown, Pennsylvania, with friends.

As he entered, his eyes focused on Olive Hammer. One look at her put Ellis Jones in a spin. He immediately put money in the juke box and asked Olive to dance. The music has not stopped for 57 years.

After they were married in 1941, Mr. Jones worked with his father in automobile sales in Reading, Pennsylvania. Very soon after their marriage, like so many of our distinguished citizens at the time, he answered America's call to duty and served in the United States Army during World War II.

Lieutenant Jones was stationed at Newport News, Virginia, as a member of the Army Transportation Corps. From there, he returned home to Pennsylvania, began his work with his uncle in the family business, the Jones Motor Company.

For almost 30 years, he played an instrumental role in the success of the business, one that grew to be among the largest trucking companies east of the Mississippi River. Jones Motor boasted 59 terminals, almost 4,000 employees and more than 3,500 pieces of equipment. This was an amazing feat considering it all started with a single horse and wagon back in the 1800s.

Along the path of hard work, Ellis and Olive welcomed a new generation of Joneses, their children, Mary Ellis and Donald. In the mid-seventies, Jones and his brothers decided to sell the company and retire. Retirement lasted a brief 6 months, after which Mr. Jones entered the lucrative real estate business and became very active in many charitable organizations such as the American Hospital Association and the Pottstown Hospital Association.

During his spare time, he could continue to pursue the major nonfamily passion of his life, the game of golf. After picking up the first set of clubs at the age of 7, Mr. Jones' devotion to the sport culminated with his presidency of the Philadelphia Golf Association in the 1960s.

During that tenure, he worked to provide scholarships and opportunities for many hard working young people. He also served on countless boards of the United States Golf Association and as a member of many country clubs and golf societies throughout the world.

When he finally decided to slow down from all of this activity, Ellis and Ollie relocated to the State of Georgia. They chose the quiet coastal beauty of Sea Island, a spot that they had first visited in their honeymoon. The environment there was proven to be the ultimate spot to pursue new opportunities.

While preserving their already acquired interests, it also served as a meeting place for the entire Jones' family to congregate and forge new memories. With all of that said, to really know the tale of Ellis Jones is to realize that his greatest accomplishment continues to be his capacity as a person.

Amidst all of the challenges and successes of life, Mr. Jones always conducts himself in the highest degree of courtesy, generosity and integrity. He is concerned with the happiness and the well-being of others at every turn, as a leader, as a businessman, a father, a grandfather, a husband or a friend.

Recently, Mr. Jones has been battling the evils of cancer, a war he has been waging for some 7 years. It has been a difficult time for him and his loved ones, but through it all he has maintained his positive attitude built upon the love of his family.

Ellis Jones' life is nothing short of remarkable, an American dream come true that seems to guide the brush strokes of my Norman Rockwell painting. One need only look to his family and friends to see the reflection of his charmed life.

Mr. Speaker, I would like to extend my heartfelt best wishes to Mr. Jones as he watches today from Georgia, as well as members of the Jones family throughout the country.

In closing, I would like to read a piece Mr. Jones wrote just a few weeks ago. I think it is an appropriate testament to the life of this great man and is something from which we all can learn, and I quote: I have always believed that the game of life, like the game of golf, was the last gentleman's game and I have tried to play both as such, a gentleman. If I have been successful, it is because of my love from and my love for my wonderful wife, our blessed children and grandchildren and my many loyal and supportive friends. Looking back over the entire course, I can say in all honesty, what a game, what a life, what a lucky guy I have been, end of quote.

Mr. Speaker, our prayers are with Mr. Jones and his family and for the blessings all have received from the life of Horace Ellis Jones.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from the District of Columbia (Ms. NORTON) is recognized for 5 minutes.

(Ms. NORTON addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

EXPORT OF AG PRODUCTS STIFLED

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota (Mr. GUTKNECHT) is recognized for 5 minutes.

Mr. GUTKNECHT. Mr. Speaker, you may have seen in the Washington Post, the Wall Street Journal, the New York Times and other newspapers, articles about the current farm crisis. The hard times in farm country are real and demand immediate attention.

The $5.5 billion package introduced by the chairman of the House Committee on Agriculture and the half billion dollars approved by the Senate are good starters.

Unfortunately, some folks cannot resist making a political football out of the misfortune of others. These folks say that the 1996 farm bill, which the President signed, is to blame for all the woes in farm country.

Mr. Speaker, I would have preferred to avoid the blame game, but if the goal of the Democrats is to place the blame they do not have to look very far. How about the congressional Democrats' unwilling less to pass fast track trade negotiating authority with their president? At least he used to say this was so critical to U.S. farmers and ranchers. When one-third of our farmers' cash receipts come from exports, how can congressional Democrats defend their opposition to fast track?

When EU subsidies in 1997 were at their highest level in this decade, at nearly $47 billion compared to $5.3 billion here in the United States, how can they oppose fast track?

When the start of the next World Trade talks are only 5 months away, why would Democrats oppose the President's request for fast track so that the United States can have a seat at the negotiating table in order to tear down these trade barriers?

The answer may be the Democrats are more interested in collecting big labor PAC checks for their reelections than protecting their own farmers.

Mr. Speaker, the fact is, fast track is not my only priority but it is one of our most important priorities. It is the priority also of most of the U.S. leading farm and ranch organizations.

It only makes sense. In 1996, when ag exports were at their all time high, $60 billion, farm income was up, but now that ag exports have dropped over the last 2 years by an estimated $5 billion, farm income is down.

How about trade sanctions? Over the past 60 years, Mr. Speaker, we have imposed approximately 120 different sanctions. Despite relatively peaceful times, guess which administration has imposed over half of these sanctions in just the past 6 years? You guessed it. This one.

This administration is willing to impose unilateral sanctions at the drop of a hat, and I am not sure what these sanctions have accomplished in the way of national security. What I do know is that it forecloses U.S. ag sales to millions of the world consumers. If we still want to place the blame, what has the administration been up to while ag exports have been precipitously dropping?

You would think they would be scrambling to sell ag commodities using the ag export enhancement tools authorized under that dreadful 1996 farm bill, but according to a recent General Accounting Office report, that is not true. The administration has used only 44 percent under the dairy export incentive programs to promote U.S. dairy exports. This is despite a mandate in the horrible farm bill that says that the DEIP program should be used to the maximum extent practical under GATT. Despite an annualized $5 billion authorization under the 1996 farm bill for the GSM export program to move our ag products, this administration has used only $3.2 billion and $2.9 billion in the 1996 and 1997 fiscal years respectively.

In other words, $3.9 billion in GSM export assistance went to waste while our ag exports have tumbled.

Guess how much of the 1.5 billion export enhancement program dollars authorized under the farm bill have actually been used by this administration? If you guessed only $7 million, you would be right.

Mr. Speaker, the President and congressional Democrats know that the success of the 1996 farm bill depends on favorable tax and regulatory policy, improved research and crop insurance and perhaps, most importantly, trade. The Democrats resisted and continue to resist tax relief for farmers or for anyone else, as far as that goes.

The administration is talking about a new EPA program with more regulations that could strangle many of my dairy, beef and pork producers who are already overregulated. The President held hostage ag research money until he got food stamp money for legal aliens. He also held hostage critical crop insurance money to fix funding problems that he created back in 1994.

□ 1600

When it comes to trade, the President and Congressional Democrats are AWOL.

Democrats also charged that Republicans somehow have taken away the safety net for farmers. As a former Democratic Chairman of the House Agriculture Committee, Mr. DE LA GARZA pointed out, over the last decade on the Democrat's watch, Congress has cut the agriculture farm bill by more than $60 billion.

Importantly, the Republican House budget resolution does not call for a single cut in support of U.S. farmers and ranchers.

Mr. Speaker, I could remind our Congressional Democrat friends that if we go back to supply management, for every acre we leave unplanted, Argentina will be happy to plant one.

Mr. Speaker, it is time to cut the rhetoric and work together. It is time to get the job done for American farmers. It is time to open our trade relations with our partners and get more export enhancement programs going so that we get more farm income to our farmers.

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Under a previous order of the House, the gentlewoman from New York Ms. SLAUGHTER is recognized for 5 minutes.

(Ms. SLAUGHTER addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

THE NEED FOR AN ASIAN STRATEGY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska (Mr. BEREUTER) is recognized for 5 minutes.

Mr. BEREUTER. Mr. Speaker, today this Member will introduce legislation that requires the administration to establish a $100 million assistance and food security initiative for Indonesia and Southeast Asia in fiscal year 1999. I would say it very much happens to compliment what the gentleman from Minnesota just said about coping with our own farm crisis or difficulties at the same time that we are reaching out to help for a food shortage problem which is expected to be severe this year in Indonesia.

This legislation, in the works for several weeks by this Member, is consistent with recent urgent proposals or suggestions by distinguished Indonesian experts in America, like Ambassador Paul Wolfowitz of the Brookings Institution, and the former Ambassador, Robert Zoellick, President and CEO of the Center for Strategic and International Studies, for a prompt Congressional response to the Asian financial crisis, and, more specifically, to Indonesia's current plight.

In an opinion piece published in the Washington Post on July 23, 1998, Mr. Zoellick, former Undersecretary of State during the Bush Administration, eloquently argues that now is a definitive moment in the lives of a generation of Asians, and that America's response to the current crisis could be as important as America's response to Europe 50 years ago.

Because Ambassador Zoellick makes the case for a coherent foreign policy strategy better than anyone so far, I would say, this Member would include excerpts from his op-ed piece entitled ''An Asian Strategy.'' I would like to read two paragraphs from it at this point.

He says as follows: First, Congress should enact a major humanitarian package for Indonesia. The need is urgent. The combination of drought and economic collapse has not only impoverished half of the world's fourth-most populous country, but raised the real danger of famine. Indonesia's new president already is urging his 200 million citizens to fast twice a week to conserve supplies. All the talk of IMF packages and economic recovery will be only chatter until there is political stability in Indonesia, and there will be no stability if people cannot eat. Indeed, Indonesia's ethnic peace, even its very coherence as a Nation is at risk. And if Indonesia sinks further, the rest of Southeast Asia will bear the burden of its dead weight.''

''America has a proud tradition of humanitarian relief for people in need; it also has farmers who would welcome a boost in prices. If Congress expands the administration's recently announced grain purchases into a full-fledged relief plan, it can draw in Japan, the European Union and even some private U.S. business people who have signaled a willingness to contribute. This initiative would send a powerful, symbolic and practical message about America's concern for the plight of average Asians, not just bankers and magnates.''

That is what Mr. Zoellick has to say.

Mr. Speaker, now is not the time, I would say, for the United States to balk at its responsibilities as the world's only superpower. The United States fought a Cold War and spent hundreds of billions of dollars, perhaps trillions of dollars, to advance our ideology of global capitalism and democracy.

In Asia, capitalism was adopted with an enthusiasm that has proven so strong that authoritarian leaders found democracy following right behind. From Taiwan to the Republic of Korea and Indonesia, for example, our most important principles are being embraced and tested by people willing to put their lives on the line.

As Mr. Zoellick rightly states, we have an important choice to make that will affect an entire Asian generation's perception of us and what we stand for. We can tell hard working Indonesians that they can sell their products here, or we can close our markets. We can join the rest the world in providing humanitarian assistance, or we can turn our back. We can send our experts to help them rebuild their economy, or we can wait until it is too late. We can pool resources and share risk with the world's industrialized countries to the regional capital markets or we can let them dry up.

Mr. Speaker, the United States can pay now or it can pay later. If the U.S. Congress and the president agree to develop a proper response to the current crisis in Asia, the costs will be minimal and the rewards unfathomable. Can one put a price on democracy in Indonesia or stability in the Asia Pacific region? Or, we can wait and see how the troubled Asian economies do own their own without our assistance.

Perhaps they will recuperate in several years through excellent management and astute decision making. But what if they do not? What will be the costs if we do nothing and find the region still in crisis in five years? How much will it cost us to maintain our security umbrella in an insecure region? What will happen to the U.S. economy if the Asian Pacific region slips into depression? Most importantly, will Asians continue to look to the United States for leadership if they do nothing?

Mr. Speaker, I urge Members to cosponsor this new Indonesian assistance legislation, which will also be very important to our export base and to our entire economy and foreign policy.

A CHRONOLOGY OF IMPORTANT POLITICAL AND CULTURAL EVENTS IN PUERTO RICO (1493–1997)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. SERRANO) is recognized for 5 minutes.

Mr. SERRANO. Mr. Speaker, I rise today to speak about a subject which is of great importance to many of us in my community, and certainly should be of great importance to all Americans.

Tomorrow we will observe, July 25, 1998, the 100th anniversary of the relationship between the United States and Puerto Rico. One hundred years ago, the United States troops, during the Spanish-American War, invaded Puerto Rico, and since then Puerto Rico for these 100 years has been a territory of the United States.

Tomorrow, throughout the 50 states and on the island of Puerto Rico, there will be different groups involved in different forms of observances or celebrations. Some will celebrate the day claiming that, in their belief, this relationship has been the best thing that ever happened to the Island of Puerto Rico. Others, on the other hand, will lament the relationship and feel that it has been totally unfair.

Some groups on one side, as I said, will claim that nothing has gone wrong for these 100 years, and some folks on the other side will say that nothing has gone right for these 100 years.

I believe that somewhere in between is the truth. But in order to really speak about this subject and how we got here and where we are and where all Americans should begin to deal with this issue, I think it is important to take just a couple of minutes to talk a little bit about the history of how we got here.

Puerto Rico, as so many of you may know, was discovered in 1493 by Christopher Columbus, and from then to 1898 it was a colony of Spain. In 1508, the first Governor in Puerto Rico was assigned, and his name was Juan Ponce de Leon, or, as he is better known within the 50 states, as Ponce de Leon.

The years went on, and Puerto Rico remained no better than a full colony of Spain. But by 1865, nearly 400 years later, there was already discussion between the Spanish government and the Island of Puerto Rico in terms of creating a new arrangement.

Therefore in 1865, a royal decree was issued convoking delegates from Cuba and Puerto Rico to Madrid to discuss possible reforms to the colonial regime. The Puerto Rican delegates go there and they speak about decentralizing the municipal government, having more powers as people, taking some of the powers from the Governor, who was appointed by Spain, and abolishing slavery. No accord is reached, and the delegates who speak out for such reforms are in fact persecuted. Meanwhile, back in New York, the Republican Society of Cuba and Puerto Rico is established to promote the cause of independence for both islands.

In 1895 the Puerto Rican section of the governing body of the Cuban Revolutionary Party is established in New York, and Puerto Ricans at that time adopt their own flag, which is the same as the Cuban flag, with the colors reversed. Jose Marti is the leader of the party, and it is right here within the 50 states, in New York, that the movement against Spain for independence for Puerto Rico comes into play.

However, something happens on the way to 1898. Spain, for whatever reason, begins to realize that times have to change, and so Spain begins to discuss the possibility of granting autonomy to the Island of Puerto Rico.

On February 9, 1898, Puerto Rico's autonomous government is inaugurated with a provisional cabinet. It provided a high degree of administrative autonomy for Puerto Rico, and, under the charter, the Island was governed by the local parliament, composed of two chambers and a Governor general. The chambers were the Administrative Council, which were elected, and a version of the House of Representatives, popularly elected.

These chambers had full legislative authority except over such matters that the Spanish government wanted to keep, and these folks were then allowed to go to Spain and represent the Puerto Rican community, the Island of Puerto Rico, in Spain.

It is interesting to note that in this agreement the people representing Puerto Rico in Spain had actually reached more autonomy and more powers than the current delegate from Puerto Rico enjoys as a Member of the U.S. Congress.

But that could not take place, because, in the meantime, on February 15, the sinking of the American ship the *Maine* provided an immediate reason for the Spanish-American war. During that war, elections are held in Puerto Rico and this government, which then will represent Puerto Rico in Spain with many more powers, is elected.

On July 25, after the defeat of the Spanish in Cuba, General Nelson Miles leads an American landing in Guanica on the southern coast of Puerto Rico. On October 18th of that year, San Juan surrenders, and a U.S. military government is established in Puerto Rico.

On December 10, the treaty of Paris is signed and the Spanish-American War ends, and Puerto Rico is given to the United States, the political and civil rights of its inhabitants to be determined by the U.S. Congress.

From then on, Puerto Rico and the United States for a couple of years try to figure out what that relationship will be. But through 1899, in a few years, a military government continues.

Nothing really changes until 1900, when a new act is passed here which ended the military administration and set up a civil government. Very little self-government, however, was granted. The President would appoint a Governor, the members of the upper legislative house in Puerto Rico, and the executive council, where no Puerto Rican was allowed to serve, and the judges of the Supreme Court. Only the House of Representatives on the island was wholly elected by the people in Puerto Rico, and then it was determined that Puerto Rico would have a commissioner who would serve in the House of Representatives with no voting status.

In 1904, Puerto Ricans at that time are not granted U.S. citizenship. They become in fact citizens of Puerto Rico. An argument, by the way, that continues to be dealt with today, because many people still wonder if in imposing American citizenship later, that Puerto Rican citizenship in fact was done away with. Everything then is run by the United States Congress.

□ 1615

In 1917, a very important day in the history, on March 2, the Jones Act comes into effect, and by it, Congress determines that all Puerto Ricans born in Puerto Rico will be American citizens. Since that date, everybody born on the island of Puerto Rico is an American citizen. The only difference and the most important difference, and perhaps the tragic difference, is that if you are born in Puerto Rico you are an American citizen and you move to any of the 50 States, you enjoy the same rights as any citizen within those 50 States, but if you remain on the island of Puerto Rico, still an American citizen, you do not enjoy the same rights as the other 50 States.

That puts into play then the question, what kind of American citizenship is it? Is it possible for us to actually have granted different kinds of American citizenship, one for those who live within the 50 States, and one for those who live outside? To this day, there are very bright people arguing that it is impossible to have granted 2 different kinds, but the effect is that there are 2 different kinds of citizenship, and they express themselves differently.

Nothing then really changes in Puerto Rico until 1950. What happens in those years is that a governor is appointed, and there are different situations that are created. But during that period of time, an independence movement grows, which continues to demand, as it did during the period with Spain, that Puerto Rico be liberated and in fact be given its independence.

That independence movement is persecuted heavily, to the point where its leader, Pedro Albizu Campos, is a man who is jailed for over 27 years for advocating for independence of Puerto Rico

during that time. Also, there are incidents where violent acts are committed and force is used both by the government and by citizens.

At that time also a party grows, various parties grow in Puerto Rico, one of them being the Republican Party, a statehood party, an independence party, a party that wants to take the present status in the 1930s and 1940s and bring it to a new relationship, one that is not statehood or independence.

Finally in the early 1950s it is decided that Congress will offer the Puerto Rico community in Puerto Rico something called commonwealth status. Commonwealth allows for certain rights to be carried out on the island, but commonwealth still does not provide for the ability to vote for President, for the ability to vote for 6 or 7 Members of Congress as Puerto Rico would be entitled to, or for the ability to vote for 2 Senators. On the other hand, commonwealth also does not allow for Puerto Rico's independence. So I think we have to fully understand, and I think the problem that we face these days when we discuss this issue and as we celebrate, commemorate, observe or lament over the 100-year relationship, tomorrow, July 25, is the fact that such a large number of Americans, if not the vast majority, have no idea what the relationship is between the United States and Puerto Rico.

If one goes through any neighborhood in this country and you ask people, are you aware that all people who live on the island of Puerto Rico are citizens like you, you would be shocked to find a large number of people do not have the slightest idea. If you then ask them, do you know that Puerto Ricans served in our wars and participated in our wars and were drafted just like all other Americans when we had a draft, the answer would be no, I did not know that. If you then tell them that they were and that they are citizens and they still do not vote for President, that would shock anywhere, I would say, from 75, 80, 90 percent of the American people who are not aware of the relationship. I think what will happen tomorrow and throughout the rest of this year is more and more people will become aware of the relationship and become aware of the need to speak about where the future of that relationship should take us.

Now, let me digress for a second and just set myself up as an example of the uniqueness or the embarrassment of that relationship. I was born in Puerto Rico. I came to New York, as so many Puerto Ricans did, when I was a very young child. I studied in New York, I became involved in politics, I served in the State assembly; I then came here in 1990. I am a Member of Congress. One cannot really express better fulfillment of one's citizenship than what I have accomplished personally, yet my cousins who live on the island of Puerto Rico do not have the same rights I have, the difference being that I moved and they did not.

That is almost to suggest that if one stays in Texas or one stays in New York, one would have less rights than if one came to California. Well, I am sure there are probably some Californians who would like Texans and New Yorkers to have less rights, but that is just the way we behave in this country. The fact of life is that these folks are there with a totally different system of government overseeing them.

So the commonwealth came in and the commonwealth was set up basically to tell the United Nations, I believe, look, we are obeying the rules, we are doing what you wanted us to do; we do not have a situation that can create a problem for anybody. Puerto Rico is not a colony.

Now, in order to fully understand how people feel about the different status options, one has to understand that in the early 1950s there was a strong, and in the 1940s and 1930s, a strong nationalist movement, a movement that wanted independence for Puerto Rico, and that movement in history will speak to this more and more every day, was discredited, both by people here in Washington and people who lent themselves to that in Puerto Rico.

It was suggested somehow that if one wanted independence for Puerto Rico, one wanted the worst for the island, one was not a good American, one was not a good Puerto Rican, and that was the way people were treated. So many of its leadership was jailed. Within a democracy, Puerto Rico being an arm of the United States, if you will, is supposed to behave in a democratic fashion, and yet to the folks who supported independence, they were, many of them were just discredited and many of them were jailed.

In 1952, after the commonwealth issue came in, and by the way, the way commonwealth came in was the United States gave the people of Puerto Rico a choice: Commonwealth, yes or no. There has never been, and we should note this at this moment, there has never been a congressionally, federally sponsored vote on the island of Puerto Rico which has asked the people of Puerto Rico, do you support independence, do you support Statehood, or do you support remaining the way you are now, or making changes? There have been different kinds of votes to speak to that, but never the full question asked.

So in the early 1950s, the question was, do you want to become a commonwealth, or do you want to remain the kind of territory you are now? Yes or no. So, of course, most of the people voted yes to better the conditions, because as my friend from Guam, BOB UNDERWOOD has said at times, there are bad colonies and there are slightly better off colonies, and people at that time opted to become I guess a better off colony, but still did not have the rights of an independent nation or a State. They were allowed to pick their own Constitution, write their own Constitution. But get this: Anything in the Constitution had to be approved by the Federal Government, and Puerto Rico cannot pass any laws that will not be accepted by Congress. If so, then they just cannot continue to be as laws in Puerto Rico.

So for all of these 40 years, 50 years, Puerto Rico has been a commonwealth of the United States, and during that time, on many occasions, there have been attempts to solve the present status dilemma.

On July 23, 1967, based on the recommendation of the Commission on the Status of Puerto Rico, a plebiscite, an election was held, to determine which status Puerto Ricans want among commonwealth, Statehood or independence. Little more than 66 percent of all registered voters participated.

Now, for us in the States 66 percent is a large turnout, but Puerto Rico is a place where 85, 90 percent of the people vote, so when 66 percent turns out, it means there was kind of dissent on the issue on the ballot. The popular Democratic Party which defends commonwealth defended commonwealth in the campaign. A problem developed in the Republican Party which supported statehood with the old guard saying we will not participate and the younger guard saying we will, and then the Independence Party abstained from the election at all.

So basically we had half of the Statehood Party saying we will not participate, all of the independence movement saying, it is not a fair plebiscite, and only the Commonwealth Party participating, and the results indicated just that: Commonwealth received 60 percent of the vote, statehood nearly 39, and independence less than 1 percent.

The statehooders who participated in the plebiscite and went on and formed their own party, the new Progressive Party which got the governor reelected, and it was the first defeat for the Democratic Party in 28 years. By the way, just for clarification, the fact that they call themselves Popular Democrats has really nothing to do with the Democratic Party in this country, it is just a title.

In 1970, President Nixon said it is time to do something, let us talk about statehood or independence for Puerto Rico, but nothing happened. Again, in 1971 the same thing. In 1977, and every year since then there has been a discussion as to what the future of Puerto Rico will be. Then, finally, this year, for the first time in a long time, and a bill was passed here by one of our colleagues, sponsored by one of our colleagues on the Republican side, the gentleman from Alaska (Mr. YOUNG), which would allow the choice between the present commonwealth, statehood or independence.

The bill was supported and is supported by those who support statehood; it is supported by those who support independence; it is not supported by the Commonwealth Party, because

they feel that in no way does it really speak to what they wish to be. What the bill does is speak to what we are, to what Puerto Rico is, to what the relationship is, and therein lies the problem.

The United States has spent, our country has spent a lot of time and a lot of energy basically suggesting to the world what democratic principles they should follow, and I think that there is not a single person listening or watching us that does not agree that we have a role to play in promoting democracy throughout the world.

I think the big question we have to ask ourselves, and especially the younger people in this country who will be around for a long, long time have to ask is, is it right for this country on one hand to preach democracy throughout the world and on the other hand hold for 100 years tomorrow a colony, a territory in the Caribbean. For the Puerto Rican community, the pain goes deeper. Before these 100 years which will be culminated tomorrow, we spent 405 years with Spain. That is 505 years of a colonial status, the longest running colony in the world.

Now, understand that our government, for the first time in passing the bill on the House floor, admitted in legislation, in writing that Puerto Rico, in fact, was a territory of the United States. For years we have been telling the U.N. that we were something else. No, Puerto Rico is a commonwealth that has a special understanding. Look, it is very simple. If you do not have the same rights other American citizens have, you can call it what you want, it is not a state, it is not an independent nation, it is a colony.

Why should this be important to all Americans? Why should all Americans be concerned with this issue? Well, because we have invaded Puerto Rico, Puerto Rico did not invade us, so we have to eventually come to a conclusion on this subject.

Secondly, one cannot have nearly 4 million, 3.8 American citizens living in Puerto Rico not enjoying the same rights that other Americans have.

□ 1630

So I think the time has come, and perhaps that is what this observance will begin tomorrow. For this Congress, for this Senate, for the American people, for the American media to become aware of the issue and begin to discuss the possibility of finding a solution.

For this Congressman, the solution is very simple. Either we take Puerto Rico in as the 51st State of the Union, or we grant them, work with them on attaining full independence.

I believe, unlike some of my colleagues and unlike some people on the island or in the Puerto Rican communities in the United States, I believe that the Puerto Rican people on the island are fully equipped, talented enough, and intelligent enough to be the 51st State of the Union. I also believe that those folks are talented enough, educated enough, to be a successful independent Nation.

What they should not continue to be is a people in limbo. And we should not continue to profess to be the safekeepers of democracy and democratic principles and allow that situation to exist.

On many occasions on this House Floor I mix, to the dismay of some of my colleagues, I relate the issues of Cuba and Puerto Rico. People say what is the relationship? Well, the relationship is very simple. We spend a lot of time and energy demanding, quote-unquote, democratic changes in Cuba. How will those democratic changes satisfy us? If they become the kind of changes which allow for people to vote and deal with the issues. That is what we claim.

Well, the same thing has to happen in Puerto Rico. And tomorrow as people observe, lament, or celebrate this relationship, I think it is important that we Americans take a step back and analyze what role, if any, we want to play in this issue.

I do not think, in all honesty, that the American educational system on this issue has done the job it should do. I know for a fact that not enough time is taken, not enough energy is expended, not enough resources, if any, are spent on dealing with this issue in our school system. To educate young people to the fact that we have this situation.

There are, of course, concerns. Most people in this Congress are concentrating on the issue of statehood and they will not move on the issue of Puerto Rico because they are dealing with the issue of statehood.

Mr. Speaker, I said a few seconds ago that the issue could be independence. It does not have to be statehood. Either way, it has to be solved and the problem is that too many people spend too much time determining what kind of a state Puerto Rico would be.

I have two things to say about that. One is if we do not want a state that looks and sounds and acts like Puerto Rico, independence is the solution. Just do that. But if we are now going to question Puerto Ricans to see what kind of good American citizens they would make, it might be 100 years too late. After all, not a single Puerto Rican was question on the issue of language when he was sent off to World War I, World War II, Korea, Vietnam, the Gulf War. That was never a question. Now that has become a question.

Do Puerto Ricans speak English? Should we have a state where the majority of the people do not speak English? I hate to tell my colleagues, but there are states in this country where a majority of people who do not speak English. They speak an English, but the English that they have been speaking for a while now has been badly put together.

We could easily suggest that the time for the relationship has come to a point where it is time that we solve it simply by taking an up-or-down vote, independence or statehood, and not play with anything in between, and I mean that.

This present status is neither here nor there, neither for us or for the people who live in Puerto Rico. It is an unfair status for us, because we should not have a colony in the Caribbean. And it is an unfair status for the people in Puerto Rico, because they should take their place in the world as a free Nation or take the place as a State of the Union.

And so I am hopeful, Mr. Speaker, that as we continue to deliberate on this issue, and as the news media covers the fact that tomorrow there will be everything, as I said, from laments to celebration, from joy to sadness, from demonstrations to joyous exuberant demonstrations that we will see on TV and in the newspapers. We will see pictures and video of people celebrating their citizenship and people questioning what kind of citizenship they have. We will see people in Puerto Rico and in the New York community and other Puerto Rican communities throughout the Nation showing glee at the fact that we have reached 100 years with the U.S., and we will also see people lamenting the fact that we have spent these 100 years in this kind of a condition.

Mr. Speaker, I think it is important for all Americans to try to reach a point. So I would hope that all Americans begin to speak to their representatives and to tell them that we have to solve this situation. I would hope that within the next few years, Puerto Rico and the United States can reach an agreement. An agreement to either bring it in as the 51st state, or to grant it independence. Nothing else is acceptable.

The present status is embarrassing to us. It is embarrassing to the Puerto Rican people. It is wrong. It is unfair.

I can think back, and I will close with this, Mr. Speaker. I can think back to my father and to my mother. They came to New York from Puerto Rico. He, with 2 years of school, and my mother with 6 years of school. They came in 1950, and they brought up my brother and me, my brother Eli and me.

They always told us to do everything that good families do. To work hard, obey the law, to study, and to be good citizens. But those two folks, as much lacking formal education as they were, were always very much aware of the fact that there was something wrong with the relationship and that they would always tell us that that relationship some day had to come to a conclusion.

They are no longer with me. They were not here on March 28, 1990, 38 years exactly to the date when they came from Puerto Rico, when I was elected to Congress and got sworn in. And, in fact, I held my swearing in. I asked then Speaker Foley to swear me

in a day after I was supposed to, so that I could pay tribute to their arrival in New York and their fight to create a community and create a family and to celebrate my accomplishment in their honor.

They always told us that this had to be settled somehow. Tomorrow, as we commemorate the 100th year anniversary, I think it behooves the United States Congress to move ahead and create a better situation for itself and for Puerto Rico. To do anything else would be a shame. To do anything else would be an undemocratic act.

CONFERENCE REPORT ON H.R. 4059

Mr. PACKARD submitted the following conference report and statement on the bill (H.R. 4059) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes:

CONFERENCE REPORT (H. REPT. 105–647)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4059) ''making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes'', having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for military construction, family housing, and base realignment and closure functions administered by the Department of Defense, for the fiscal year ending September 30, 1999, and for other purposes, namely:

MILITARY CONSTRUCTION, ARMY

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Army as currently authorized by law, including personnel in the Army Corps of Engineers and other personal services necessary for the purposes of this appropriation, and for construction and operation of facilities in support of the functions of the Commander in Chief, $868,726,000, to remain available until September 30, 2003: Provided, That of this amount, not to exceed $64,269,000 shall be available for study, planning, design, architect and engineer services, and host nation support, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, NAVY

For acquisition, construction, installation, and equipment of temporary or permanent public works, naval installations, facilities, and real property for the Navy as currently authorized by law, including personnel in the Naval Facilities Engineering Command and other personal services necessary for the purposes of this appropriation, $604,593,000, to remain available until September 30, 2003: Provided, That of this amount, not to exceed $60,846,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, AIR FORCE

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Air Force as currently authorized by law, $615,809,000, to remain available until September 30, 2003: Provided, That of this amount, not to exceed $38,092,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, DEFENSE-WIDE

(INCLUDING TRANSFER OF FUNDS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, installations, facilities, and real property for activities and agencies of the Department of Defense (other than the military departments), as currently authorized by law, $553,114,000, to remain available until September 30, 2003: Provided, That such amounts of this appropriation as may be determined by the Secretary of Defense may be transferred to such appropriations of the Department of Defense available for military construction or family housing as he may designate, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation or fund to which transferred: Provided further, That of the amount appropriated, not to exceed $26,005,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

DEPARTMENT OF DEFENSE MILITARY UNACCOMPANIED HOUSING IMPROVEMENT FUND

(RESCISSION OF FUNDS)

Of the funds appropriated for ''Department of Defense Military Unaccompanied Housing Improvement Fund'' under Public Law 104–196, $5,000,000 is hereby rescinded.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $142,403,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, AIR NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $169,801,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, ARMY RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $102,119,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, NAVAL RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the reserve components of the Navy and Marine Corps as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $31,621,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, AIR FORCE RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air Force Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $34,371,000, to remain available until September 30, 2003.

NORTH ATLANTIC TREATY ORGANIZATION SECURITY INVESTMENT PROGRAM

For the United States share of the cost of the North Atlantic Treaty Organization Security Investment Program for the acquisition and construction of military facilities and installations (including international military headquarters) and for related expenses for the collective defense of the North Atlantic Treaty Area as authorized in Military Construction Authorization Acts and section 2806 of title 10, United States Code, $154,000,000, to remain available until expended.

FAMILY HOUSING, ARMY

For expenses of family housing for the Army for construction, including acquisition, replacement, addition, expansion, extension and alteration and for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, as follows: for Construction, $135,290,000, to remain available until September 30, 2003; for Operation and Maintenance, and for debt payment, $1,094,697,000; in all $1,229,987,000.

FAMILY HOUSING, NAVY AND MARINE CORPS

For expenses of family housing for the Navy and Marine Corps for construction, including acquisition, replacement, addition, expansion, extension and alteration and for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, as follows: for Construction, $295,590,000, to remain available until September 30, 2003; for Operation and Maintenance, and for debt payment, $912,293,000; in all $1,207,883,000.

FAMILY HOUSING, AIR FORCE

For expenses of family housing for the Air Force for construction, including acquisition, replacement, addition, expansion, extension and alteration and for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, as follows: for Construction, $280,965,000, to remain available until September 30, 2003; for Operation and Maintenance, and for debt payment, $783,204,000; in all $1,064,169,000.

FAMILY HOUSING, DEFENSE-WIDE

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for construction, including acquisition, replacement, addition, expansion, extension and alteration, and for operation and maintenance, leasing, and minor construction, as authorized by law, as follows: for Construction, $345,000, to remain available until September 30, 2003; for Operation and Maintenance, $36,899,000; in all $37,244,000.

DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND

For the Department of Defense Family Housing Improvement Fund, $2,000,000, to remain available until expended, as the sole source of

funds for planning, administrative, and oversight costs incurred by the Housing Revitalization Support Office relating to military family housing initiatives undertaken pursuant to 10 U.S.C. 2883, pertaining to alternative means of acquiring and improving military family housing and supporting facilities.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III

For deposit into the Department of Defense Base Closure Account 1990 established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991 (Public Law 101–510), $427,164,000, to remain available until expended: Provided, That not more than $271,800,000 of the funds appropriated herein shall be available solely for environmental restoration, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV

For deposit into the Department of Defense Base Closure Account 1990 established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991 (Public Law 101–510), $1,203,738,000, to remain available until expended: Provided, That not more than $426,036,000 of the funds appropriated herein shall be available solely for environmental restoration, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

GENERAL PROVISIONS

SEC. 101. None of the funds appropriated in Military Construction Appropriations Acts shall be expended for payments under a cost-plus-a-fixed-fee contract for construction, where cost estimates exceed $25,000, to be performed within the United States, except Alaska, without the specific approval in writing of the Secretary of Defense setting forth the reasons therefor.

SEC. 102. Funds appropriated to the Department of Defense for construction shall be available for hire of passenger motor vehicles.

SEC. 103. Funds appropriated to the Department of Defense for construction may be used for advances to the Federal Highway Administration, Department of Transportation, for the construction of access roads as authorized by section 210 of title 23, United States Code, when projects authorized therein are certified as important to the national defense by the Secretary of Defense.

SEC. 104. None of the funds appropriated in this Act may be used to begin construction of new bases inside the continental United States for which specific appropriations have not been made.

SEC. 105. No part of the funds provided in Military Construction Appropriations Acts shall be used for purchase of land or land easements in excess of 100 percent of the value as determined by the Army Corps of Engineers or the Naval Facilities Engineering Command, except: (1) where there is a determination of value by a Federal court; or (2) purchases negotiated by the Attorney General or his designee; or (3) where the estimated value is less than $25,000; or (4) as otherwise determined by the Secretary of Defense to be in the public interest.

SEC. 106. None of the funds appropriated in Military Construction Appropriations Acts shall be used to: (1) acquire land; (2) provide for site preparation; or (3) install utilities for any family housing, except housing for which funds have been made available in annual Military Construction Appropriations Acts.

SEC. 107. None of the funds appropriated in Military Construction Appropriations Acts for minor construction may be used to transfer or relocate any activity from one base or installation to another, without prior notification to the Committees on Appropriations.

SEC. 108. No part of the funds appropriated in Military Construction Appropriations Acts may be used for the procurement of steel for any construction project or activity for which American steel producers, fabricators, and manufacturers have been denied the opportunity to compete for such steel procurement.

SEC. 109. None of the funds available to the Department of Defense for military construction or family housing during the current fiscal year may be used to pay real property taxes in any foreign nation.

SEC. 110. None of the funds appropriated in Military Construction Appropriations Acts may be used to initiate a new installation overseas without prior notification to the Committees on Appropriations.

SEC. 111. None of the funds appropriated in Military Construction Appropriations Acts may be obligated for architect and engineer contracts estimated by the Government to exceed $500,000 for projects to be accomplished in Japan, in any NATO member country, or in countries bordering the Arabian Gulf, unless such contracts are awarded to United States firms or United States firms in joint venture with host nation firms.

SEC. 112. None of the funds appropriated in Military Construction Appropriations Acts for military construction in the United States territories and possessions in the Pacific and on Kwajalein Atoll, or in countries bordering the Arabian Gulf, may be used to award any contract estimated by the Government to exceed $1,000,000 to a foreign contractor: Provided, That this section shall not be applicable to contract awards for which the lowest responsive and responsible bid of a United States contractor exceeds the lowest responsive and responsible bid of a foreign contractor by greater than 20 percent: Provided further, That this section shall not apply to contract awards for military construction on Kwajalein Atoll for which the lowest responsive and responsible bid is submitted by a Marshallese contractor.

SEC. 113. The Secretary of Defense is to inform the appropriate committees of Congress, including the Committees on Appropriations, of the plans and scope of any proposed military exercise involving United States personnel thirty days prior to its occurring, if amounts expended for construction, either temporary or permanent, are anticipated to exceed $100,000.

SEC. 114. Not more than 20 percent of the appropriations in Military Construction Appropriations Acts which are limited for obligation during the current fiscal year shall be obligated during the last two months of the fiscal year.

(TRANSFER OF FUNDS)

SEC. 115. Funds appropriated to the Department of Defense for construction in prior years shall be available for construction authorized for each such military department by the authorizations enacted into law during the current session of Congress.

SEC. 116. For military construction or family housing projects that are being completed with funds otherwise expired or lapsed for obligation, expired or lapsed funds may be used to pay the cost of associated supervision, inspection, overhead, engineering and design on those projects and on subsequent claims, if any.

SEC. 117. Notwithstanding any other provision of law, any funds appropriated to a military department or defense agency for the construction of military projects may be obligated for a military construction project or contract, or for any portion of such a project or contract, at any time before the end of the fourth fiscal year after the fiscal year for which funds for such project were appropriated if the funds obligated for such project: (1) are obligated from funds available for military construction projects and (2) do not exceed the amount appropriated for such project, plus any amount by which the cost of such project is increased pursuant to law.

(TRANSFER OF FUNDS)

SEC. 118. During the five-year period after appropriations available to the Department of Defense for military construction and family housing operation and maintenance and construction have expired for obligation, upon a determination that such appropriations will not be necessary for the liquidation of obligations or for making authorized adjustments to such appropriations for obligations incurred during the period of availability of such appropriations, unobligated balances of such appropriations may be transferred into the appropriation ''Foreign Currency Fluctuations, Construction, Defense'' to be merged with and to be available for the same time period and for the same purposes as the appropriation to which transferred.

SEC. 119. The Secretary of Defense is to provide the Committees on Appropriations of the Senate and the House of Representatives with an annual report by February 15, containing details of the specific actions proposed to be taken by the Department of Defense during the current fiscal year to encourage other member nations of the North Atlantic Treaty Organization, Japan, Korea, and United States allies bordering the Arabian Gulf to assume a greater share of the common defense burden of such nations and the United States.

(TRANSFER OF FUNDS)

SEC. 120. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, proceeds deposited to the Department of Defense Base Closure Account established by section 207(a)(1) of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526) pursuant to section 207(a)(2)(C) of such Act, may be transferred to the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to be merged with, and to be available for the same purposes and the same time period as that account.

SEC. 121. No funds appropriated pursuant to this Act may be expended by an entity unless the entity agrees that in expending the assistance the entity will comply with sections 2 through 4 of the Act of March 3, 1933 (41 U.S.C. 10a–10c, popularly known as the ''Buy American Act'').

SEC. 122. (a) In the case of any equipment or products that may be authorized to be purchased with financial assistance provided under this Act, it is the sense of the Congress that entities receiving such assistance should, in expending the assistance, purchase only American-made equipment and products.

(b) In providing financial assistance under this Act, the Secretary of the Treasury shall provide to each recipient of the assistance a notice describing the statement made in subsection (a) by the Congress.

(TRANSFER OF FUNDS)

SEC. 123. Subject to thirty days prior notification to the Committees on Appropriations, such additional amounts as may be determined by the Secretary of Defense may be transferred to the Department of Defense Family Housing Improvement Fund from amounts appropriated for construction in ''Family Housing'' accounts, to be merged with and to be available for the same purposes and for the same period of time as amounts appropriated directly to the Fund: Provided, That appropriations made available to the Fund shall be available to cover the costs, as defined in section 502(5) of the Congressional Budget Act of 1974, of direct loans or loan guarantees issued by the Department of Defense pursuant to the provisions of subchapter IV of chapter 169, title 10, United States Code, pertaining to alternative means of acquiring and improving military family housing and supporting facilities.

SEC. 124. None of the funds appropriated or made available by this Act may be obligated for Partnership for Peace Programs or to provide support for non-NATO countries.

SEC. 125. Payments received by the Secretary of the Navy pursuant to subsection (b)(1) of section 2842 of the National Defense Authorization Act, 1993 (Public Law 102–484) are appropriated and shall be available for the purpose authorized in subsection (d) of that section.

SEC. 126. (a) Not later than 60 days before issuing any solicitation for a contract with the private sector for military family housing, the Secretary of the military department concerned shall submit to the congressional defense committees the notice described in subsection (b).

(b)(1) A notice referred to in subsection (a) is a notice of any guarantee (including the making of mortgage or rental payments) proposed to be made by the Secretary to the private party under the contract involved in the event of—

(A) the closure or realignment of the installation for which housing is provided under the contract;

(B) a reduction in force of units stationed at such installation; or

(C) the extended deployment overseas of units stationed at such installation.

(2) Each notice under this subsection shall specify the nature of the guarantee involved and assess the extent and likelihood, if any, of the liability of the Federal Government with respect to the guarantee.

(c) In this section, the term ''congressional defense committees'' means the following:

(1) The Committee on Armed Services and the Military Construction Subcommittee, Committee on Appropriations of the Senate.

(2) The Committee on National Security and the Military Construction Subcommittee, Committee on Appropriations of the House of Representatives.

(TRANSFER OF FUNDS)

SEC. 127. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, amounts may be transferred from the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to the fund established by section 1013(d) of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3374) to pay for expenses associated with the Homeowners Assistance Program. Any amounts transferred shall be merged with and be available for the same purposes and for the same time period as the fund to which transferred.

SEC. 128. It is the sense of the Congress that the Secretary of the Army should name the ''All American Parkway'' at Fort Bragg, North Carolina, as the ''W.G. 'Bill' Hefner All American Parkway''.

This Act may be cited as the ''Military Construction Appropriations Act, 1999''.

And the Senate agree to the same.

RON PACKARD,
JOHN EDWARD PORTER,
DAVID L. HOBSON,
ROGER F. WICKER,
JACK KINGSTON,
MIKE PARKER,
TODD TIAHRT,
ZACH WAMP,
BOB LIVINGSTON,
W.G. (BILL) HEFNER,
JOHN W. OLVER,
CHET EDWARDS,
BUD CRAMER,
NORMAN DICKS,
DAVID OBEY,
Managers on the Part of the House.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4059) making appropriations for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes, submit the following joint statement to the House of Representatives and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report.

The Senate deleted the entire House bill after the enacting clause and inserted the Senate bill (S. 2160). The conference agreement includes a revised bill.

ITEMS OF GENERAL INTEREST

Matters Addressed by Only One Committee.—The language and allocations set forth in House Report 105–578 and Senate Report 105–213 should be complied with unless specifically addressed to the contrary in the conference report and statement of the managers. Report language included by the House which is not changed by the report of the Senate or the conference, and Senate report language which is not changed by the conference is approved by the committee of conference. The statement of the managers, while repeating some report language for emphasis, does not intend to negate the language referred to above unless expressly provided herein. In cases in which the House or the Senate have directed the submission of a report from the Department of Defense, such report is to be submitted to both House and Senate Committees on Appropriations.

Financial Management.—The conferees agree that general reductions included in the conference agreement are based on such factors as savings through favorable bids, reduced overhead costs, downsizing or cancellation due to force structure changes (if any), other administrative cost reduction initiatives, revised economic assumptions, and inflation re-estimates. The conferees direct that no project for which funds were previously appropriated, or for which funds are appropriated in this bill, may be cancelled as a result of general reductions included in the conference agreement.

The conference agreement includes reductions totaling $21,300,000 which result from re-estimation of inflation undertaken by the Office of Management and Budget as part of the mid-session review of the budget request. The conferees direct the Department to distribute these reductions proportionally against each project and activity in each account, as follows:

Reductions resulting from economic assumptions in OMB's mid-session review of the budget request

Account	*Amount*
Military Construction, Army	$2,000,000
Military Construction, Navy	1,000,000
Military Construction, Air Force	1,000,000
Military Construction, Defense-wide	1,300,000
NATO Security Investment Program	1,000,000
Family Housing Operations, Army	3,000,000
Family Housing Construction, Navy	1,000,000
Family Housing Operations, Navy	3,000,000
Family Housing Construction, Air Force	1,000,000
Family Housing Operations, Air Force	2,000,000
Base Realignment and Closure, Part III	2,000,000
Base Realignment and Closure, Part IV	3,000,000
	$21,300,000

Real Property Maintenance: Reporting Requirement.—The conferees agree to the following general rules for repairing a facility under Operation and Maintenance account funding:

Components of the facility may be repaired by replacement, and such replacement can be up to current standards or codes.

Interior arrangements and restorations may be included as repair, but additions, new facilities, and functional conversions must be performed as military construction projects.

Such projects may be done concurrent with repair projects, as long as the final conjunctively funded project is a complete and usable facility.

The appropriate Service Secretary shall submit a 21-day notification prior to carrying out any repair project with an estimated cost in excess of $10,000,000.

MILITARY CONSTRUCTION, ARMY

The conference agreement appropriates $868,726,000 for Military Construction, Army, instead of $780,599,000 as proposed by the House, and $810,476,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $64,269,000 for study, planning, design, architect and engineer services, and host nation support instead of $63,792,000 as proposed by the House and $67,269,000 as proposed by the Senate.

Kentucky—Fort Campbell: Sabre Heliport.—The conferees recognize the critical importance of the Sabre Heliport to military operations at Fort Campbell and understand that this facility needs essential renovations in order to operate both safely and efficiently. The U.S. Army Aeronautical Services Agency (USAASA) has issued a temporary waiver that allows the facility to continue normal operations until April 2001. Accordingly, the conferees direct the Secretary of the Army to report to the congressional defense committees not later than January 15, 1999, on their plan and timetable to make the necessary airfield improvements.

New York—Fort Drum: Consolidated Soldier/Family Support Center.—The conferees have deferred funding for this project, without prejudice, and the Army is encouraged to include this project in the budget request for fiscal year 2000.

Unspecified Minor Construction.—Within the increased funds appropriated above the budget request for Army, Unspecified Minor Construction, the Army is directed to provide the needed athletic facilities, such as ball fields and a running track, at Camp McGovern, Bosnia-Herzegovina.

MILITARY CONSTRUCTION, NAVY

The conference agreement appropriates $604,593,000 for Military Construction, Navy, instead of $570,643,000 as proposed by the House, and $565,030,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $60,846,000 for study, planning, design, architect and engineer services instead of $60,346,000 as proposed by the House and $62,146,000 as proposed by the Senate.

Florida—Key West Naval Air Station: Compatible Use Easements.—The conferees direct the Navy to report on the need for continuation of existing compatible use easements which prevent construction of facilities on privately owned land in connection with the operation of the Key West Naval Air Station. This report is to be submitted within 30 days of enactment of this Act.

MILITARY CONSTRUCTION, AIR FORCE

The conference agreement appropriates $615,809,000 for Military Construction, Air Force, instead of $550,475,000 as proposed by the House, and $627,874,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $38,092,000 for study, planning, design, architect and engineer services instead of $37,592,000 as proposed by

the House and $39,522,000 as proposed by the Senate.

California—Beale AFB: Flightline Fire Station.—The conferees direct the Air Force to accelerate design and to include this project in the budget request for fiscal year 2000.

Kansas—McConnell AFB: KC–135 Squadron Operations/Aircraft Maintenance Unit #3.—The conferees direct the Air Force to accelerate design and to include this project in the budget request for fiscal year 2000.

New York—Rome Labs: Consolidated Intelligence and Reconnaissance Laboratory.—The conferees direct the Air Force to accelerate the design of the Consolidated Intelligence and Reconnaissance Research Site at the Department's Rome Laboratory in New York and include this project in its fiscal year 2000 Military Construction budget request.

MILITARY CONSTRUCTION, DEFENSE-WIDE

The conference agreement appropriates $553,114,000 for Military Construction, Defense-wide, instead of $611,075,000 as proposed by the House, and $571,485,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $26,005,000 for study, planning, design, architect and engineer services instead of $24,866,000 as proposed by the House and $25,066,000 as proposed by the Senate.

Chemical Demilitarization Program.—The conference agreement includes full funding of all requested projects related to the chemical demilitarization program, and also includes a general reduction of $50,500,000 against the entire program based on unobligated prior year funds, delays in obtaining the required environmental and construction permits, and possible delays in equipment delivery.

Energy Conservation Investment Program.—In future budget submissions, the conferees expect project-level information on the Energy Conservation Investment Program (ECIP) to be presented in tabular form, rather than in Form 1391 detail.

MILITARY UNACCOMPANIED HOUSING IMPROVEMENT FUND

Military Unaccompanied Housing Improvement Fund.— The conferees agree to rescind $5,000,000 from the Military Unaccompanied Housing Improvement Fund. The House and Senate bills had no similar provision. This rescinds the full unobligated balance of funds, due to the absence of any programmed or anticipated projects under this account.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

The conference agreement appropriates $142,403,000 for Military Construction, Army National Guard, instead of $70,338,000 as proposed by the House, and $124,599,000 as proposed by the Senate.

Iowa-Camp Dodge: Damaged and Destroyed Facilities.—The conferees direct the National Guard Bureau to report on tornado and wind damage sustained on June 29, 1998. This report is to be submitted within 30 days of enactment of this Act, and is to include an assessment of requirements for repair and replacement.

Montana—Fort Harrison: Sewer System.—The conferees agree to grant the Army National Guard reprogramming approval up to the amount of $1,200,000 to cover the Army National Guard's contribution for connecting the Fort Harrison complex to the city sewer system, subject to approval of the proposed source of funds.

Montana—Helena: Armed Forces Reserve Center.—The conferees direct that the total funding provided for this facility shall include the purchase and installation of prewired workstations and furnishings.

North Carolina—Fort Bragg: Military Education Facility.—The conferees recognize the importance of the Military Education Facility to the Army National Guard and direct the National Guard Bureau to begin the planning and design and site preparation for this National Guard facility. The conferees direct the Department to include this project in the Future Year Defense Plan (FYDP).

MILITARY CONSTRUCTION, AIR NATIONAL GUARD

The conference agreement appropriates $169,801,000 for Military Construction, Air National Guard, instead of $97,701,000 as proposed by the House, and $163,161,000 as proposed by the Senate.

California—Moffett Federal Airfield: Composite Maintenance Hangar.—The conferees acknowledge the urgent and compelling need to replace the existing World War II facility at Moffett Federal Airfield and encourage the Department to include this project in the fiscal year 2000 budget request.

Georgia—Savannah IAP: Composite Support Complex.—The conferees direct the Air National Guard to include this project in the budget request for fiscal year 2000, as programmed in the Future Year Defense Plan submitted in support of the fiscal year 1999 budget.

MILITARY CONSTRUCTION, ARMY RESERVE

The conference agreement appropriates $102,119,000 for Military Construction, Army Reserve, instead of $71,894,000 as proposed by the House, and $114,349,000 as proposed by the Senate.

Utah—Salt Lake City: U.S. Army Reserve Center (Phase II).—The conferees agree to provide $5,076,000 as the second and final funding phase for a U.S. Army Reserve Center / Organizational Maintenance Shop / Direct Support-General Support Facilities / Equipment Concentration Site. Together with $12,714,000 appropriated in fiscal year 1998 as the first funding phase, this provides a total of $17,790,000 for this project.

MILITARY CONSTRUCTION, NAVAL RESERVE

The conference agreement appropriates $31,621,000 for Military Construction, Naval Reserve, instead of $33,721,000 as proposed by the House, and $21,621,000 as proposed by the Senate.

MILITARY CONSTRUCTION, AIR FORCE RESERVE

The conference agreement appropriates $34,371,000 for Military Construction, Air Force Reserve, instead of $35,371,000 as proposed by the House, and $22,835,000 as proposed by the Senate.

NORTH ATLANTIC TREATY ORGANIZATION SECURITY INVESTMENT PROGRAM

The conference agreement appropriates $154,000,000 for the North Atlantic Treaty Organization Security Investment Program (NSIP), instead of $169,000,000 as proposed by the House, and $152,600,000 as proposed by the Senate.

North Atlantic Treaty Organization Security Investment Program Funds.—The conferees agree to a provision renumbered Section 124, proposed by the Senate, which prohibits the use of NSIP funds for any aspect of the Partnership for Peace Program or support to non-NATO countries. The President's budget request for fiscal year 1999 included $56,900,000 for the Department of Defense and an additional $80,000,000 of foreign military financing, administered by the Department of State, for the Partnership for Peace Program. The proposed funding level should provide sufficient resources for any expansion initiatives anticipated by the Administration.

FAMILY HOUSING—OVERVIEW

Reprogramming Criteria.—The reprogramming criteria that apply to military construction projects (25 percent of the funded amount or $2,000,000, whichever is less) also apply to new housing construction projects and to improvement projects over $2,000,000.

Family Housing Operation and Maintenance.—The conferees direct that the details of all expenditures from the Family Housing Operation and Maintenance accounts which exceed $20,000 per unit, per year for major maintenance and repair of non-general and flag officer quarters be included as part of the budget justification material.

Exclusion of Costs Associated with Environmental Hazard Remediation from Maintenance and Repair Limits.—The conferees revise the requirement for an after-the-fact notification for projects when the costs associated with environmental hazard remediation such as asbestos removal, radon abatement, lead-based paint removal or abatement, and any other legislated environmental hazard remediation cause the maintenance and repair thresholds of $20,000 for a military family housing unit, or $25,000 for a General or Flag Officer Quarter to be exceeded. The notification shall include work, scope, cost breakout and other details pertinent to the environmental hazard remediation and shall be reported on a semi-annual basis. An after-the-fact notification is acceptable provided that such remediation requirements could not be reasonably anticipated at the time of the budget submission. This exclusion applies to projects appropriated in this budget year, and also projects appropriated in prior years for which construction contracts have not been completed.

FAMILY HOUSING, ARMY

The conference agreement appropriates $135,290,000 for Construction, Family Housing, Army, instead of $82,840,000 as proposed by the House and $124,490,000 as proposed by the Senate.

The conferees direct that the following projects are to be accomplished within the increased amount provided for construction improvements:

Alaska-Fort Richardson (40 units)	$7,400,000
Kentucky-Fort Campbell (104 units)	8,800,000
New Mexico-White Sands Missile Range (36 units)	3,650,000

The conference agreement appropriates $1,094,697,000 for Operation and Maintenance, Family Housing, Army, instead of $1,097,697,000 as proposed by the House and $1,104,733,000 as proposed by the Senate.

The conference agreement appropriates a total of $1,229,987,000 for Family Housing, Army, instead of $1,180,537,000 as proposed by the House and $1,229,223,000 as proposed by the Senate.

FAMILY HOUSING, NAVY AND MARINE CORPS

The conference agreement appropriates $295,590,000 for Construction, Family Housing, Navy and Marine Corps, instead of $130,457,000 as proposed by the House and $286,590,000 as proposed by the Senate.

The conferees direct that the following projects are to be accomplished within the increased amount provided for construction improvements:

California—Camp Pendleton (171 units)	$10,000,000
Washington—Whidbey Island NAS (80 units)	5,800,000

The conference agreement appropriates $912,293,000 for Operation and Maintenance, Family Housing, Navy and Marine Corps, instead of $915,293,000 as proposed by the House and Senate.

The conference agreement appropriates a total of $1,207,883,000 for Family Housing, Navy and Marine Corps, instead of $1,045,750,000 as proposed by the House and $1,201,883,000 as proposed by the Senate.

Washington—Naval Station Puget Sound, Everett: Real Property Conveyance.—Section 125 of this Act provides an appropriation of

$6,000,000 in proceeds from the sale of land and family housing units at Paine Field. This funding shall be used for the acquisition of land and/or housing units in the vicinity of, or for, Naval Station Everett as authorized in Section 2842 of Public Law 102–484.

FAMILY HOUSING, AIR FORCE

The conference agreement appropriates $280,965,000 for Construction, Family Housing, Air Force, instead of $207,880,000 as proposed by the House and $297,475,000 as proposed by the Senate.

The conferees direct that the following projects are to be accomplished within the increased amount provided for construction improvements:

Georgia—Moody AFB (68 units)	$5,220,000
North Carolina—Seymour Johnson AFB (70 units)	8,000,000
South Carolina—Charleston AFB (94 units)	9,110,000

The conference agreement appropriates $783,204,000 for Operation and Maintenance, Family Housing, Air Force, instead of $785,204,000 as proposed by the House and $789,995,000 as proposed by the Senate.

The conference agreement appropriates a total of $1,064,169,000 for Family Housing, Air Force, instead of $993,084,000 as proposed by the House and $1,087,470,000 as proposed by the Senate.

FAMILY HOUSING, DEFENSE-WIDE

The conference agreement appropriates $345,000 for Construction, Family Housing, Defense-wide, as proposed by the House and Senate.

The conference agreement appropriates $36,899,000 for Operation and Maintenance, Family Housing, Defense-wide, as proposed by the House and Senate.

The conference agreement appropriates a total of $37,244,000 for Family Housing, Defense-wide, as proposed by the House and Senate.

DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND

The conference agreement appropriates $2,000,000 for the Department of Defense Family Housing Improvement Fund instead of $242,438,000 as proposed by the House and $7,000,000 as proposed by the Senate. The reduction from the level proposed by the House reflects full funding of construction projects and construction improvement projects in the traditional family housing accounts, rather than in the Family Housing Improvement Fund. Transfer authority is provided for the execution of any qualifying project under privatization authority which resides in the Fund.

The conferees note that the Housing Revitalization Support Office (HRSO) proposed to expend 90 percent of the $7,000,000 budget request for consultant support. Further, HRSO will expend $14,150,000 for consultant support for fiscal years 1996 through 1998, which represents 90 percent of all resources available for HRSO overhead. These expenditures for consultant services have not produced any contracts awarded under the 1996 privatization authorities.

The conferees support the Department's privatization efforts, and recommend an appropriation of $2,000,000 based on available balances and excessive allocation for consultant services.

The conferees continue to be concerned over the delay in execution of family housing construction projects for which funds have been appropriated, for possible privatization efforts. The new authorities were signed into law in February 1996, yet no new agreements have been finalized to build or renovate military family housing. Several projects are being considered, yet only one project, at Lackland AFB, is close to contract signing. The conferees strongly believe that the Department needs to use all available tools to address the family housing program in an optimum manner. This includes the traditional construction program, privatization, and adequate use of existing private sector housing. The conferees remind the Department that Congress approved the new privatization authorities as a pilot project, and that these authorities will expire on February 10, 2001. It was never the intent of the House and Senate Appropriations Committees for this program to become a substitute for the traditional housing construction program.

The conferees direct the Office of the Under Secretary of Defense for Acquisition and Technology to carefully review the planned privatization efforts and narrow the scope to a reasonable number of projects which may be executed prior to the expiration of the pilot project authority. The conferees expect to be notified on October 1, 1998, of a revised, scaled-back, reasonable plan for the privatization effort. In addition, the conferees anticipate that all prior year appropriated family housing construction projects which have been placed on hold will be released for construction at that time, unless specific justification is provided to Congress. Following the October 1st report, the Department is expected to report quarterly to the House and Senate Appropriations Committees on the status of all privatization efforts and the status of all family housing construction and construction improvement projects for which funds have been appropriated.

The conferees direct the Department to display all family housing construction and construction improvement projects which are anticipated for privatization as such in the fiscal year 2000 budget. This display should include a detailed plan of the time frame for execution of each privatization effort.

In addition, the Secretary of Defense is directed to report to the House and Senate Committees on Appropriations by December 1, 1998, on an integrated family housing strategy for the Department of Defense. This strategy should focus on the maximum use of existing civilian housing, the use of enhanced housing referral services, coordination of housing allowances, and appropriate use of privatization and traditional construction options. In particular, this report should include a detailed plan for integrating the DOD offices which have responsibilities for the military's family housing program. Responsibility for privatization and for construction, operation and maintenance lies with the Under Secretary of Defense for Acquisition and Technology. Appropriations for military-owned and leased family housing are included in the Services' family housing accounts. Responsibility for housing allowances is under the Under Secretary for Defense for Personnel and Readiness, and housing allowances are included in the Services' military personnel accounts. The conferees are concerned that privatization shifts funding from military family housing construction, operations, and maintenance accounts to military personnel accounts to pay for increased housing allowances, which are used to pay rent to developers of privatized housing. The conferees believe that this is not being coordinated by the Department, nor is it being budgeted for adequately. The conferees believe that in order to have a truly integrated family housing policy, these functions need to be overseen by one office within the Department.

The conferees request the Comptroller General to monitor the progress of the Department of Defense's and individual Services' implementation of the family housing privatization initiative. The monitoring of the program shall include, but not be limited to, obtaining information on the status of family housing projects, reviewing life-cycle costs analyses for projects, and determining whether the privatization initiative is being integrated and coordinated with the Department's other family housing programs. The conferees request that the Comptroller General keep the House and Senate Committees on Appropriations apprised of the progress and submit a report to the Congress no later than March 31, 2000.

HOMEOWNERS ASSISTANCE FUND, DEFENSE

The conference agreement appropriates no funds for the Homeowners Assistance Fund, Defense instead of $7,500,000 as proposed by the House and $12,800,000 as proposed by the Senate.

The conferees have included a new provision, Section 127, as proposed by the Senate, which allows the transfer of funds from the Base Realignment and Closure account into the Homeowners Assistance Fund, Defense. Any amounts transferred into the fund shall be available to pay for expenses associated with the program. Due to this transfer authority, the conferees believe a direct appropriation to this account for fiscal year 1999 is not necessary. The total estimated requirements for fiscal year 1999 are estimated at $109,735,000 and will be funded with transfer of appropriated funds, revenue from sales of acquired property and prior year unobligated balances. The Comptroller of the Department of Defense is to notify the House and Senate Subcommittees on Military Construction twenty-one days prior to the use of the transfer authority.

BASE REALIGNMENT AND CLOSURE—OVERVIEW

Construction Projects: Administrative Provision.—The conferees agree that any transfer of funds which exceeds reprogramming thresholds for any construction project financed by any Base Realignment and Closure Account shall be subject to a 21-day notification to the Committees, and shall not be subject to reprogramming procedure.

Construction Budget Data.—The conferees are concerned about the accuracy and reliability of the base realignment and closure (BRAC) construction budget data provided annually to the Congress. The Office of the Department of Defense Inspector General and the General Accounting Office recently found that the Services submitted BRAC military construction data in the fiscal years 1997 and 1998 military construction budgets based on overstated requirements and unsupported specifications and costs. They also found that the major commands of the Services did not effectively implement management control procedures established for the BRAC military construction planning, programming and budgeting process. This has resulted in overstated and invalid BRAC requirements and lack of supporting documentation. The conferees direct the Department to take the necessary corrective action to ensure that these deficiencies are corrected in the fiscal year 2000 budget submission.

Future Costs of Environmental Restoration.—The conferees direct the Department of Defense to submit a legislative proposal for the establishment of a Treasury account entitled ''Base Realignment and Closure Environmental Restoration'', rather than budgeting for future costs in the Operation and Maintenance accounts. The conferees direct that future costs for environmental restoration related to the four rounds of base closure conducted from 1988 through 1995 shall be programmed and budgeted in this new account.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III

The conference agreement appropriates $427,164,000 for the Base Realignment and

Closure Account, Part III instead of $433,464,000 as proposed by the House and Senate. Within the amount appropriated, the conference agreement earmarks $271,800,000 for environmental restoration, as proposed by the House and Senate.

Reprogramming Action.—The Committees have approved a reprogramming request which accelerated one construction project from fiscal year 1999 to fiscal year 1998, allowing the program to absorb a reduction of $4,300,000 from the budget request.

Revised Economic Assumptions.—As described earlier in this report, the conferees recommend a reduction of $2,000,000 from the budget request based on reestimation of inflation.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV

The conference agreement appropriates $1,203,738,000 for the Base Realignment and Closure Account, Part IV instead of $1,297,240,000 as proposed by the House and Senate. Within the amount appropriated, the conference agreement earmarks $426,036,000 for environmental restoration, as proposed by the House and Senate.

Reprogramming Actions.—The Committees have approved reprogramming requests which accelerated four construction projects from fiscal year 1999 to fiscal year 1998, allowing the program to absorb a reduction of $28,802,000 from the budget request.

Revised Economic Assumptions.—As described earlier in this report, the conferees recommend a reduction of $3,000,000 from the budget request based on reestimation of inflation.

Unreported Proceeds.—The Services have collected $35,700,000 more in proceeds from land sales and leases at closing or realigning bases than reported in the fiscal year 1999 budget request. Statutes and Department of Defense guidance state that proceeds from the transfer, lease, or disposal of property due to the Base Realignment and Closure process shall be deposited into the Base Closure Accounts. The conferees understand that, because such proceeds were collected after the development of the budget, the Air Force did not report $21,000,000 worth of proceeds, the Army did not report $3,900,000, and the Navy did not report $10,800,000. The conferees direct the Services to deposit these proceeds into the Base Realignment and Closure Account, and have reduced the Base Realignment and Closure Account, Part IV fiscal year 1999 appropriation by $35,700,000 to reflect this action.

Funds Previously Withheld.—The conferees recommend a reduction of $26,000,000 to the Base Realignment and Closure Account, Part IV. This reduction is based on funds that were previously withheld from obligation based on an inflation rate that was lower than expected. At the time the fiscal year 1999 budget was submitted to Congress, these funds were withheld from obligation, but have subsequently been made available. Thus, the budget request is overstated by $26,000,000.

Kentucky—Louisville Naval Ordnance Station: Environmental Restoration.—The conferees urge the Navy to pursue the feasibility for use of bioremediation technologies (such as treatment by microbes and plants) for cleanup of sub-surface contamination of soils and groundwater, and to utilize such technologies if they are proven to be cost-effective.

GENERAL PROVISIONS

The conference agreement includes general provisions that were in both the House and Senate versions of the bill that were not amended.

The conference agreement includes Section 101, as proposed by the House, prohibiting the expenditure of funds for payments under a cost-plus-a-fixed-fee contract for construction, where cost estimates exceeded $25,000, to be performed within the United States, except Alaska, without the specific approval in writing of the Secretary of Defense, instead of similar language as proposed by the Senate.

The conference agreement includes Section 105, as proposed by the House, which makes a technical correction to the word ''per centum'', instead of language as proposed by the Senate.

The conference agreement includes Section 112 as proposed by the House, which makes a technical correction to the word ''per centum'', instead of language as proposed by the Senate.

The conference agreement includes Section 114, as proposed by the House, which makes a technical correction to the word ''per centum'', instead of language as proposed by the Senate.

The conference agreement includes a provision, Section 121, as proposed by the House, which prohibits the expenditure of funds except in compliance with the Buy American Act. The Senate bill contained no similar provision.

The conference agreement includes a provision, Section 122, as proposed by the House, which states the Sense of the Congress notifying recipients of equipment or products authorized to be purchased with financial assistance provided in this Act to purchase American-made equipment and products. The Senate bill contained no similar provision.

The conference agreement includes a provision renumbered Section 123, as proposed by the Senate, permitting the transfer of funds from Family Housing, Construction accounts to the DOD Family Housing Improvement Fund, instead of language as proposed by the House.

The conference agreement includes a provision renumbered Section 124, as proposed by the Senate, stating that none of the funds appropriated or made available by this Act may be obligated for Partnership for Peace Programs or to provide support for non-NATO countries.

The conference agreement includes a provision renumbered Section 127, as proposed by the Senate, providing transfer authority from the Base Realignment and Closure (BRAC) accounts to the Homeowners Assistance Program (HAP). The House bill contained no similar provision.

The conference agreement includes a provision renumbered Section 128, as proposed by the House, stating that it is the sense of the Congress that the Secretary of the Army should name the ''All American Parkway'' at Fort Bragg, North Carolina, as the ''W.G. ''Bill'' Hefner All American Parkway''.

Those general provisions that were not included in the conference agreement follow:

The conference agreement deletes the Senate provision stating that the sole source of funds for planning, administrative, and oversight costs incurred by the Housing Revitalization Support Office must come from the DOD Family Housing Improvement Fund. This provision is included in the appropriations paragraph for the ''Department of Defense Family Housing Improvement Fund'' as proposed in the House bill.

The conference agreement deletes the Senate provision increasing the ''Military Construction, Army National Guard'' appropriation and decreasing the ''Military Construction, Army Reserve'' appropriation. The House bill contained no similar provision.

The conference agreement deletes the Senate provision increasing the ''Military Construction, Navy'' appropriation and the ''Family Housing, Air Force'' appropriation and decreasing the ''Military Construction, Defense-wide'' appropriation. The House bill contained no similar provision.

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
ALABAMA		
ARMY		
ANNISTON ARMY DEPOT		
AMMUNITION CONTAINERIZATION COMPLEX	3,550	3,550
FORT RUCKER		
AVIATION WARFIGHTING SIMULATION CENTER	---	10,000
PROVOST MARSHAL/FIRE STATION COMPLEX	---	4,300
REDSTONE ARSENAL		
AIRFIELD OPERATIONS CENTER	---	1,550
MISSILE SOFTWARE ENGINEERING ANNEX (PHASE II)	13,600	13,600
AIR FORCE		
MAXWELL AFB		
FIRE TRAINING FACILITY	1,837	1,837
OFFICER TRAINING SCHOOL DINING FACILITY	4,796	4,796
OFFICER TRAINING SCHOOL STUDENT DORMITORIES	12,765	12,765
ARMY NATIONAL GUARD		
MONTGOMERY		
US PROPERTY AND FISCAL OFFICE	---	6,000
AIR FORCE RESERVE		
MAXWELL AFB		
CONSOLIDATED AIRCRAFT MAINTENANCE FACILITY	5,200	5,200
TOTAL, ALABAMA	41,748	63,598
ALASKA		
ARMY		
FORT WAINWRIGHT		
CENTRALIZED VEHICLE WASH FACILITY	---	3,100
WHOLE BARRACKS RENEWAL (PHASE I)	---	16,000
AIR FORCE		
EIELSON AFB		
CONSOLIDATED MUNITIONS FACILITY	4,352	4,352
DEFENSE-WIDE		
ELMENDORF AFB		
REPLACE HYDRANT FUEL SYSTEM (PHASE I)	19,500	19,500
AIR NATIONAL GUARD		
KULIS ANGB (ANCHORAGE)		
VEHICLE MAINTENANCE/FIRE STATION COMPLEX	---	10,400
TOTAL, ALASKA	23,852	53,352
ARIZONA		
NAVY		
FLAGSTAFF NAVAL OBSERVATORY		
OPTIC INTERFEROMETER SUPPORT FACILITY	990	990
YUMA MARINE CORPS AIR STATION		
BACHELOR ENLISTED QUARTERS	11,010	11,010
AIR FORCE		
LUKE AFB		
CONTROL TOWER	---	3,400
ARMY NATIONAL GUARD		
PAPAGO MILITARY RESERVATION (PHOENIX)		
COMBINED SUPPORT MAINTENANCE SHOP	10,640	10,640
AIR NATIONAL GUARD		
TUSCON INTERNATIONAL AIRPORT AGS		
COMPOSITE SUPPORT COMPLEX	---	7,500
TOTAL, ARIZONA	22,640	33,540
ARKANSAS		
ARMY		
PINE BLUFF ARSENAL		
AMMUNITION DEMILITARIZATION FACILITY (PHASE III)	16,500	---
AIR FORCE		
LITTLE ROCK AFB		
UPGRADE SEWAGE TREATMENT PLANT	---	1,500
DEFENSE-WIDE		
PINE BLUFF ARSENAL		
AMMUNITION DEMILITARIZATION FACILITY (PHASE III)	---	16,500
ARMY NATIONAL GUARD		
BENTON		
READINESS CENTER	---	1,988
TOTAL, ARKANSAS	16,500	19,988

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
CALIFORNIA		
ARMY		
FORT IRWIN		
CHILD DEVELOPMENT CENTER	---	5,100
EDUCATION CENTER	---	2,700
HELIPORT (PHASE III)	7,000	7,000
NAVY		
CAMP PENDLETON MARINE CORPS BASE		
BACHELOR ENLISTED QUARTERS	12,400	12,400
BACHELOR ENLISTED QUARTERS	15,840	15,840
FITNESS CENTER	---	5,010
HELICOPTER OUTLYING LANDING FIELD	---	7,180
CHINA LAKE NAVAL AIR WARFARE CENTER WEAPONS DIVISION		
MISSILE MAGAZINES	3,240	3,240
SURVIVABILITY LIVE FIRE COMPLEX	---	6,900
LEMOORE NAVAL AIR STATION		
AIRFRAMES FACILITY MODIFICATIONS	1,510	1,510
HANGAR RENOVATIONS	5,430	5,430
TRAINING FACILITY ADDITION	4,270	4,270
WEAPONS ASSEMBLY FACILITY IMPROVEMENTS	9,430	9,430
MIRAMAR MARINE CORPS AIR STATION		
BACHELOR ENLISTED QUARTERS	29,570	29,570
NAVAL FACILITY SAN CLEMENTE ISLAND		
BACHELOR ENLISTED QUARTERS	8,350	8,350
SAN DIEGO NAVAL SUBMARINE BASE		
SUBMARINE SUPPORT FACILITY	11,400	11,400
AIR FORCE		
EDWARDS AFB		
RENOVATE AIRCRAFT MAINTENANCE FACILITY	10,361	10,361
TRAVIS AFB		
CONTROL TOWER	---	4,250
VANDENBERG AFB		
ADD/ALTER MISSILE MAINTENANCE FACILITY	9,500	9,500
SPACE INITITAL QUALIFICATION TRAINING ACADEMIC FAC	9,209	9,209
DEFENSE-WIDE		
BEALE AFB		
ADD/ALTER PHYSIOLOGICAL SUPPORT FACILITY	3,500	3,500
CAMP PENDLETON MARINE CORPS BASE		
MEDICAL/DENTAL CLINIC REPLACEMENT (MARGARITA)	3,100	3,100
MEDICAL/DENTAL CLINIC REPLACEMENT (SAN MATEO)	3,200	3,200
EDWARDS AFB		
ADD/ALTER AEROSPACE MEDICAL CLINIC	6,000	6,000
NAVAL AMPHIBIOUS BASE, CORONADO		
SOF AMPHIBIOUS OPERATIONS FACILITY	3,600	3,600
SAN DIEGO NAVAL HOSPITAL		
WATER STORAGE TANK	1,350	1,350
TRAVIS AFB		
PATIENT MOVEMENT ITEMS/OPERATIONS AND DIST CENTER	1,700	1,700
TOTAL, CALIFORNIA	159,960	191,100
COLORADO		
ARMY		
FORT CARSON		
RAILYARD EXPANSION (PHASE II)	---	23,000
AIR FORCE		
FALCON AFB		
OPERATIONAL SUPPORT FACILITY	9,601	9,601
US AIR FORCE ACADEMY (COLORADO SPRINGS)		
ADD/ALTER PREP SCHOOL BUILDINGS	4,413	4,413
ARMY RESERVE		
FORT CARSON		
ADD/ALTER ORGANIZATIONAL MAINTENANCE SHOP/ EQUIPMENT CONCENTRATION SITE	1,101	1,101
TOTAL, COLORADO	15,115	38,115
CONNECTICUT		
NAVY		
NSB NEW LONDON		
WATERFRONT IMPROVEMENTS	---	11,330
ARMY RESERVE		
WEST HARTFORD		
LAND ACQUISITION	1,491	1,491
TOTAL, CONNECTICUT	1,491	12,821

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
DELAWARE		
ARMY NATIONAL GUARD		
DAGSBORO		
READINESS CENTER	---	3,609
DISTRICT OF COLUMBIA		
NAVY		
COMMANDANT, NAVAL DISTRICT (WASHINGTON, DC)		
FITNESS CENTER	790	790
AIR FORCE		
BOLLING AFB		
HONOR GUARD TECHNICAL SCHOOL	2,948	2,948
TOTAL, DISTRICT OF COLUMBIA	3,738	3,738
FLORIDA		
ARMY		
MIAMI		
SOUTHCOM HEADQUARTERS AND LAND ACQUISITION	26,700	---
NAVY		
JACKSONVILLE NAVAL AIR STATION		
ADD/ALTER BUILDING #118	---	1,500
KEY WEST NAVAL AIR STATION		
CHILD DEVELOPMENT CENTER	3,730	3,730
MAYPORT NAVAL STATION		
AFLOAT TRAINING GROUP FACILITY	---	3,163
WHARF ELECTRICAL IMPROVEMENTS	---	3,000
WHITING FIELD NAVAL AIR STATION		
AIRFIELD ALTERATIONS	---	1,400
AIR FORCE		
EGLIN AFB		
DORMITORY	7,866	7,866
SANTA ROSA ISLAND TEST SITES	12,571	12,571
EGLIN AFB AUXILIARY FIELD 9 (HURLBURT FIELD)		
CONTROL TOWER	2,014	2,014
FIRE TRAINING FACILITY	1,823	1,823
MACDILL AFB		
DINING FACILITY	---	4,800
FIRE TRAINING FACILITY	2,494	2,494
KC-135 SIMULATOR FACILITY	2,514	2,514
TYNDALL AFB		
CONTROL TOWER	---	3,600
DEFENSE-WIDE		
DEF FUEL SUPPORT POINT JACKSONVILLE-MAYPORT ANNEX		
REPLACE FUEL TANKS	11,020	11,020
DEFENSE FUEL SUPPORT POINT JACKSONVILLE		
REPLACE FUEL TANKS	11,000	11,000
EGLIN AFB		
CENTRAL ENERGY PLANT (EGLIN HOSPITAL)	9,200	9,200
EGLIN AFB AUXILIARY FIELD 9 (HURLBURT FIELD)		
CLEAR WATER AIRCRAFT RINSE	2,400	2,400
EGLIN AFB AUXILIARY FIELD 3 (DUKE FIELD)		
ASSAULT STRIP RUNWAY	---	5,100
GENERAL PURPOSE AIRCRAFT MAINTENANCE SHOP	2,210	2,210
MACDILL AFB		
RENOVATE COMMAND AND CONTROL FACILITY	8,400	8,400
PENSACOLA NAVAL AIR STATION		
ADD/ALTER HOSPITAL/LIFE SAFETY UPGRADES	25,400	25,400
AIR FORCE RESERVE		
HOMESTEAD ARB		
DORMITORY RENOVATION	---	4,600
TOTAL, FLORIDA	129,342	129,805
GEORGIA		
ARMY		
FORT BENNING		
WHOLE BARRACKS COMPLEX RENEWAL	28,600	28,600
NAVY		
ALBANY MARINE CORPS LOGISTICS BASE		
CHILD DEVELOPMENT CENTER	---	2,800
KINGS BAY NAVAL SUBMARINE BASE		
MAGNETIC SILENCING FACILITY MODIFICATIONS	---	2,550

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
AIR FORCE		
ROBINS AFB		
DEPOT PLANT SERVICES FACILITY	11,894	11,894
DEFENSE-WIDE		
MOODY AFB		
ALTER CENTRAL MEDICAL FACILITY/ADD DENTAL CLINIC	11,000	11,000
FORT STEWART		
MEDICAL/DENTAL CLINIC REPLACEMENT	10,400	10,400
AIR NATIONAL GUARD		
ROBINS AFB		
B1 WEAPONS RELEASE SYSTEMS/LOAD CREW TRAINING FAC.	3,250	3,250
NAVY RESERVE		
ATLANTA NAVAL AIR STATION		
HANGAR ADDITION	---	4,100
TOTAL, GEORGIA	65,144	74,594
HAWAII		
ARMY		
SCHOFIELD BARRACKS		
LAND ACQUISITION, KAHUKU TRAINING AREA	---	23,500
WHOLE BARRACKS COMPLEX RENEWAL	47,500	47,500
NAVY		
KANEOHE BAY MARINE CORPS AIR STATION		
BACHELOR ENLISTED QUARTERS	27,410	27,410
BACHELOR ENLISTED QUARTERS (PHASE I)	---	15,000
PEARL HARBOR NAVAL SUBMARINE BASE		
BACHELOR ENLISTED QUARTERS MODERNIZATION	8,060	8,060
PEARL HARBOR FLEET AND INDUSTRIAL SUPPLY CENTER		
CENTRAL RECEIVING FACILITY	9,730	9,730
PEARL HARBOR NAVAL STATION		
ELECTRICAL DISTRIBUTION SYSTEM UPGRADES	18,180	18,180
PEARL HARBOR NAVAL SHIPYARD		
ENGINEERING MANAGEMENT BUILDING	11,400	11,400
PEARL HARBOR NAVY PUBLIC WORKS CENTER		
SEWER OUTFALL EXTENSION	22,877	22,877
STEAM CONDENSATE RETURN SYSTEM	6,090	6,090
WAHIAWA NAVAL COMPUTER AND TELECOM AREA MASTER STATION (EASTERN PACIFIC)		
FIRE STATION	1,970	1,970
AIR FORCE		
HICKAM AFB		
REPAIR AIRFIELD PAVEMENT	5,890	5,890
AIR NATIONAL GUARD		
HICKAM AFB		
REPLACE BASE CIVIL ENG. MAINTENANCE FACILITY	---	5,100
TOTAL, HAWAII	159,107	202,707
IDAHO		
AIR FORCE		
MOUNTAIN HOME AFB		
B1-B CONVENTIONAL MUNITIONS SHOP	---	4,100
B1-B MUNITIONS STORAGE IGLOOS	---	1,500
DORMITORY	8,897	8,897
LAND ACQUISITION	1,000	1,000
RANGE IMPROVEMENTS	2,400	2,400
ARMY NATIONAL GUARD		
GOWEN FIELD (BOISE)		
ADD/ALTER READINESS CENTER	4,224	4,224
TOTAL, IDAHO	16,521	22,121
ILLINOIS		
ARMY		
ROCK ISLAND ARSENAL		
ELECTRICAL DISTRIBUTION SYSTEM	5,300	5,300
NAVY		
GREAT LAKES NAVAL TRAINING CENTER		
APPLIED INSTRUCTION BUILDING MODIFICATIONS	5,750	5,750
GAS TURBINE TRAINING FACILITY	7,410	7,410
SMALL ARMS RANGE	---	6,790

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
DEFENSE-WIDE		
GREAT LAKES NAVAL STATION		
HOSPITALMAN SCHOOL ADDITION	7,100	7,100
TOTAL, ILLINOIS	25,560	32,350
INDIANA		
ARMY		
CRANE ARMY AMMUNITION ACTIVITY		
AMMUNITION CONTAINERIZATION COMPLEX (PHASE II)	7,100	7,100
NEWPORT ARMY AMMUNITION PLANT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	27,500	---
AMMUNITION DEMILITARIZATION SUPPORT	2,000	---
NAVY		
CRANE NAVAL SURFACE WARFARE CENTER		
AIRBORNE ELECTRONIC WARFARE CENTER	---	11,110
DEFENSE-WIDE		
NEWPORT ARMY AMMUNITION PLANT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	---	27,500
AMMUNITION DEMILITARIZATION SUPPORT	---	2,000
AIR NATIONAL GUARD		
HULMAN REGIONAL AIRPORT (TERRE HAUTE)		
FUEL CELL CORROSION CONTROL AND FIRE STATION	---	6,000
TOTAL, INDIANA	36,600	53,710
IOWA		
ARMY NATIONAL GUARD		
CAMP DODGE		
FUEL DISPENSING FACILITY	737	737
AIR NATIONAL GUARD		
DES MOINES		
REPLACE SECURITY POLICE OPERATION FACILITY	---	4,000
SIOUX GATEWAY AIRPORT (SIOUX CITY)		
ADD/ALTER AIRCRAFT CORROSION CONTROL FACILITY	---	6,500
TOTAL, IOWA	737	11,237
KANSAS		
ARMY		
FORT LEAVENWORTH		
US DISCIPLINARY BARRACKS (PHASE II)	29,000	29,000
FORT RILEY		
WHOLE BARRACKS COMPLEX RENEWAL	---	16,500
AIR FORCE		
MCCONNELL AFB		
WATER STORAGE AND PUMPING FACILITY	---	4,450
AIR NATIONAL GUARD		
FORBES FIELD AGS (PAULINE)		
KC-135 MAINTENANCE HANGAR UPGRADE	---	9,800
MCCONNELL AFB		
ADD/ALTER AVIONICS SHOP	---	5,900
TOTAL, KANSAS	29,000	65,650
KENTUCKY		
ARMY		
BLUEGRASS ARMY DEPOT (RICHMOND)		
AMMUNITION CONTAINERIZATION COMPLEX	5,300	5,300
FORT CAMPBELL		
WHOLE BARRACKS COMPLEX RENEWAL	41,000	41,000
WHOLE BARRACKS COMPLEX RENEWAL (PHASE II)	---	7,000
FORT KNOX		
MULTI-PURPOSE DIGITAL TRAINING RANGE (PHASE I)	---	7,000
DEFENSE-WIDE		
FORT CAMPBELL		
AIRCRAFT MAINTENANCE HANGAR	15,000	15,000
ARMY NATIONAL GUARD		
WESTERN KENTUCKY TRAINING SITE (GREENVILLE)		
TRAINING COMPLEX (PHASES IV AND V)	5,435	5,435
AIR NATIONAL GUARD		
STANDIFORD FIELD, LOUISVILLE		
REPLACE COMPOSITE AERIAL PORT/AIRLIFT CONTROL ELEMENT FACILITY	---	4,100
TOTAL, KENTUCKY	66,735	84,835

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
LOUISIANA		
ARMY		
FORT POLK		
CONSOLIDATED RAIL COMPLEX	---	8,300
AIR FORCE		
BARKSDALE AFB		
PHYSICAL FITNESS CENTER	---	9,300
DEFENSE-WIDE		
BARKSDALE AFB		
ADD/ALTER MEDICAL CLINICS	3,450	3,450
NAVY RESERVE		
NEW ORLEANS NAVAL AIR STATION		
BACHELOR ENLISTED QUARTERS	---	9,520
ENGINE TEST CELL MODIFICATIONS	2,200	2,200
NEW ORLEANS NAVAL SUPPORT ACTIVITY		
GALLEY ADDITION	---	1,730
AIR FORCE RESERVE		
NEW ORLEANS NAVAL AIR STATION		
RENOVATE MAINTENANCE HANGAR #4	---	5,200
TOTAL, LOUISIANA	5,650	39,700
MARYLAND		
ARMY		
ABERDEEN PROVING GROUND		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	26,500	---
AMMUNITION DEMILITARIZATION SUPPORT	1,850	---
FORT DETRICK		
PHYSICAL FITNESS TRAINING CENTER	3,550	3,550
FORT MEADE		
EMERGENCY SERVICES CENTER	---	5,300
NAVY		
INDIAN HEAD NAVAL SURFACE WARFARE CENTER DIVISION		
ANNEALING OVEN FACILITY	6,680	6,680
CONTINUOUS PROCESSING SCALE-UP FACILITY	---	6,590
U.S. NAVAL ACADEMY		
DEMOLISH NAVAL RADIO TRANSMITTER FACILITY TOWERS	---	4,300
AIR FORCE		
ANDREWS AFB		
CHILD DEVELOPMENT CENTER	4,448	4,448
DEFENSE-WIDE		
ABERDEEN PROVING GROUND		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	---	26,500
AMMUNITION DEMILITARIZATION SUPPORT	---	1,850
FORT MEADE		
PERIMETER FENCE (WEST)	668	668
TOTAL, MARYLAND	43,696	59,886
MASSACHUSETTS		
AIR FORCE		
HANSCOM AFB		
RENOVATE ACQUISITION MANAGEMENT FACILITY	---	10,000
ARMY NATIONAL GUARD		
BARNES ANGB (WESTFIELD)		
ARMY AVIATION SUPPORT FACILITY	---	9,274
ARMY RESERVE		
FORT DEVENS		
RESERVE REGIONAL SUPPORT COMMAND HEADQUARTERS FAC.	3,335	3,335
NAVY RESERVE		
FORT DEVENS		
RESERVE CENTER RENOVATIONS	840	840
TOTAL, MASSACHUSETTS	4,175	23,449
MICHIGAN		
AIR NATIONAL GUARD		
ALPENA COUNTY REGIONAL AIRPORT (ALPENA)		
FIRE STATION	---	5,100
SANITARY SEWER SYSTEM	3,900	3,900
SELFRIDGE ANGB (MT CLEMENS)		
REPLACE CONTROL TOWER/RADAR APPROACH CONTROL CTR.	5,200	5,200
INFRASTRUCTURE UPGRADE	---	9,800

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
ARMY RESERVE		
WALKER		
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINT SHOP..	9,439	9,439
TOTAL, MICHIGAN.....	18,539	33,439
MINNESOTA		
ARMY NATIONAL GUARD		
CAMP RIPLEY		
MULTI-PURPOSE MACHINE GUN/SNIPER RANGE.....	1,023	1,023
NAVY RESERVE		
NAVAL RESERVE READINESS COMMAND (MINNEAPOLIS)		
ADMINISTRATIVE HEADQUARTERS BUILDING.....	3,630	3,630
AIR FORCE RESERVE		
MINNEAPOLIS-ST PAUL INTERNATIONAL AIRPORT		
CONSOLIDATED LODGING FACILITY (PHASE I).....	---	3,236
TOTAL, MINNESOTA.....	4,653	7,889
MISSISSIPPI		
NAVY		
GULFPORT NAVAL CONSTRUCTION BATTALION CENTER		
BACHELOR ENLISTED QUARTERS REPLACEMENT.....	10,670	10,670
MERIDIAN NAVAL AIR STATION		
AIR OPERATIONS FACILITY.....	---	3,280
AIR FORCE		
COLUMBUS AFB		
BACHELOR OFFICERS QUARTERS.....	---	5,700
KEESLER AFB		
STUDENT DORMITORIES (2).....	29,770	29,770
TRAINING SUPPORT FACILITY.....	5,756	5,756
DEFENSE-WIDE		
CAMP SHELBY		
REPLACE BULK FUEL FACILITY.....	5,300	5,300
KEESLER AFB		
BIOENVIRONMENTAL ENGINEERING FACILITY.....	700	700
STENNIS SPACE CENTER		
SOF OPERATIONS SUPPORT FACILITY.....	---	5,500
ARMY NATIONAL GUARD		
BROOKHAVEN		
REGIONAL TRAINING CENTER/OMS.....	---	5,247
TOTAL, MISSISSIPPI.....	52,196	71,923
MISSOURI		
ARMY		
FORT LEONARD WOOD		
ENGINEER QUALIFICATION RANGE.....	5,200	5,200
RECEPTION BARRACKS.....	---	23,000
AIR NATIONAL GUARD		
ROSECRANS MEMORIAL AIRPORT (ELWOOD)		
UPGRADE AIRCRAFT PARKING APRON (PHASE I).....	---	9,600
TOTAL, MISSOURI.....	5,200	37,800
MONTANA		
AIR FORCE		
MALMSTROM AFB		
REPLACE DORMITORY.....	---	7,900
ARMY NATIONAL GUARD		
HELENA		
RESERVE CENTER.....	---	21,690
TOTAL, MONTANA.....	---	29,590
NEBRASKA		
AIR NATIONAL GUARD		
LINCOLN MUNICIPAL AIRPORT		
JOINT MEDICAL TRAINING FACILITY.....	---	3,350
NEVADA		
AIR FORCE		
INDIAN SPRINGS AUXILIARY AIR FIELD		
UNMANNED AERIAL VEHICLE LOGISTICS AND TRAINING FAC	3,965	3,965

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
UNMANNED AERIAL VEHICLE SQUADRON OPERATIONS/ AIRCRAFT MAINTENANCE UNIT	7,059	7,059
UNMANNED AERIAL VEHICLE COMMUNICATION MAINTENANCE FACILITY/INFRASTRUCTURE/UTILITIES	3,989	3,989
NELLIS AFB		
DORMITORY	6,378	6,378
ARMY NATIONAL GUARD		
CARSON CITY		
READINESS CENTER	---	5,860
TOTAL, NEVADA	21,391	27,251
NEW JERSEY		
ARMY		
FORT MONMOUTH		
SOFTWARE ENGINEERING CENTER ADDITION	---	7,600
PICATINNY ARSENAL		
PRECISION MUNITIONS FACILITY	---	8,400
AIR FORCE		
MCGUIRE AFB		
DINING FACILITY	6,044	6,044
ARMY RESERVE		
FORT DIX		
AMMUNITION SUPPLY POINT	---	8,731
TOTAL, NEW JERSEY	6,044	30,775
NEW MEXICO		
AIR FORCE		
HOLLOMAN AFB		
PHYSICAL FITNESS CENTER	---	11,100
KIRTLAND AFB		
NUCLEAR WEAPONS INTEGRATION FACILITY	---	6,800
FIRE TRAINING FACILITY	1,774	1,774
DEFENSE-WIDE		
HOLLOMAN AFB		
WAR READINESS MATERIAL WAREHOUSE	1,300	1,300
ARMY NATIONAL GUARD		
TAOS		
READINESS CENTER	---	3,300
TOTAL, NEW MEXICO	3,074	24,274
NEW YORK		
ARMY		
FORT DRUM		
AERIAL GUNNERY RANGE (PHASE II)	---	9,000
INDOOR FIRING RANGE	---	4,650
U S MILITARY ACADEMY (WEST POINT)		
CADET PHYSICAL DEVELOPMENT CENTER (PHASE I)	12,000	12,000
DEFENSE-WIDE		
U S MILITARY ACADEMY (WEST POINT)		
ELEMENTARY SCHOOL ADDITION/RENOVATION	2,840	2,840
AIR NATIONAL GUARD		
HANCOCK FIELD (SYRACUSE)		
UPGRADE PARKING APRON AND TAXIWAYS	---	9,500
ARMY RESERVE		
FORT WADSWORTH		
ADD/ALTER US ARMY RESERVE CENTER (PHASE I)	6,424	6,424
AIR FORCE RESERVE		
NIAGARA FALLS ARS		
CONSOLIDATED MAINTENANCE FACILITY	---	3,900
TOTAL, NEW YORK	21,264	48,314
NORTH CAROLINA		
ARMY		
FORT BRAGG		
BARRACKS UPGRADE	---	10,600
DEPLOYMENT STAGING COMPLEX	30,000	30,000
FORCE PROTECTION FACILITIES	---	8,300
WHOLE BARRACKS COMPLEX RENEWAL	47,000	47,000
NAVY		
CAMP LEJEUNE MARINE CORPS BASE		
FIRE STATION	1,830	1,830

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
INFRASTRUCTURE PHYSICAL SECURITY	12,770	12,770
CHERRY POINT MARINE CORPS AIR STATION		
AIRCRAFT FIRE AND RESCUE STATION ADDITION	1,620	1,620
CHILD DEVELOPMENT CENTER	4,420	4,420
AIR FORCE		
SEYMOUR JOHNSON AFB		
EDUCATION CENTER AND LIBRARY	---	6,100
DEFENSE-WIDE		
FORT BRAGG		
WAR READINESS MATERIAL WAREHOUSE	6,500	6,500
CAMP LEJEUNE MARINE CORPS BASE		
BREWSTER MIDDLE SCHOOL	16,900	16,900
POPE AFB		
HYDRANT FUEL SYSTEM	4,100	4,100
TOTAL, NORTH CAROLINA	125,140	150,140
NORTH DAKOTA		
AIR FORCE		
GRAND FORKS AFB		
ADD TO PHYSICAL FITNESS CENTER	---	8,800
FIRE TRAINING FACILITY	2,686	2,686
MINOT AFB		
TAXIWAY REPAIR	---	8,500
DEFENSE-WIDE		
GRAND FORKS AFB		
ADD/ALTER MEDICAL/DENTAL CLINIC	5,600	5,600
ARMY NATIONAL GUARD		
BISMARCK		
ARMY AVIATION SUPPORT FAC/READINESS CTR EXPANSION	6,240	6,240
AIR NATIONAL GUARD		
HECTOR FIELD (FARGO)		
ADD/ALTER BASE SUPPLY COMPLEX	---	3,650
REGIONAL FIRE TRAINING FACILITY	800	800
TOTAL, NORTH DAKOTA	15,326	36,276
OHIO		
AIR FORCE		
WRIGHT-PATTERSON AFB		
ACQUISITION MANAGEMENT COMPLEX (PHASE IV-A)	22,000	22,000
AIR NATIONAL GUARD		
SPRINGFIELD-BECKLEY MUNICIPAL AIRPORT		
BASE CIVIL ENGINEER/SECURITY FORCES COMPLEX	---	5,000
ARMY RESERVE		
GAHANNA		
US ARMY RESERVE CENTER PURCHASE	3,115	3,115
AIR FORCE RESERVE		
WRIGHT-PATTERSON AFB		
ALTER C-141C FLIGHT SIMULATION TRAINING FACILITY	---	1,600
TOTAL, OHIO	25,115	31,715
OKLAHOMA		
ARMY		
MCALESTER ARMY AMMUNITION PLANT		
AMMUNITION CONTAINERIZATION COMPLEX	10,800	10,800
FORT SILL		
TACTICAL EQUIPMENT SHOP (PHASE I)	13,800	13,800
WHOLE BARRACKS COMPLEX RENEWAL	20,500	20,500
AIR FORCE		
ALTUS AFB		
RAMP AND AIRFIELD LIGHTING	---	5,300
CONTROL TOWER	---	4,000
TINKER AFB		
COMBAT COMMUNICATIONS SQUADRON OPERATIONS FACILITY	5,085	5,085
SQUADRON OPERATION AND MOBILITY CENTER	---	10,800
DORMITORY	9,100	9,100
VANCE AFB		
ADD/ALTER PHYSICAL FITNESS CENTER	---	4,400
FIRE TRAINING FACILITY	1,823	1,823
DEFENSE-WIDE		
FORT SILL		
REPLACE FUEL STORAGE FACILITY	3,500	3,500

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
ARMY NATIONAL GUARD		
LEXINGTON		
ARMY AVIATION SUPPORT FACILITY EXPANSION	7,382	7,382
TOTAL, OKLAHOMA	71,990	96,490
OREGON		
ARMY		
UMATILLA ARMY DEPOT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE IV)	50,950	---
DEFENSE-WIDE		
UMATILLA ARMY DEPOT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE IV)	---	50,950
PENNSYLVANIA		
NAVY		
PHILADELPHIA NAVAL SURFACE WARFARE CENTER SHIP SYSTEMS ENGINEERING STATION		
INTEGRATED SHIP CONTROL AND DIAGNOSTIC FACILITY	---	2,410
NAVICP MECHANICSBURG		
CHILD DEVELOPMENT CENTER	---	1,600
NAVICP PHILADELPHIA		
CHILD DEVELOPMENT CENTER	---	1,550
DEFENSE-WIDE		
CARLISLE BARRACKS		
HEALTH CLINIC ADDITION	4,678	4,678
ARMY NATIONAL GUARD		
LATROBE		
READINESS CENTER	---	2,479
ARMY RESERVE		
OAKDALE		
99TH REGIONAL SUPPORT COMMAND (PHASE II)	---	19,512
TOTAL, PENNSYLVANIA	4,678	32,229
RHODE ISLAND		
NAVY		
NEWPORT NAVAL EDUCATION AND TRAINING CENTER		
BOILER PLANT MODIFICATIONS	5,630	5,630
NEWPORT NAVAL UNDERWATER SYSTEMS CENTER		
UNDERSEA WARFARE FACILITY	9,140	9,140
TOTAL, RHODE ISLAND	14,770	14,770
SOUTH CAROLINA		
NAVY		
BEAUFORT MARINE CORPS AIR STATION		
MISSILE MAGAZINES	1,770	1,770
CHARLESTON NAVAL WEAPONS STATION		
ORDNANCE RAILROAD REALIGNMENT	9,737	9,737
PARRIS ISLAND MARINE CORPS RECRUIT DEPOT		
FEMALE RECRUIT BARRACKS	---	8,030
WEAPONS BATTALLION MESSHALL	7,960	7,960
AIR FORCE		
CHARLESTON AFB		
C-17 LIFE SUPPORT FACILITY	4,701	4,701
C-17 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	7,639	7,639
C-17 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	6,769	6,769
DINING FACILITY	5,221	5,221
AIR NATIONAL GUARD		
MCENTIRE AIR NATIONAL GUARD STATION (EASTOVER)		
ADD/ALTER AIRCRAFT MAINTENANCE COMPLEX	---	9,000
ARMY NATIONAL GUARD		
SPARTANBURG		
READINESS CENTER	---	5,260
TOTAL, SOUTH CAROLINA	43,797	66,087
SOUTH DAKOTA		
AIR FORCE		
ELLSWORTH AFB		
ADD/ALTER SQUADRON OPERATIONS FACILITY	---	6,500

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
AIR NATIONAL GUARD		
JOE FOSS FIELD (SIOUX FALLS)		
VEHICLE MAINTENANCE AND AIRCRAFT SUPPORT EQUIPMENT COMPLEX	---	5,200
TOTAL, SOUTH DAKOTA	---	11,700
TENNESSEE		
AIR FORCE		
ARNOLD AFB		
TEST FACILITIES COOLING TOWER	---	11,600
AIR NATIONAL GUARD		
MCGHEE-TYSON AIR NATIONAL GUARD BASE (KNOXVILLE)		
RELOCATE AIRCRAFT PARKING APRON (PHASE I)	---	10,000
TOTAL, TENNESSEE	---	21,600
TEXAS		
ARMY		
FORT BLISS		
TACTICAL VEHICLE OVERPASS	---	4,100
FORT HOOD		
RAILHEAD FACILITY (PHASE I)	17,500	17,500
FORT SAM HOUSTON		
WHOLE BARRACKS COMPLEX RENEWAL	21,800	21,800
DINING FACILITY	---	5,500
NAVY		
INGLESIDE NAVAL STATION		
BACHELOR ENLISTED QUARTERS (PHASE IV)	---	12,200
AIR FORCE		
DYESS AFB		
B-1B MUNITIONS MAINTENANCE FACILITY	---	3,350
B-1B SUPPORT EQUIPMENT SHOP ADDITION	---	1,400
LACKLAND AFB		
DORMITORY	6,800	6,800
OPERATIONS FACILITY	8,130	8,130
LAUGHLIN AFB		
CONSOLIDATED BASE OPERATIONS FACILITY	---	3,815
CONTROL TOWER	---	3,500
RANDOLPH AFB		
BASE OPERATIONS FACILITY	3,166	3,166
GOODFELLOW AFB		
STUDENT DORMITORY	---	7,300
DEFENSE-WIDE		
FORT HOOD		
BLOOD DONOR CENTER	3,100	3,100
PRIMARY CARE CLINIC	11,000	11,000
NAVY RESERVE		
GALVESTON		
MARINE RESERVE TRAINING CENTER	4,090	4,090
TOTAL, TEXAS	75,586	116,751
UTAH		
ARMY		
TOOELE ARMY DEPOT		
AMMUNITION CONTAINERIZATION COMPLEX	3,900	3,900
AIR FORCE		
HILL AFB		
WAR READINESS ASSET WAREHOUSE	---	2,600
ARMY RESERVE		
SALT LAKE CITY		
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINTENANCE SHOP/DIRECT SUPPORT - GENERAL SUPPORT/EQUIPMENT CONCENTRATION SITE	13,200	---
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINTENANCE SHOP (PHASE II)	---	5,076
AIR FORCE RESERVE		
HILL AFB		
MUNITIONS HANDLING AND STORAGE FACILITY	---	1,900
TOTAL, UTAH	17,100	13,476

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
VERMONT		
AIR NATIONAL GUARD		
BURLINGTON INTERNATIONAL AIRPORT		
BASE SUPPLY COMPLEX	---	5,500
VIRGINIA		
ARMY		
CHARLOTTESVILLE		
NATIONAL GROUND INTELLIGENCE CENTER FACILITY	46,200	46,200
FORT EUSTIS		
PHYSICAL FITNESS CENTER	---	4,650
WHOLE BARRACKS COMPLEX RENEWAL	36,531	36,531
FORT MYER		
BARRACKS RENOVATION	---	6,200
NAVY		
DAHLGREN NAVAL SURFACE WARFARE CENTER		
WARFARE DEFENSES TECHNICAL FACILITY	---	10,550
WEAPONS SYSTEM DEVELOPMENT LABORATORY ADDITION	5,130	5,130
DAM NECK TACTICAL TRAINING GROUP (ATLANTIC)		
TRAINING BUILDING ADDITION	2,430	2,430
NORFOLK FLEET INDUSTRIAL SUPPLY CENTER		
FIRE STATION	1,770	1,770
NORFOLK FLEET TRAINING CENTER		
ENGINEERING TRAINING FAC ADDITION AND RENOVATION	5,700	5,700
NORFOLK NAVAL STATION		
BERTHING PIER (PHASE I)	32,030	32,030
NORFOLK NAVAL SHIPYARD (PORTSMOUTH)		
DREDGING	6,180	6,180
OCEANA NAVAL AIR STATION		
FITNESS CENTER	---	6,400
DEFENSE-WIDE		
CHEATHAM ANNEX		
FLEET HOSPITAL SUPPORT OFFICE - OPERATIONAL WAREHOUSE	9,400	9,400
FLEET HOSPITAL SUPPORT OFFICE - ADMINISTRATIVE OFFICE	1,900	1,900
DEFENSE SUPPLY CENTER (RICHMOND)		
CONVERT WAREHOUSE TO ADMINISTRATIVE SPACE	10,500	10,500
PORTSMOUTH NAVAL HOSPITAL		
HOSPITAL REPLACEMENT (PHASE X)	17,954	17,954
ARMY NATIONAL GUARD		
POWHATAN		
READINESS CENTER	2,435	2,435
ARMY RESERVE		
FORT BELVOIR		
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINTENANCE SHOP/AREA MAINTENANCE SUPPORT ACTIVITY	10,314	10,314
FORT EUSTIS		
AVIATION SUPPORT FACILITY	11,618	11,618
NAVY RESERVE		
NORFOLK NAVAL AIR RESERVE CENTER		
HANGAR ALTERATIONS	1,660	1,660
TOTAL, VIRGINIA	201,752	229,552
WASHINGTON		
ARMY		
FORT LEWIS		
CENTRAL VEHICLE WASH FACILITY	4,650	4,650
CLOSE COMBAT TACTICAL TRAINER BUILDING	7,600	7,600
CONSOLIDATED FUEL FACILITY	3,950	3,950
TANK TRAIL EROSION MITIGATION (YAKIMA)	2,000	2,000
NAVY		
BREMERTON STRATEGIC WEAPONS FACILITY (PACIFIC)		
SECURITY FACILITY UPGRADES	2,750	2,750
PUGET SOUND NAVAL SHIPYARD (BREMERTON)		
COMMUNITY SUPPORT FACILITY	---	4,300
AIR FORCE		
FAIRCHILD AFB		
CONVERT NOSEDOCK TO WASHRACK FACILITY	---	3,700
KC-135 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	7,620	7,620
SURVIVAL ACADEMIC TRAINING SUPPORT CENTER	---	3,900
MCCHORD AFB		
C-17 ADD/ALTER AIRCRAFT MAINTENANCE SHOP	2,321	2,321
C-17 ADD/ALTER SIMULATOR FACILITY	1,823	1,823

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
C-17 ADD/ALTER AEROSPACE GROUND EQUIPMENT MAINTENANCE FACILITY	2,110	2,110
C-17 ALTER COMPOSITE SHOP	1,630	1,630
C-17 ALTER MAINTENANCE HANGARS	6,427	6,427
C-17 FLIGHTLINE SUPPORT FACILITY	4,029	4,029
C-17 LIFE SUPPORT EQUIPMENT FACILITY	4,413	4,413
C-17 RAMP/HYDRANT FUELS SYSTEM	18,025	18,025
C-17 REPAIR BASE ROADS	2,224	2,224
C-17 SHORTFIELD ASSAULT STRIP	2,321	2,321
C-17 SQUADRON OPERATIONS/AIRCRAFT MAINTENANCE UNIT	6,524	6,524
DEFENSE-WIDE		
BANGOR NAVAL SUBMARINE BASE		
DISEASE VECTOR ECOLOGY AND CONTROL CENTER	5,700	5,700
BREMERTON NAVAL HOSPITAL		
ADD/ALTER HOSPITAL	28,000	28,000
MCCHORD AFB		
CLINIC/WAR READINESS MATERIAL WAREHSE REPLACEMENT	20,000	20,000
AIR FORCE RESERVE		
MCCHORD AFB		
CONSOLIDATED MEDICAL TRAINING FACILITY	---	3,400
ARMY RESERVE		
FORT LAWTON (SEATTLE)		
US ARMY RESERVE CENTER	---	10,713
TOTAL, WASHINGTON	134,117	160,130
WEST VIRGINIA		
ARMY NATIONAL GUARD		
CAMP DAWSON (KINGWOOD)		
READINESS CENTER	4,465	---
REGIONAL TRAINING INSTITUTE	---	13,595
WISCONSIN		
AIR NATIONAL GUARD		
VOLK FIELD (CAMP DOUGLAS)		
UPGRADE RUNWAY AND TAXIWAY	9,600	9,600
ARMY RESERVE		
FORT MCCOY		
CRASH RESCUE STATION	1,850	1,850
MACHINE GUN RANGE	2,032	2,032
TOTAL, WISCONSIN	13,482	13,482
WYOMING		
ARMY NATIONAL GUARD		
CAMP GUERNSEY		
COMBINED SUPPORT MAINTENANCE SHOP	---	13,891
CONUS CLASSIFIED		
ARMY		
CLASSIFIED LOCATIONS		
CLASSIFIED PROJECT	4,600	4,600
BELGIUM		
ARMY		
BELGIUM		
CHILD DEVELOPMENT CENTER	6,300	6,300
GERMANY		
ARMY		
CONN BARRACKS (SCHWEINFURT)		
WHOLE BARRACKS COMPLEX RENEWAL	18,000	18,000
KITZINGEN FAMILY HOUSING (WUERZBURG)		
CHILD DEVELOPMENT CENTER	4,250	4,250
AIR FORCE		
SPANGDAHLEM AB		
CONSOLIDATED AIR CONTROL SQUADRON OPERATIONS FAC	4,466	---
DORMITORY	9,501	9,501
TOTAL, GERMANY	36,217	31,751
GREECE		
NAVY		
SOUDA BAY CRETE NAVAL SUPPORT ACTIVITY		
BACHELOR ENLISTED QUARTERS	5,260	5,260

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
GUAM		
NAVY		
NAVAL ACTIVITIES (GUAM)		
SPECIAL WARFARE UNIT FACILITY	5,500	5,500
WATERFRONT CONSOLIDATION FACILITIES	4,810	4,810
DEFENSE-WIDE		
NAVAL ACTIVITIES (GUAM)		
ELEMENTARY SCHOOL ADDITION AND RENOVATION	8,600	8,600
HIGH SCHOOL ADDITION AND CONVERSION	4,500	4,500
TOTAL, GUAM	23,410	23,410
ITALY		
NAVY		
NAPLES NAVAL SUPPORT ACTIVITY		
PUBLIC WORKS FACILITY (CAPODICHINO)	18,270	18,270
DEFENSE-WIDE		
SIGONELLA NAVAL AIR STATION		
FLIGHT LINE DISPENSARY	5,300	5,300
TOTAL, ITALY	23,570	23,570
KOREA		
ARMY		
CAMP CASEY		
WHOLE BARRACKS COMPLEX RENEWAL	13,400	13,400
PHYSICAL FITNESS CENTER	---	8,000
CAMP CASTLE		
WHOLE BARRACKS COMPLEX RENEWAL	18,226	18,226
CAMP HUMPHREYS		
WHOLE BARRACKS COMPLEX RENEWAL	8,500	8,500
CAMP STANLEY		
WHOLE BARRACKS COMPLEX RENEWAL	5,800	5,800
AIR FORCE		
KUNSAN AB		
DORMITORY	5,958	5,958
OSAN AB		
DORMITORY	7,496	7,496
TOTAL, KOREA	59,380	67,380
KWAJALEIN		
ARMY		
KWAJALEIN ATOLL		
POWER PLANT (ROI NAMUR ISLAND) (PHASE I)	12,600	12,600
DEFENSE-WIDE		
MISSILE RANGE		
MULTI PURPOSE MISSILE TEST FACILITIES	4,600	---
TOTAL, KWAJALEIN	17,200	12,600
PORTUGAL		
DEFENSE-WIDE		
LAJES FIELD (AZORES)		
FUEL PUMPHOUSE AND TANKS	7,700	7,700
PUERTO RICO		
DEFENSE-WIDE		
FORT BUCHANAN		
ELEMENTARY SCHOOL	8,805	8,805
ROOSEVELT ROADS NAVAL STATION		
OPERATIONS FACILITY	9,600	9,600
TOTAL, PUERTO RICO	18,405	18,405
TURKEY		
AIR FORCE		
INCIRLIK AB		
CENTRAL SECURITY CONTROL FACILITY	2,949	2,949
UNITED KINGDOM		
NAVY		
ST MAWGAN JOINT MARITIME COMMUNICATION CENTER		
EDUATION CENTER ADDITION	2,010	2,010

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
AIR FORCE		
RAF LAKENHEATH		
DORMITORIES (2)	15,838	15,838
RAF MILDENHALL		
DORMITORY	10,926	10,926
KC-135 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	14,034	14,034
DEFENSE-WIDE		
RAF LAKENHEATH		
HOSPITAL ANNEX REPLACEMENT	10,800	10,800
TOTAL, UNITED KINGDOM	53,608	53,608
NATO		
NATO SECURITY INVESTMENT PROGRAM	185,000	155,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
TOTAL, NATO	185,000	154,000
WORLDWIDE UNSPECIFIED		
ARMY		
UNSPECIFIED WORLDWIDE LOCATIONS		
HOST NATION SUPPORT	20,450	20,450
PLANNING AND DESIGN	41,819	43,819
UNSPECIFIED MINOR CONSTRUCTION	10,000	12,500
GENERAL REDUCTION	---	-6,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-2,000
NAVY		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	58,346	60,846
UNSPECIFIED MINOR CONSTRUCTION	8,900	9,900
GENERAL REDUCTION	---	-5,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
AIR FORCE		
UNSPECIFIED WORLDWIDE LOCATIONS		
UNSPECIFIED MINOR CONSTRUCTION	7,135	8,135
PLANNING AND DESIGN	35,592	38,092
GENERAL REDUCTION	---	-11,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
DEFENSE-WIDE		
UNSPECIFIED WORLDWIDE LOCATIONS		
ENERGY CONSERVATION INVESTMENT PROGRAM	46,950	46,950
CONTINGENCY CONSTRUCTION	9,390	4,890
GENERAL REDUCTION	---	-12,000
GENERAL REDUCTION - CHEMICAL DEMILITARIZATION	---	-50,500
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,300
PLANNING AND DESIGN		
SPECIAL OPERATIONS COMMAND	1,450	4,150
DEF THREAT REDUCTION/TREATY COMPLIANCE AGENCY	100	100
BALLISTIC MISSILE DEFENSE ORGANIZATION	12,561	10,000
DOD DEPENDENT SCHOOLS	---	1,000
DEFENSE LEVEL ACTIVITIES	2,200	2,200
DEFENSE MEDICAL SUPPORT ACTIVITY	8,555	8,555
SUBTOTAL, PLANNING AND DESIGN	24,866	26,005
UNSPECIFIED MINOR CONSTRUCTION		
SPECIAL OPERATIONS COMMAND	4,200	1,500
DEFENSE FINANCE AND ACCOUNTING SERVICE	1,500	1,500
DEF THREAT REDUCTION/TREATY COMPLIANCE AGENCY	900	900
JOINT CHIEFS OF STAFF	3,595	3,595
DOD DEPENDENT SCHOOLS	999	999
DEFENSE MEDICAL SUPPORT ACTIVITY	1,900	1,900
DEFENSE MANPOWER AND PERSONNEL CENTER	15,000	15,000
DEFENSE LEVEL ACTIVITIES	3,000	3,000
SUBTOTAL, UNSPECIFIED MINOR CONSTRUCTION	31,094	28,394
DEPARTMENT OF DEFENSE MILITARY UNACCOMPANIED HOUSING IMPROVEMENT FUND		
RESCISSION (FISCAL YEAR 1997, P.L. 104-196)	---	-5,000
ARMY NATIONAL GUARD		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	4,548	9,048

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
UNSPECIFIED MINOR CONSTRUCTION	546	5,046
GENERAL REDUCTION	---	-2,000
AIR NATIONAL GUARD		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	8,549	8,549
UNSPECIFIED MINOR CONSTRUCTION	3,462	7,502
GENERAL REDUCTION	---	-4,000
ARMY RESERVE		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	7,368	7,368
NAVY RESERVE		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	1,974	2,974
UNSPECIFIED MINOR CONSTRUCTION	877	877
AIR FORCE RESERVE		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	2,432	2,432
UNSPECIFIED MINOR CONSTRUCTION	2,903	2,903
TOTAL, WORLDWIDE UNSPECIFIED	327,201	245,880
WORLDWIDE VARIOUS		
DEFENSE-WIDE		
VARIOUS LOCATIONS		
CONFORMING STORAGE FACILITIES	1,300	1,300
FAMILY HOUSING, ARMY		
ALABAMA		
REDSTONE ARSENAL (118 UNITS)	14,000	14,000
HAWAII		
SCHOFIELD BARRACKS (64 UNITS)	14,700	14,700
NORTH CAROLINA		
FORT BRAGG (170 UNITS)	19,800	19,800
TEXAS		
FORT HOOD (154 UNITS)	21,600	21,600
VIRGINIA		
FORT LEE (80 UNITS)	---	13,000
CONSTRUCTION IMPROVEMENTS	28,629	48,479
PLANNING AND DESIGN	6,350	6,350
GENERAL REDUCTION	-1,639	-2,639
SUBTOTAL, CONSTRUCTION	103,440	135,290
OPERATION AND MAINTENANCE		
INTEREST PAYMENTS	3	3
LEASING	202,155	202,155
MISCELLANEOUS ACCOUNT	415	415
MAINTENANCE OF REAL PROPERTY	467,914	467,914
UTILITIES ACCOUNT	250,407	250,407
SERVICES ACCOUNT	52,222	52,222
MANAGEMENT ACCOUNT	87,125	80,089
FURNISHINGS ACCOUNT	44,492	44,492
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-3,000
SUBTOTAL, OPERATION AND MAINTENANCE	1,104,733	1,094,697
TOTAL, FAMILY HOUSING, ARMY	1,208,173	1,229,987
FAMILY HOUSING, NAVY AND MARINE CORPS		
CALIFORNIA		
LEMOORE NAVAL AIR STATION (162 UNITS)	30,379	30,379
HAWAII		
PEARL HARBOR PUBLIC WORKS CENTER (150 UNITS)	29,125	29,125
CONSTRUCTION IMPROVEMENTS	211,991	227,791
PLANNING AND DESIGN	15,618	15,618
GENERAL REDUCTION	-6,323	-6,323

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
SUBTOTAL, CONSTRUCTION	280,790	295,590
OPERATION AND MAINTENANCE		
MAINTENANCE OF REAL PROPERTY	414,967	414,967
LEASING	135,079	135,079
MISCELLANEOUS ACCOUNT	293	293
MANAGEMENT ACCOUNT	82,331	82,331
FURNISHINGS ACCOUNT	33,199	33,199
UTILITIES ACCOUNT	184,519	184,519
SERVICES ACCOUNT	64,829	64,829
MORTGAGE INSURANCE PREMIUMS	76	76
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-3,000
SUBTOTAL, OPERATION AND MAINTENANCE	915,293	912,293
TOTAL, FAMILY HOUSING, NAVY AND MARINE CORPS	1,196,083	1,207,883
FAMILY HOUSING, AIR FORCE		
ALABAMA		
MAXWELL AFB (143 UNITS)	16,300	16,300
ALASKA		
EIELSON AFB (46 UNITS)	12,932	12,932
CALIFORNIA		
EDWARDS AFB (48 UNITS)	12,580	12,580
VANDENBERG AFB (95 UNITS)	18,499	18,499
DELAWARE		
DOVER AFB (55 UNITS)	8,998	8,998
FLORIDA		
MACDILL AFB (48 UNITS)	7,609	7,609
PATRICK AFB (46 UNITS)	9,692	9,692
TYNDALL AFB (122 UNITS)	14,500	14,500
MISSISSIPPI		
KEESLER AFB (52 UNITS)	---	6,800
COLUMBUS AFB (52 UNITS)	---	6,800
MONTANA		
MALMSTROM AFB (50 UNITS)	---	10,000
NEBRASKA		
OFFUTT AFB (HOUSING MAINTENANCE FACILITY)	900	900
OFFUTT AFB (HOUSING OFFICE)	870	870
OFFUTT AFB (90 UNITS)	12,212	12,212
NEVADA		
NELLIS AFB (28 UNITS)	---	5,000
NEW MEXICO		
KIRTLAND AFB (37 UNITS)	6,400	6,400
OHIO		
WRIGHT-PATTERSON AFB (40 UNITS)	5,600	5,600
TEXAS		
DYESS AFB (64 UNITS)	9,415	9,415
SHEPPARD AFB (65 UNITS)	---	7,000
WASHINGTON		
FAIRCHILD AFB (HOUSING OFFICE/MAINTENANCE FACILITY)	1,692	1,692
FAIRCHILD AFB (14 UNITS)	2,300	2,300
CONSTRUCTION IMPROVEMENTS	81,778	104,108
PLANNING AND DESIGN	11,342	11,342
GENERAL REDUCTION	-7,584	-9,584
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
SUBTOTAL, CONSTRUCTION	226,035	280,965
OPERATION AND MAINTENANCE		
MORTGAGE INSURANCE PREMIUMS	32	32
MAINTENANCE OF REAL PROPERTY	388,659	388,659
MISCELLANEOUS ACCOUNT	5,240	5,240
LEASING	118,071	118,071
FURNISHINGS ACCOUNT	37,218	36,427
UTILITIES ACCOUNT	152,214	152,214
SERVICES ACCOUNT	36,066	35,849

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
MANAGEMENT ACCOUNT	52,495	48,712
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-2,000
SUBTOTAL, OPERATION AND MAINTENANCE	789,995	783,204
TOTAL, FAMILY HOUSING, AIR FORCE	1,016,030	1,064,169
FAMILY HOUSING, DEFENSE-WIDE		
CONSTRUCTION IMPROVEMENTS (NSA) (MENWITH HILL, UNITED KINGDOM) (27 UNITS)	50	50
CONSTRUCTION IMPROVEMENTS (DLA) (RICHMOND, VA CARPORTS AND SHELTERS; LATHROP, CA FENCING)	295	295
SUBTOTAL, CONSTRUCTION	345	345
OPERATION AND MAINTENANCE		
FURNISHINGS ACCOUNT (NSA)	126	126
FURNISHINGS ACCOUNT (DIA)	2,153	2,153
FURNISHINGS ACCOUNT (DLA)	125	125
MANAGEMENT ACCOUNT (NSA)	70	70
MANAGEMENT ACCOUNT (DLA)	244	244
MISCELLANEOUS ACCOUNT (NSA)	735	735
SERVICES ACCOUNT (NSA)	355	355
SERVICES ACCOUNT (DLA)	51	51
UTILITIES ACCOUNT (NSA)	450	450
UTILITIES ACCOUNT (DLA)	424	424
LEASING (NSA)	12,292	12,292
LEASING (DIA)	18,847	18,847
MAINTENANCE OF REAL PROPERTY (NSA)	496	496
MAINTENANCE OF REAL PROPERTY (DLA)	531	531
SUBTOTAL, OPERATION AND MAINTENANCE	36,899	36,899
TOTAL, FAMILY HOUSING, DEFENSE-WIDE	37,244	37,244
DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND		
DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND	7,000	2,000
HOMEOWNERS ASSISTANCE FUND		
HOMEOWNERS ASSISTANCE FUND	12,800	---
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III		
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III	433,464	429,164
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-2,000
SUBTOTAL	433,464	427,164
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV		
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV	1,297,240	1,268,438
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-3,000
INFLATION SAVINGS PREVIOUSLY WITHHELD	---	-26,000
UNREPORTED PROCEEDS	---	-35,700
SUBTOTAL	1,297,240	1,203,738
TOTAL, BASE REALIGNMENT AND CLOSURE	1,730,704	1,630,902
GENERAL PROVISIONS		
SECTION 125 (FAMILY HOUSING, PAINE FIELD, EVERETT, WA)	6,000	6,000
GRAND TOTAL	7,784,074	8,449,742

CONFERENCE TOTAL—WITH COMPARISONS

The total new budget (obligational) authority for the fiscal year 1999 recommended by the Committee of Conference, with comparisons to the fiscal year 1998 amount, the 1999 budget estimates, and the House and Senate bills for 1999 follow:

New budget (obligational) authority, fiscal year 1998.	$9,208,468,000
Budget estimates of new (obligational) authority, fiscal year 1999	7,784,074,000
House bill, fiscal year 1999	8,234,074,000
Senate bill, fiscal year 1999	8,480,574,000
Conference agreement, fiscal year 1999	8,449,742,000
Conference agreement compared with:	
New budget (obligational) authority, fiscal year 1998	−758,726,000
Budget estimates of new (obligational) authority, fiscal year 1999	+665,668,000
House bill, fiscal year 1999	+215,668,000
Senate bill, fiscal year 1999	−30,832,000

RON PACKARD,
JOHN EDWARD PORTER,
DAVID L. HOBSON,
ROGER F. WICKER,
JACK KINGSTON,
MIKE PARKER,
TODD TIAHRT,
ZACH WAMP,
BOB LIVINGSTON,
W.G. (BILL) HEFNER,
JOHN W. OLVER,
CHET EDWARDS,
BUD CRAMER,
NORMAN DICKS,
DAVID OBEY,
Managers on the Part of the House.

CONRAD BURNS,
KAY BAILEY HUTCHISON,
LAUCH FAIRCLOTH,
LARRY E. CRAIG,
TED STEVENS,
PATTY MURRAY,
HARRY REID,
DANIEL K. INOUYE,
ROBERT C. BYRD,
Managers on the Part of the Senate.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. YATES (at the request of Mr. GEPHARDT) for today, on account of illness in the family.

Mr. FORD (at the request of Mr. GEPHARDT) for today, on account of personal business.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. FILNER) to revise and extend their remarks and include extraneous material:)

Mr. CONYERS, for 5 minutes, today.

Mr. ENGEL, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Ms. SLAUGHTER, for 5 minutes, today.

Mr. FALEOMAVAEGA, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Mr. LAMPSON, for 5 minutes, today.

(The following Members (at the request of Mr. COLLINS) to revise and extend their remarks and include extraneous material:)

Mr. GUTKNECHT, for 5 minutes, today.

Mr. BEREUTER, for 5 minutes, today.

Mr. COLLINS, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

Mr. OBERSTAR, and to include extraneous material, notwithstanding the fact it exceeds two pages and is estimated by the Public Printer to cost $1,508.

(The following Members (at the request of Mr. FILNER) and to include extraneous material:)

Mr. KIND.

Mr. BARRETT of Wisconsin.

Mr. MARKEY.

Mr. HALL of Ohio.

Mr. POSHARD.

Mr. COSTELLO.

Mr. HAMILTON.

Mr. ROEMER.

Ms. NORTON.

Mrs. MEEK of Florida.

Mr. LIPINSKI.

Mr. CONYERS.

Mr. FORD.

Mr. SANDERS.

Ms. ESHOO.

(The following Members (at the request of Mr. COLLINS) and to include extraneous material:)

Mr. SMITH of Michigan.

Mr. SHAW.

Mr. GILMAN.

Mr. RADANOVICH.

ADJOURNMENT

Mr. SERRANO. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 4 o'clock and 38 minutes p.m.), under its previous order, the House adjourned until Monday, July 27, 1998, at 10:30 a.m., for morning hour debates.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

10269. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Pyripoxyfen (2-[1-methyl-2- (4-phenoxyp enoxy)ethoxy]pyridine; Pesticide Tolerance [OPP–300666; FRL–5794–6] (RIN: 2070–AB78) received June 29, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

10270. A communication from the President of the United States, transmitting his request to make available appropriations of $100,000,000 in budget authority for the Department of Health and Human Services' Low Income Home Energy Assistance Program, pursuant to Public Law 105—78; (H. Doc. No. 105—289); to the Committee on Appropriations and ordered to be printed.

10271. A letter from the Assistant Secretary of the Army (Research, Development and Acquisition), Department of Army, transmitting notification of munitions disposal, pursuant to 50 U.S.C. 1512(4); to the Committee on National Security.

10272. A letter from the Assistant Secretary, Health Affairs, Department of Defense, transmitting a report on the Sharing Agreement Authorized Under Section 743 of the FY98 Defense Authorization Act Between The Secretary of the Air Force and Gerald Champion Memorial Hospital, pursuant to Public Law 105—85; to the Committee on National Security.

10273. A letter from the Director, Office of Rulemaking Coordination, Department of Energy, transmitting the Department's final rule—Security And Control Of Nuclear Explosives And Nuclear Weapons—received July 7, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on National Security.

10274. A letter from the Acting Director, Office of Management and Budget, transmitting an account for contributions to defray costs of U.S.operations in Southwest Asia; to the Committee on National Security.

10275. A letter from the Secretary of Defense, transmitting a report to Congress entitled ''Medical Tracking System for Members Deployed Overseas,'' pursuant to Pun. L. 105—85; to the Committee on National Security.

10276. A letter from the Acting Director of Communications and Legislative Affairs, Equal Employment Opportunity Commission, transmitting the Department's final rule—Waiver of Rights and Claims Under the Age Discrimination Act (ADEA) [29 CFR Part 1625] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and the Workforce.

10277. A letter from the Secretary of Labor, transmitting a report entitled ''Minimum Wage and Overtime Hours Report''; to the Committee on Education and the Workforce.

10278. A letter from the Secretary of Energy, transmitting the Department's report entitled, ''Summary of Expenditures of Rebates from the Low-Level Radioactive Waste Surcharge Escrow Account for Calendar Year 1997,'' pursuant to 42 U.S.C. 2120e(d)(2)(E)(ii)(II); to the Committee on Commerce.

10279. A letter from the Director, Office of Rulemaking Coordination, Department of Energy, transmitting the Department's final rule—Worker Protection Management For DOE Federal And Contractor Employees—received July 7, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10280. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—National Priorities List for Uncontrolled Hazardous Waste Sites [FRL–6130–9] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10281. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Walla Walla and Pullman, Washington, and Hermiston, Oregon) [MM Docket No. 97–246; RM–9205; RM–9250] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10282. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—

Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Shenandoah, Virginia) [MM Docket No. 98–30; RM–9228] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10283. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Canton, Normal and Heyworth, Illinois) [MM Docket No. 96–225; RM–8894; RM–9004] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10284. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Federal-State Joint Board on Universal Service [CC Docket No. 96–45] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10285. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of the Commission's Rules Concerning Maritime Communications [PR Docket No. 92–257; RM–7956; RM–8031; RM–8352] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10286. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Point Arena, California) [MM Docket No. 97–236; RM–9186] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10287. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Horseshoe Beach and Otter Creek, Florida) [MM Docket No. 97–239; RM–9195; RM–9237] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10288. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations, (Salmon, Idaho) [MM Docket No. 98–51; RM–9241] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10289. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Gurdon, Arkansas) [MM Docket No. 98–40] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10290. A letter from the Acting Secretary, Federal Trade Commission, transmitting the Commission's final rule—Amended Enforcement Policy Concerning Clear and Conspicuous Disclosure in Foreign Language Advertising and Sales Materials—received June 29, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10291. A letter from the Secretary of Health and Human Services, transmitting the fifteenth annual report to Congress of the Orphan Products Board (OPB), pursuant to 42 U.S.C. 236(e); to the Committee on Commerce.

10292. A letter from the Secretary, Securities and Exchange Commission, transmitting the Commission's final rule—Exemption for Investment Advisers Operating in Multiple States; Revisions to Rules Implementing Amendment s to the Investment Advisers Act of 1940; Investment Advisers with Principal Offices and Places of Business in Colorado or Iowa [Release No. IA–1733, File No. S7–28–97] (RIN: 3235–AH22) received July 20, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10293. A letter from the Secretary of Defense, transmitting second half FY 1997 semi-annual report on Program Activities to Facilitate Weapons Destruction and Nonproliferation in the Former Soviet Union, pursuant to 22 U.S.C. 5956; to the Committee on International Relations.

10294. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–386, ''Sex Offender Registration Temporary Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10295. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–383, ''School Transit Subsidy Act of 1978 Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10296. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–385, ''Abatement of Controlled Dangerous Substance Nuisances Temporary Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10297. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 12–393, ''Quick Payment Temporary Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10298. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–405 ''Windshield Wipers and Headlamp Regulation Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10299. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–404 ''Closing of a Public Alley in Square 185, S.O. 97–106, Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10300. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–384, ''Bishop Aimilianos Laloussis Park Designation Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10301. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–407, ''Closing of 8th, L, and M Streets, N.W., and the Closing of Public Alleys in Squares 400, 401, 402, 426, 425, and 424, S.O. 96–90, Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10302. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–402 ''Washington Convention Center Authority Financing Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10303. A letter from the Director, Personnel and Family Readiness Division, Department of the Navy, transmitting the annual report of the Retirement Plan for Civilian Employees of the United States Marine Corps Morale, Welfare and Recreation Support Activity, and Miscellaneous Nonappropriated Fund Instrumentalities, pursuant to 31 U.S.C. 9503(a)(1)(B); to the Committee on Government Reform and Oversight.

10304. A letter from the Acting Assistant General Counsel for Regulations, Department of Education, transmitting the Department's final rule—Administration of grants and agreements with institutions of higher education, hospitals, and other non-profit organizations; and Uniform administrative requirements for grants and cooperative agreements to State and local governments [34 CFR Parts 74 and 80] received July 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform and Oversight.

10305. A letter from the Acting Director, Office of Management and Budget, transmitting a copy of the report, ''Agency Compliance with Title II of the Unfunded Mandates Reform Act of 1995,'' pursuant to 2 U.S.C. 1538; to the Committee on Government Reform and Oversight.

10306. A letter from the Chairman, U.S. Merit Systems Protection Board, transmitting a report entitled ''Federal Supervisors and Strategic Human Resources Management''; to the Committee on Government Reform and Oversight.

10307. A letter from the Secretary of Health and Human Services, transmitting a report on the Indian Lands Open Dump Cleanup Act of 1997; to the Committee on Resources.

10308. A letter from the Acting Secretary, Federal Trade Commission, transmitting the Commission's final rule—Organization, General Procedures, Rules of Practice for Adjudicative Proceedings [16 CFR Parts 0, 1, and 3] received July 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

10309. A letter from the Attorney, National Council on Radiation Protection and Measurements, transmitting the 1997 annual report of independent auditors who have audited the records of the National Council on Radiation Protection and Measurements, pursuant to Public Law 88—376, section 14(b) (78 Stat. 323); to the Committee on the Judiciary.

10310. A letter from the Executive Director, National Mining Hall of Fame and Museum, transmitting the Museum's 1997 audited financial statement and a copy of Form 990 which was filed with the Internal Revenue Service, pursuant to 36 U.S.C. 4111; to the Committee on the Judiciary.

10311. A letter from the Chief Counsel, Bureau of the Public Debt, transmitting the Department's final rule—Regulations Governing Book-Entry Treasury BONDS, Notes, and Bills; Determination Regarding State Statutes; Georgia, Florida and Connecticut [Department of the Treasury Circular, Public Debt Series, No. 2–86] received July 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

10312. A letter from the Secretary of Health and Human Services, transmitting the Department's final rule—Child Support Enforcement Program Quarterly Wage and Unemployment Compensations Claims Reporting to the National Directory of New Hires (RIN: 0970–AB67) received June 31, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

10313. A letter from the Secretary of Energy, transmitting a draft of proposed legislation to provide for a more competitive electric power industry, and for other purposes; jointly to the Committees on Commerce and the Judiciary.

10314. A letter from the Secretary of Health and Human Services, transmitting

the Department's ''Major'' final rule—Medicare Program; Medicare Coverage of and Payment for Bone Mass Measurements [HCFA–3004–IFC] (RIN: 0938–AI89) received June 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); jointly to the Committees on Commerce and Ways and Means.

10315. A letter from the Administrator, Agency for International Development, transmitting a quarterly update report on development assistance program allocations updated as of March 31, 1998, pursuant to 22 U.S.C. 2413(a); jointly to the Committees on International Relations and Appropriations.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk of printing and reference to the proper calendar, as follows:

Mr. SMITH of Texas: Committee on the Judiciary. S. 1304. An act for the relief of Belinda McGregor (Rept. 105–646).

Mr. PACKARD: Committee of Conference. Conference report on H.R. 4059. A bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes (Rept. 105–647). Ordered to be printed.

Mr. WOLF: Committee on Appropriations. H.R. 4328. A bill making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes (Rept. 105–648). Referred to the Committee of the Whole House on the State of the Union.

Mr. GOODLING: Committee on Education and the Workforce. H.R. 3254. A bill to amend the Individuals with Disabilities Education Act to clarify the requirements relating to reducing or withholding payments to States under that Act; with an amendment (Rept. 105–649). Referred to the Committee of the Whole House on the State of the Union.

REPORTS OF COMMITTEES ON PRIVATE BILLS AND RESOLUTIONS

Under Clause 2 of rule XIII reports of committees were delivered to the Clerk of printing and reference to the proper calendar, as follows:

Mr. SMITH of Texas: Committee on the Judiciary. H.R. 379. A bill for the relief of Larry Errol Pieterse (Rept. 105–644. Referred to the Committee of the Whole House.

Mr. SMITH of Texas: Committee on the Judiciary. H.R. 2744. A bill for the relief of Chong Ho Kwak, (Rept. 105–645). Referred to the Committee of the Whole House.

PUBLIC BILLS AND RESOLUTIONS

Under clause 5 of rule X and clause 4 of rule XXII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. SMITH of Oregon:

H.R. 4326. A bill to transfer administrative jurisdiction over certain Federal lands located within or adjacent to the Rogue River National Forest and to clarify the authority of the Bureau of Land Management to sell and exchange other Federal lands in Oregon; to the Committee on Resources.

By Mr. SAXTON (for himself, Mr. HUNTER, Mr. GINGRICH, Mr. ARMEY, Mr. SPENCE, Mr. LIVINGSTON, Mr. WELDON of Pennsylvania, and Mrs. BONO):

H.R. 4327. A bill to direct the President to commence an emergency program to build and field as quickly as possible a theater missile defense system capable of defending against the type of ballistic missile that was flight tested by Iran on July 21, 1998; to the Committee on National Security.

By Mr. WOLF:

H.R. 4328. A bill making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes.

By Mr. CASTLE:

H.R. 4329. A bill to require the design of the obverse side of the $1 coin to depict the Statue of Liberty; to the Committee on Banking and Financial Services.

By Mr. COLLINS (for himself and Mr. TANNER):

H.R. 4330. A bill to amend the Internal Revenue Code of 1986 to allow capital gains treatment and an exception from the uniform capitalization rules for timber which is more than 4 years old when harvested; to the Committee on Ways and Means.

By Mr. HILL:

H.R. 4331. A bill to provide for the establishment of an interpretive center and museum at Fort Peck Dam, Montana, and to provide further protection for significant fossil remains in the vicinity of Fort Peck Dam; to the Committee on Transportation and Infrastructure.

By Mr. HULSHOF (for himself, Mr. MCCRERY, Mr. JEFFERSON, Mr. COLLINS, Mr. WELLER, Mr. CRANE, Mr. KLECZKA, Mr. BUNNING of Kentucky, Mr. SAM JOHNSON, Ms. DUNN of Washington, Mr. NUSSLE, Mr. CHRISTENSEN, Mr. WATKINS, Mr. BAKER, Mr. BACHUS, Mr. SESSIONS, Mrs. NORTHUP, and Ms. GRANGER):

H.R. 4332. A bill to amend the Internal Revenue Code of 1986 to repeal the 4.3-cent motor fuel excise taxes on railroads and inland waterway transportation which remain in the general fund of the Treasury; to the Committee on Ways and Means.

By Mrs. MALONEY of New York:

H.R. 4333. A bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage of annual mammograms and annual prostate cancer screening tests following the model established under the Medicare Program; to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. YOUNG of Alaska:

H.R. 4334. A bill to prohibit the construction of new facilities and structures within the boundaries of the George Washington Memorial Parkway along the Potomac River in Virginia between the Francis Scott Key Bridge and the Theodore Roosevelt Memorial Bridge; to the Committee on Resources.

By Mr. YOUNG of Alaska (for himself, Mr. HERGER, Mr. POMBO, Mr. NETHERCUTT, Mrs. CHENOWETH, Mr. SMITH of Oregon, and Mr. CRAPO):

H.R. 4335. A bill to transfer to the Secretary of the Interior the functions of the Secretary of Commerce and the National Marine Fisheries Service under the Endangered Species Act of 1973; to the Committee on Resources.

By Mr. BARR of Georgia:

H. Con. Res. 308. Concurrent resolution expressing the sense of the Congress with respect to the failure of Attorney General Janet Reno to seek application for an independent counsel to investigate a number of matters relating to the financing of campaigns in the 1996 Federal election, including the conduct of President Clinton and Vice President Gore; to the Committee on the Judiciary.

By Mr. PAYNE (for himself, Mr. BERMAN, Mr. GILMAN, Mr. SMITH of New Jersey, Mr. MENENDEZ, Mr. LANTOS, and Mr. HASTINGS of Florida):

H. Con. Res. 309. Concurrent resolution condemning the forced abduction of Ugandan children and their use as soldiers; to the Committee on International Relations.

ADDITIONAL SPONSORS

Under clause 4 of rule XXII, sponsors were added to public bills and resolutions as follows:

H.R. 59: Mr. WHITFIELD.
H.R. 303: Ms. DELAURO.
H.R. 997: Mr. KOLBE.
H.R. 1126: Mr. SANDLIN, Mr. CRANE, and Ms. DUNN of Washington.
H.R. 1283: Ms. VELAZQUEZ.
H.R. 1289: Ms. KAPTUR.
H.R. 1382: Ms. KAPTUR and Mr. KING of New York.
H.R. 1401: Mr. SANDERS.
H.R. 1450: Mr. STOKES.
H.R. 1773: Mr. WAMP.
H.R. 1995: Mr. FRANKS of New Jersey.
H.R. 2023: Mr. ROTHMAN.
H.R. 2409: Mr. KAPTUR and Mr. SOUDER.
H.R. 2456: Mrs. WILSON.
H.R. 2602: Mr. LANTOS.
H.R. 2635: Ms. VELAZQUEZ and Mr. UPTON.
H.R. 2754: Mr. SHERMAN and Ms. CHRISTIAN-GREEN.
H.R. 2951: Mr. HAYWORTH.
H.R. 3068: Ms. LEE.
H.R. 3081: Mrs. CLAYTON and Mr. MALONEY of Connecticut.
H.R. 3215: Mrs. THURMAN.
H.R. 3248: Mr. ENSIGN and Mr. COLLINS.
H.R. 3254: Mr. CAMPBELL, Mrs. BONO, Mr. ROYCE, and Mr. THOMAS.
H.R. 3290: Mrs. BONO.
H.R. 3320: Mr. FORBES, Mr. BISHOP, Ms. MCKINNEY, and Mr. ADAM SMITH of Washington.
H.R. 3400: Mr. SHERMAN and Ms. CHRISTIAN-GREEN.
H.R. 3445: Mr. FALEOMAVAEGA.
H.R. 3567: Mr. METCALF.
H.R. 3572: Mr. LAMPSON.
H.R. 3610: Mr. GORDON and Mr. DEAL of Georgia.
H.R. 3629: Mr. SOUDER.
H.R. 3681: Mr. BACHUS.
H.R. 3734: Mr. PICKERING.
H.R. 3780: Mr. LEWIS of Georgia, Mr. ENSIGN, Mr. CALVERT, and Mr. CRANE.
H.R. 3783: Mr. BUYER, Ms. FURSE, Mr. FOLEY, and Mr. CHRISTENSEN.
H.R. 3876: Mr. THOMPSON, Mr. GORDON, Mr. CARDIN, Mr. EVANS, Ms. MCKINNEY, Mr. LAMPSON, Mr. NADLER, and Mr. SHERMAN.
H.R. 3918: Mr. SERRANO, Mr. SCHUMER, and Mr. NADLER.
H.R. 3992: Mr. WELLER, Mr. BUNNING of Kentucky, Mr. GOODE, Mr. SESSIONS, Mr. TALENT, and Mr. BONILLA.
H.R. 3995: Mr. FRANK of Massachusetts, Mr. VENTO, and Ms. ROYBAL-ALLARD.
H.R. 4009: Mr. BOSWELL, Mr. CRAMER, Mr. BONIOR, Ms. FURSE, Mrs. CAPPS, and Ms. MCCARTHY of Missouri.
H.R. 4025: Mrs. THURMAN.
H.R. 4028: Mr. TAYLOR of Mississippi, Mr. FILNER, and Ms. KAPTUR.
H.R. 4031: Mr. RUSH, Mr. WAXMAN, and Ms. FURSE.
H.R. 4071: Mr. OBERSTAR, Mr. STRICKLAND, and Mr. ADERHOLT.

H.R. 4078: Mr. MCGOVERN, Mr. ABERCROMBIE, and Mr. FORD.

H.R. 4095: Mr. BONIOR, Mr. FALEOMAVAEGA, Mr. MENENDEZ, and Mr. BEREUTER.

H.R. 4121: Ms. LOFGREN, Mr. ENGLISH of Pennsylvania, Mrs. THURMAN, Mr. GREENWOOD, and Ms. SANCHEZ.

H.R. 4134: Mr. BALDACCI.

H.R. 4167: Mr. CHRISTENSEN.

H.R. 4188: Mr. BILIRAKIS.

H.R. 4204: Mr. MCCOLLUM, Mr. NUSSLE, and Mr. BLUNT.

H.R. 4206: Mr. DINGELL, Ms. ROYBAL-ALLARD, Mr. TOWNS, Mr. SCHUMER, Mr. MARKEY, Ms. MCKINNEY, Mrs. MORELLA, Mr. PALLONE, Mr. PAYNE, and Mr. MATSUI.

H.R. 4209: Mr. ENGEL.

H.R. 4211: Mr. EHLERS, Mr. HASTINGS of Florida, and Mr. ENGLISH of Pennsylvania.

H.R. 4213: Mr. FOLEY and Mr. RILEY.

H.R. 4224: Mr. LEWIS of Georgia, Mr. BAESLER, and Mr. BONIOR.

H.R. 4233: Mr. SABO, Mr. STARK, Mrs. CLAYTON, Ms. FURSE, Mrs. TAUSCHER, and Mr. FILNER.

H.R. 4250: Mr. BLUNT, Mr. KNOLLENBERG, and Mr. HILL.

H.R. 4258: Mr. CANNON and Mr. BURR of North Carolina.

H.R. 4265: Mr. NORWOOD, Mr. EDWARDS, Mr. HILL, Ms. GRANGER, and Mr. INGLIS of South Carolina.

H.R. 4275: Mr. ROGERS, Mr. HOUGHTON, Mrs. EMERSON, Mr. HINCHEY, Mr. WATTS of Oklahoma, Mr. NEY, Mr. CLYBURN, Mr. RAHALL, Mr. PETERSON of Minnesota, Mr. BALDACCI, Ms. DELAURO, Mr. WISE, Mr. MCGOVERN, Mr. SANDLIN, Mr. LAMPSON, Mr. BOSWELL, Mr. LIPINSKI, Mr. BORSKI, Mr. HOLDEN, Ms. NORTON, Mr. WALSH, Mr. BOUCHER, Mr. BUNNING of Kentucky, Mr. ADERHOLT, Mr. BOEHLERT, and Mr. WICKER.

H.R. 4281: Mr. GOODE.

H. Con. Res. 122: Mr. ABERCROMBIE, Mr. ENGEL, Mr. FORBES, Mr. HINCHEY, Ms. ROS-LEHTINEN, Mr. SPRATT, Mr. WAXMAN, and Mr. YATES.

H. Con. Res. 148: Mr. FRANKS of New Jersey.

H. Con. Res. 184: Mr. MCGOVERN.

H. Con. Res. 185: Mr. UNDERWOOD, Mr. MARKEY, Mr. HOYER, Mr. OLVER, Mrs. MALONEY of New York, Mr. SABO, Mr. PITTS, and Mr. LAMPSON.

H. Con. Res. 203: Mr. PETRI.

H. Con. Res. 239: Ms. KILPATRICK.

H. Con. Res. 299: Mr. STUMP, Mr. CAMPBELL, and Mr. HASTINGS of Washington.

H. Con. Res. 303: Mr. HINCHEY.

H. Con. Res. 304: Mr. CARDIN, Mrs. KELLY, Mr. MILLER of California, and Mr. BONIOR.

PETITIONS, ETC.

Under clause 1 of rule XXII, petitions and papers were laid on the clerk's desk and referred as follows:

69. The SPEAKER presented a petition of Peter Strzelczyk, M.D., citizen of Katowise, Poland, relative to a demand for damages for the estate of his wife, Ewa Strzelczyk, resulting from the Cavalese, Italy tragedy; to the Committee on the Judiciary.

70. Also, a petition of Peter Strzelczyk, M.D., citizen of Katowise, Poland, relative to a demand for damages for the estate of his son, Filip Strzelczyk, resulting from the Cavalese, Italy tragedy; to the Committee on the Judiciary.

DISCHARGE PETITIONS

Under clause 3 of rule XXVII, the following discharge petition was filed:

Petition 7. July 20, 1998, by Mr. GANSKE on House Resolution 486, was signed by the following Members: Greg Ganske, John D. Dingell, Michael R. McNulty, John W. Olver, Sherrod Brown, Bob Filner, Alcee L. Hastings, Eddie Bernice Johnson, Lois Capps, Elijah E. Cummings, Jesse L. Jackson, Jr., Gregory W. Meeks, Barney Frank, Karen McCarthy, Lynn C. Woolsey, Anna G. Eshoo, Frank Mascara, David E. Skaggs, Ron Kind, Maurice D. Hinchey, Barbara Lee, Elizabeth Furse, Eva M. Clayton, Carrie P. Meek, Bill Pascrell, Jr., Max Sandlin, Chet Edwards, Nydia M. Velazquez, Robert E. Wise, Jr., Barbara B. Kennelly, Nick Lampson, Lloyd Doggett, Ruben Hinojosa, Steve R. Rothman, Dale E. Kildee, Jane Harman, Earl Blumenauer, Robert A. Borski, Thomas C. Sawyer, John F. Tierney, James P. McGovern, Robert A. Weygand, Bart Stupak, Lynn N. Rivers, Patsy T. Mink, Scotty Baesler, Albertr Russell Wynn, Thomas J. Manton, Sidney R. Yates, Zoe Lofgren, Rosa L. DeLauro, Jim Turner, Ellen O. Tauscher, Loretta Sanchez, Vic Snyder, Marion Berry, Sanford D. Bishop, Jr., Karen L. Thurman, Debbie Stabenow, Jay W. Johnson, Howard L. Berman, Cynthia A. McKinney, Gene Green, Ken Bentsen, Darlene Hooley, Sheila Jackson-Lee, Steny H. Hoyer, Bart Gordon, John J. LaFalce, David E. Price, Jim Davis, Danny K. Davis, Robert E. Andrews, Jose E. Serrano, Brad Sherman, Melvin L. Watt, Julia Carson, Martin Olav Sabo, David E. Bonior, Ciro D. Rodriguez, Esteban Edward Torres, Vic Fazio, Bruce F. Vento, John M. Spratt, Jr., Diana DeGette, Charles E. Schumer, Calvin M. Dooley, Carolyn McCarthy, James E. Clyburn, Robert Menendez, Edward J. Markey, Thomas H. Allen, Nita M. Lowey, James P. Moran, Ron Klink, Jim McDermott, Jerrold Nadler, Bob Clement, Paul McHale, Robert E. (Bud) Cramer, Jr., Corrine Brown, George Miller, Sam Farr, Michael F. Doyle, Robert A. Brady, Xavier Becerra, Nick J. Rahall II, Norman D. Dicks, Frank Pallone, Jr., Gerald D. Kleczka, Sander M. Levin, Neil Abercrombie, Dennis J. Kucinich, George E. Brown, Jr., Leonard L. Boswell, Tom Lantos, Peter Deutsch, Jerry F. Costello, Maxine Waters, Nancy Pelosi, Chaka Fattah, Louise McIntosh Slaughter, John Elias Baldacci, Thomas M. Barrett, Carolyn C. Kilpatrick, Henry A. Waxman, William D. Delahunt, Patrick J. Kennedy, Robert Wexler, Paul E. Kanjorski, Tony P. Hall, Marcy Kaptur, John Conyers, Jr., Joseph P. Kennedy II, Eliot L. Engel, Sam Gejdenson, David R. Obey, Fortney Pete Stark, Lane Evans, Earl Pomeroy, Tim Holden, Ralph M. Hall, James H. Maloney, Bobby L. Rush, James A. Barcia, Ike Skelton, Peter A. DeFazio, Bernard Sanders, Luis V. Gutierrez, Robert T. Matsui, Donald M. Payne, Benjamin L. Cardin, Major R. Owens, Bill Luther, William J. Coyne, Silvestre Reyes, Carolyn B. Maloney, Ted Strickland, Charles W. Stenholm, Martin T. Meehan, W. G. (Bill) Hefner, William O. Lipinski, Richard A. Gephardt, Lucille Roybal-Allard, Glenn Poshard, John Lewis, Earl F. Hilliard, Martin Frost, Gary L. Ackerman, Edolphus Towns, Bennie G. Thompson, Juanita Millender-McDonald, Adam Smith, Rod R. Blagojevich, Charles B. Rangel, Solomon Ortiz, Lee H. Hamilton, Robert C. Scott, Louis Stokes, Christopher John, William J. Jefferson, John S. Tanner, Ed Pastor, Mike McIntyre, William (Bill) Clay, Rick Boucher, Julian C. Dixon, David Minge, Allen Boyd, and Collin C. Peterson.

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:

Petition 1 by Mr. YATES on House Resolution 141: Earl Pomeroy and Frank Mascara.

Petition 6 by Mr. OBEY on House Resolution 473: Lee H. Hamilton, Ike Skelton, Neil Abercrombie and Darlene Hooley.

AMENDMENTS

Under clause 6 of rule XXIII, proposed amendments were submitted as follows:

H.R. 2183

OFFERED BY: MR. SALMON

(To the Amendments Offered By: Mr. Hutchinson)

AMENDMENT NO. 173: Add at the end the following new title:

TITLE ____—POSTING NAMES OF CERTAIN AIR FORCE ONE PASSENGERS ON INTERNET

SEC. ___01. REQUIREMENT THAT NAMES OF PASSENGERS ON AIR FORCE ONE AND AIR FORCE TWO BE MADE AVAILABLE THROUGH THE INTERNET.

(a) IN GENERAL.—The President shall make available through the Internet the name of any non-Government person who is a passenger on an aircraft designated as Air Force One or Air Force Two not later than 30 days after the date that the person is a passenger on such aircraft.

(b) EXCEPTION.—Subsection (a) shall not apply in a case in which the President determines that compliance with such subsection would be contrary to the national security interests of the United States. In any such case, not later than 30 days after the date that the person whose name will not be made available through the Internet was a passenger on the aircraft, the President shall submit to the chairman and ranking member of the Permanent Select Committee on Intelligence of the House of Representatives and of the Select Committee on Intelligence of the Senate—

(1) the name of the person; and

(2) the justification for not making such name available through the Internet.

(c) DEFINITION OF PERSON.—As used in this Act, the term ''non-Government person'' means a person who is not an officer or employee of the United States, a member of the Armed Forces, or a Member of Congress.

H.R. 4194

OFFERED BY: MR. COBURN

AMENDMENT NO. 33: At the end of the bill, insert after the last section (preceding the short title) the following new sections:

SEC. . The amounts otherwise provided by this Act are revised by reducing the amount made available under the heading ''DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—FEDERAL HOUSING ADMINISTRATION—FHA—MUTUAL MORTGAGE INSURANCE PROGRAM ACCOUNT'' for non-overhead administrative expenses necessary to carry out the Mutual Mortgage Insurance guarantee and direct loan program, and increasing the amount made available for ''DEPARTMENT OF VETERANS AFFAIRS—VETERANS HEALTH ADMINISTRATION—MEDICAL CARE'', by $199,999,999.

SEC. . The amounts otherwise provided by this Act are revised by reducing the amount made available under the heading ''DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—FEDERAL HOUSING ADMINISTRATION—FHA—GENERAL AND SPECIAL RISK PROGRAM ACCOUNT'' for non-overhead administrative expenses necessary to carry out the guaranteed and direct loan programs, and increasing the amount made available for ''DEPARTMENT OF VETERANS AFFAIRS—VETERANS HEALTH ADMINISTRATION—MEDICAL CARE'', by $103,999,999.

H.R. 4274

OFFERED BY: MR. DUNCAN

AMENDMENT NO. 1: Page 2, line 19, after ''$150,572,000'' insert ''(decreased by $61,402,000)''.

H.R. 4276

OFFERED BY: MR. KOLBE

AMENDMENT NO. 19: At the end of the bill, insert after the last section (preceding the short title) the following:

TITLE —ADDITIONAL GENERAL PROVISIONS

SEC. . None of the funds made available in this or any other Act may be used to implement, administer, or enforce Executive Order 13083 (titled ''Federalism'' and dated May 14, 1998).

H.R. 4276

OFFERED BY: MR. KOLBE

AMENDMENT NO. 20: At the end of the bill, insert after the last section (preceding the short title) the following:

TITLE —ADDITIONAL GENERAL PROVISIONS

SEC. . None of the funds made available in this Act may be used to implement, administer, or enforce Executive Order 13083 (titled ''Federalism'' and dated May 14, 1998).

H.R. 4276

OFFERED BY: MR. SANDERS

AMENDMENT NO. 21: Page 101, line 21, insert ''(increased by $4,000,000)'' after the dollar amount.

Page 102, line 3, insert ''(increased by $4,000,000)'' after the dollar amount.

Page 100, line 13 insert ''(decreased by $4,000,000)'' after the dollar amount.

H.R. 4276

OFFERED BY: MR. SANDERS

AMENDMENT NO. 22: Page 101, line 21 insert ''(increased by $4,000,000)'' after the dollar amount.

Page 102, line 3 insert ''(increased by $4,000,000)'' after the dollar amount.

Page 40, line 8 insert ''(decreased by $4,000,000)'' after the dollar amount.

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 105th CONGRESS, SECOND SESSION

Vol. 144 WASHINGTON, FRIDAY, JULY 24, 1998 No. 101

Senate

The Senate met at 9:15 a.m. and was called to order by the President pro tempore [Mr. THURMOND].

The PRESIDENT pro tempore. Today we have a guest Chaplain, the Reverend Dr. Richard Foth, Falls Church, VA. We are pleased to have you with us.

PRAYER

The guest Chaplain, the Reverend Dr. Richard Foth, Falls Church, VA, offered the following prayer:

Gracious Father, we come to You on this warm summer morning absolutely dependent on Your wisdom and Your grace. We know that our friends in the Senate have the people of this great Nation on their hearts. And, although they may not, in their own wisdom, know what is best in every instance for each citizen, You do.

So, we ask You to help this deliberative body of chosen and able men and women to keep pursuing matters of State in fresh ways, that all the people of our great land who depend on them might be the better for it.

Our Senators come to this Chamber, pressured almost beyond belief by interests of every kind. Give them, we pray, the insight to be able to differentiate between what is good and what is best. And as they do, thank You for helping them manage their personal and family concerns, while trying to focus on the matters at hand.

As the heat of this late July day is reflected in the heat of debates driven by deadline, let cool heads prevail. And, as the important task of monetary appropriations is considered, we take a moment to remember that You, too, have appropriated something for each of us: Your love and Your grace. In that Name above all names, we thank You for these things. Amen.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The able acting majority leader is recognized.

Mr. ALLARD. Mr. President, good morning.

SCHEDULE

Mr. ALLARD. Mr. President, this morning, the Senate will immediately proceed to a rollcall vote on passage of the transportation appropriations bill. Following that vote, the Senate will begin consideration of H.R. 1151, the credit union legislation. Any votes ordered today with respect to the credit union bill, or any other legislative or executive items, will be postponed, to occur on Monday, July 27, at a time to be determined by the two leaders. As always, Members will be notified when Monday's voting schedule becomes available.

I thank my colleagues for their attention. I yield the floor.

DEPARTMENT OF TRANSPORTATION AND RELATED AGENCIES APPROPRIATIONS ACT, 1999

The PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of the Department of Transportation appropriations bill, S. 2307, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 2307) making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes.

The Senate resumed consideration of the bill.

Mr. LAUTENBERG. Mr. President, the Senate's Transportation Appropriations bill for fiscal year 1999 which the Senate will approve today is of vital importance to the state of New Jersey. As the most densely populated state in the nation, efficient and effective transportation is critical to the economic well being of my state, as well as to the quality of life of its residents.

The Senate's transportation appropriations bill provides over $900 million in transportation investments to my state. In addition, New Jersey will receive tremendous benefits from investments in Amtrak services, in the William J. Hughes FAA Technical Center in Pomona, in the U.S. Coast Guard training center in Cape May, the Coast Guard air station in Pomona, and in the airports in our state, particularly Newark International Airport. This investment provides good paying jobs in the short-term, and in the long-term, it will create and maintain the infrastructure that New Jersey needs to attract and keep a strong workforce. Ultimately, these investments will serve to reduce congestion, improve air quality, and enhance New Jerseyans' quality of life.

Mr. President, I would like to highlight some of the important provisions in the Senate's bill which I was able to secure for the Garden State.

Transit is an intricate part of Northern New Jersey's transportation plan. The single largest component of New Jersey's mass transit initiatives is the Urban Core. I was pleased to secure $70 million that will go toward additional design and construction of the Hudson-Bergen Light Rail link. This rail line will reduce congestion and increase mobility, and will spur economic development in the communities along the Hudson County waterfront and into Bergen County. It will improve air quality, and provide needed construction, operation and maintenance jobs.

In addition, the $12 million that is provided for the Newark-Elizabeth Rail Link is the first significant infusion of federal dollars that will seriously initiate this project. This mass transit

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

Printed on recycled paper.

project will first link Broad Street Station to Penn Station in Newark, extending past Newark International Airport, through the City of Elizabeth and into Union County. Also part of Urban Core, the Newark-Elizabeth Rail Link is an integral part of the ''Circle of Mobility'' that will serve to reduce congestion, improve air quality, and enhance New Jerseyans' quality of life. To date I have secured over $600 million for Urban Core projects.

In addition to the Urban Core and transit formula assistance, the bill makes a number of bus and bus facility projects eligible for federal assistance. Among those are the Market Street bus maintenance facility in Paterson, New Jersey Transit jitney shuttle buses, Newark, Morris and Essex Station access and buses, the South Amboy regional intermodal transportation initiative and New Jersey Transit clean fuel buses.

The bill also allocates $4 million to the National Transit Institute at Rutgers University, of which $1 million will go toward mass transit workplace safety training.

Mr. President, I strongly believe that Amtrak is a critical component of our nation's transportation system, particularly in New Jersey and throughout the Northeast corridor. It provides safe and effective transportation to millions of customers every year, reducing congestion on our roads and in our skies. If Amtrak were not operating, there would be 18,000 cars a day on New Jersey's already dense highways. This is untenable for my state. Despite many difficulties, I am pleased that the Senate bill provides $555 million for Amtrak's national rail operations. This funding is in addition to the $2.2 billion in capital funding provided by the Amtrak Reform and Accountability Act of 1997. This investment will allow Amtrak to continue its operations for another year and further enable it to reach its goal of self-sufficiency by 2002.

Mr. President, the bill also includes a general provision concerning a High Occupancy Vehicle lane along I–287 in New Jersey. The provision would allow the state to remove the HOV restrictions without being required to reimburse the federal government for construction costs. A few years ago, I secured $140 million for the HOV lane in an appropriations bill at the request of the state. Now operational, the HOV lane is clearly not working, as only 72 cars an hour are using the lane, significantly less than the 600 cars expected. Currently, a state can appeal to the federal government to decommission an HOV lane without having to pay back the funds if it successfully makes the case that it is not ''in the public interest.'' Since the I–287 lane was directed by statute, the federal government does not have the authority to approve a state's appeal. The general provision allows New Jersey to appeal to the Federal Highway Administration that the lane is not in the public interest, and if the Secretary concurs, the state will not have to pay back the $140 million. No one is more committed to cleaner air, energy conservation, and innovations to cut traffic congestion than I. HOV lanes have worked in certain settings and I support them where they are successful. But, in New Jersey, it may be that our traffic patterns, work schedules and other issues make it difficult for the I–287 HOV lane to work. This provision removes a significant financial hurdle if the HOV lane is proven to be a failed lane.

Mr. President, to make roads in New Jersey as productive as possible, the Senate bill includes $6 million for intelligent transportation system initiatives in New Jersey. These funds will go to advance projects already underway and managed by TRANSCOM, a consortium of 14 state and local agencies in the NY/NJ/CN metropolitan area. TRANSCOM is responsible for developing and coordinating the region's traffic management and incident detection system through the deployment of significant investments in intelligent transportation systems. Over half of the congestion on the region's roadways is due to traffic incidents and it is TRANSCOM's mission to improve inter-agency response to such incidents.

Mr. President, transportation is the lifeblood of New Jersey and aviation is in the center of it. I am pleased to cite a number of provisions in this bill that improve upon the state's aviation system. First, the bill includes $11 million for the redesign of national air space, of which $3 million will be used to focus the FAA's efforts of redesigning the airspace in the New Jersey/New York metropolitan area. This funding will kick-off the redesign process, which will hopefully alleviate congestion and improve aircraft operations in the region's already dense and complex airspace, leading to fewer delays and reduced air noise levels. I was also pleased to secure $100,000 for a ''technical assistance grant'' for a community group to retain the services of an expert to ensure that citizens are represented and included during the FAA's redesign effort.

I was also pleased to secure funding that will greatly improve operations at Newark International Airport. The bill provides $2 million to begin work on installing state-of-the-art radar upgrades and runway-monitoring improvements that will reduce delays and enhance safety at the airport. Moreover, the bill includes report language that recognizes the cooperative effort among the FAA, the Port Authority of New York/New Jersey, and airport users to make Newark Airport among the best in the country. The language directs the FAA to report quarterly on the progress of the cooperative working group and outlines the various equipment and initiatives that are priorities for the airport.

The bill also includes report language expressing concern about staffing and equipment needs at New Jersey/New York area towers, the New York TRACON and the New York Air Traffic Control Center. This language will serve to direct the FAA to do all it can to improve the safety and efficiency of these facilities. And, the bill includes a provision directing the FAA to ensure that the air traffic controllers serving all the major FAA facilities in the region—air traffic control towers, the New York TRACON and the New York Center—are compensated equally. The FAA's proposed reclassification scheme would create a pay gap that does not recognize the equity of the work performed at the facilities and will force the experienced controllers serving the towers to go to the Center and the TRACON. The language prevents this from happening.

Moreover, the bill fully funds the Hughes Technical Center in Pomona. The Technical Center is the world's premier aviation testing and development center, with state-of-the-art facilities and an impressive workforce. The bill provides funding to continue the good work at the Tech Center.

Mr. President, I strongly supported funding for the Office of Pipeline Safety, and I am pleased that the bill provides $32.7 million for pipeline safety programs, with $1 million set aside for One-Call programs. These programs require anyone who is going to dig—contractors, utilities, for example—to find out the exact location of pipelines before they break ground. We in New Jersey know all too well the damage that a pipeline accident can have on victims of pipeline eruptions, and particularly to the community. Four years ago, around midnight, on March 24, 1994, a major natural gas pipeline ruptured in Edison, New Jersey, a densely populated, urban environment. This rupture caused a deafening boom, awakening residents of the Durham Woods apartment complex and changing their lives forever. The explosion was caused by third party damage, something a strong one-call program would address. Thus, the bill includes language emphasizing the importance of One-Call programs in preventing accidents. Two-thirds of all pipeline accidents are caused by people who dig without knowing of the locations of pipelines.

Mr. President, the bill also provides $2 million for the Biomechanics Consortium, of which the University of Medicine and Dentistry of New Jersey (UMDNJ) is a member. These institutions study the effects of motor vehicle crash injuries on adults and children, resulting in the deployment of more effective life-saving safety devices. These life-saving funds are extremely important and I am pleased that the bill funds this program.

Mr. President, the Coast Guard has an important presence in our state and I am pleased that it is well funded. In addition to the assistance provided to the air station in Pomona and the training center in Cape May, the bill fully funds the Coast Guard's Container Inspection Program (CIP) at $3.6

million. The CIP addresses environmental and safety problems posed by improper transport of containerized hazardous materials into U.S. ports. I established this program in 1994 to address the environmental and safety problems posed by improper transport of containerized hazardous materials into U.S. ports. This was highlighted by the 1992 Santa Clara casualty, in which several containers of highly toxic arsenic trioxide were lost overboard off the New Jersey coast, posing a substantial threat to the marine environment and its resources. Following this, the Coast Guard conducted intensive, targeted inspections and discovered wanton and widespread violations of container handling and packaging regulations. This program serves to prevent such casualties and protect the marine environment.

Mr. President, having better, more efficient transit systems, roads, airports and all other transportation systems will improve the quality of life for thousands of residents and visitors to New Jersey on a daily basis. I am glad that as Ranking Minority Member of this Transportation Appropriations Subcommittee I was able to secure this funding, as well as the bill and report language for New Jersey. I appreciate the generosity shown by the Chairman of the Subcommittee, Senator RICHARD SHELBY, who has been most cooperative and helpful throughout the process. His work will serve all New Jerseyans and the nation well.

Mrs. MURRAY. Mr. President, I rise today to extend my strong support for S. 2307, the Department of Transportation's Appropriations Bill for FY 1999. This funding comes at a critical time for our nation and in particular, Washington state.

Mr. President, as I fly home each weekend, I join thousands of other commuters in the Puget Sound Region immersed in daily and agonizing gridlock. Our State Department of Transportation is working furiously to construct HOV lanes, park and rides and additional interchanges. I applaud our State Secretary Sid Morrison for his innovative thinking and leadership during this time of enormous growth.

Our region's economic boom has brought many advantages, however, its impact on mobility in the region has been dramatic and continually frustrates motorists. This bill will provide much needed relief for our Puget Sound Region and for infrastructure improvements throughout Washington state. I am most pleased that I was able to work with the committee to secure $60 million for the Puget Sound's Regional Transit Authority, known as Sound Move. This will include $47 million for commuter rail between Seattle and Tacoma and $13 million to begin light rail construction.

Additionally, I want to express my support for the committee's work in funding the Elliot Bay Water Taxi, the Columbia River Marine Fire and Safety Association, ITS systems near Spokane's SR 395, airport improvements at Everett's Paine Field, Boeing Field and the Pullman Airport. These projects are vital to our region's multi-modal planning. The linking of car, bus, bike, ferry, plane, train and pedestrian has become the framework of every infrastructure decision.

I wanted to personally thank Chairman SHELBY and our Ranking Member, Senator LAUTENBERG for their dedicated work. Their combined efforts and leadership on our subcommittee have produced enormous results that will be felt by generations to come. I am pleased to see our commitment to Amtrak, the Coast Guard, FAA and the National Highway Traffic Safety Administration. I am committed to helping this bill remain in conference and urge my colleagues to support this important legislation.

Our work today is wonderful news for the millions of Americans sitting right now in parking lots which were once called highways.

Ms. MOSELEY-BRAUN. Mr. President, this legislation includes critical funding for our nation's airports, roads, mass transit systems, and other transportation. I want to particularly thank the managers of the bill for including funding for Amtrak, and for a number of key projects important to Illinois, including funding for Metra, Metro Link, and the Chicago Transit Authority.

I am disappointed that the legislation includes an amendment, added last night, that provides for expedited review of court challenges to the DBE program. I hope that the conferees on this bill will see fit to drop this ill-advised and unnecessary intrusion into hundreds years of judicial process.

FEDERAL LANDS HIGHWAY PROGRAM (HIGHWAY 323)

Mr. BURNS. Mr. President, I would like to clarify the Committee's intent regarding the directive to the Secretary to make funds available for Highway 323 in Southeastern Montana.

Under the Federal Lands Highway Program, the Secretary is to make funds available to conduct the environmental review, design and, to the extent possible, right-of-way acquisition for the future phased construction to a paved secondary road standard for 50.4 miles along Highway 323 between the communities of Alzada, Montana and Ekalaka, Montana.

This additional language needs to be recognized in order to discourage duplication of work that has already been completed.

Mr. SHELBY. I agree with the Senator of Montana.

FEDERAL LANDS HIGHWAY PROGRAM (HIGHWAY 93)

Mr. BURNS. Mr. President, I would like to clarify the Committee's intent on a couple of different issues in the Transportation Appropriations bill. Under the Federal Lands Highway Program account, two separate highway issues are addressed. I would like to ensure the Secretary is aware of the importance of both of these highway issues.

The first, is in Northeastern Montana. Highway 93 is the primary route from Interstate 90 to the Flathead Valley and Glacier National Park. This area is growing in recreational popularity. This beautiful valley is home to Flathead Lake. Located between Kalispell and Polson, this is the largest freshwater lake west of the Mississippi.

Glacier National Park receives numerous visitors by air and train. But the most popular means to reach the park is by Highway 93.

Big Mountain recreational ski area is located to the north of the Valley. This resort area is a year-round attraction for outdoor enthusaiasts—many of whom drive to the area by way of Highway 93.

I often travel this highway to visit my constituents on the Salish and Kootenai Indian reservation as well as my constituents in Kalispell, and Northwest Montana. Recently on this highway, I noticed I was literally traveling in bumper to bumper traffic. This is not a common phenomenon in Montana but the increased summer traffic in this area has many of the local users concerned about their safety and the safety of their passengers.

For nearly thirty years, Montana's American Legion has taken on the responsibility to remind drivers of the dangers of highway travel by placing a white cross along the roadside. The roadside along Highway 93 is littered with these white crosses.

As a result of the public outcry to help reduce the number of accidents on this highway, I, on behalf of the Montana Department of Transportation, would like to ask the Committee to direct the Secretary to authorize and release all funds designated for the four-lane expansion of Highway 93. I would also like to ask the Committee to direct the Secretary to withdraw the Federal Highway Administration's record of decision requiring resolution at the State, local and tribal levels.

Mr. SHELBY. I understand the concern expressed by my colleague from Montana. It is the intent of the Committee that the Secretary should act as we have encouraged him to and I will work with you in conference to clarify that.

The PRESIDENT pro tempore. Under the previous order, the question is, Shall the bill, S. 2307, as amended, pass? The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from Utah (Mr. BENNETT), the Senator from Montana (Mr. BURNS), the Senator from Wyoming (Mr. ENZI), the Senator from North Carolina (Mr. HELMS), the Senator from Idaho (Mr. KEMPTHORNE), the Senator From Arizona (Mr. MCCAIN), and the Senator from Alaska (Mr. STEVENS), are necessarily absent.

I further announce that, if present and voting, the Senator from Montana (Mr. BURNS) would vote ''yes.''

Mr. FORD. I announce that the Senator from California (Mrs. BOXER) and the Senator from Arkansas (Mr. BUMPERS) are necessarily absent.

The PRESIDING OFFICER (Mr. ALLARD). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 90, nays 1, as follows:

[Rollcall Vote No. 235 Leg.]

YEAS—90

Abraham	Feinstein	Lugar
Akaka	Ford	Mack
Allard	Frist	McConnell
Ashcroft	Glenn	Mikulski
Baucus	Gorton	Moseley-Braun
Biden	Graham	Moynihan
Bingaman	Gramm	Murkowski
Bond	Grams	Murray
Breaux	Grassley	Nickles
Brownback	Gregg	Reed
Bryan	Hagel	Reid
Byrd	Harkin	Robb
Campbell	Hatch	Roberts
Chafee	Hollings	Rockefeller
Cleland	Hutchinson	Roth
Coats	Hutchison	Santorum
Cochran	Inhofe	Sarbanes
Collins	Inouye	Sessions
Conrad	Jeffords	Shelby
Coverdell	Johnson	Smith (NH)
Craig	Kennedy	Smith (OR)
D'Amato	Kerrey	Snowe
Daschle	Kerry	Specter
DeWine	Kohl	Thomas
Dodd	Landrieu	Thompson
Domenici	Lautenberg	Thurmond
Dorgan	Leahy	Torricelli
Durbin	Levin	Warner
Faircloth	Lieberman	Wellstone
Feingold	Lott	Wyden

NAYS—1

Kyl

NOT VOTING—9

Bennett	Burns	Kempthorne
Boxer	Enzi	McCain
Bumpers	Helms	Stevens

The bill (S. 2307), as amended, was passed.

(The text of the bill will be printed in a future edition of the RECORD.)

Mr. SARBANES. Mr. President, I move to reconsider the vote.

Mr. D'AMATO. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER (Mr. GRAMS). Under the previous order, the Chair appoints the following Senators to serve as conferees on the transportation appropriations bill.

The Presiding Officer appointed Mr. SHELBY, Mr. DOMENICI, Mr. SPECTER, Mr. BOND, Mr. GORTON, Mr. BENNETT, Mr. FAIRCLOTH, Mr. STEVENS, Mr. LAUTENBERG, Mr. BYRD, Ms. MIKULSKI, Mr. REID of Nevada, Mr. KOHL, Mrs. MURRAY, and Mr. INOUYE conferees on the part of the Senate.

CREDIT UNION MEMBERSHIP ACCESS ACT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of H.R. 1151, which the clerk will report.

A bill (H.R. 1151) to amend the Federal Credit Union Act to clarify existing law with regard to the field of membership of Federal credit unions, to preserve the integrity and purpose of Federal credit unions, to enhance supervisory oversight of insured credit unions, and for other purposes.

The Senate proceeded to consider the bill, which had been reported from the Committee on Banking, Housing, and Urban Affairs, 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 ''Credit Union Membership Access Act''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Definitions.

TITLE I—CREDIT UNION MEMBERSHIP

Sec. 101. Fields of membership.
Sec. 102. Criteria for approval of expansion of membership of multiple common-bond credit unions.
Sec. 103. Geographical guidelines for community credit unions.

TITLE II—REGULATION OF CREDIT UNIONS

Sec. 201. Financial statement and audit requirements.
Sec. 202. Conversion of insured credit unions.
Sec. 203. Limitation on member business loans.
Sec. 204. Serving persons of modest means within the field of membership of credit unions.
Sec. 205. National Credit Union Administration Board membership.
Sec. 206. Report and congressional review requirement for certain regulations.

TITLE III—CAPITALIZATION AND NET WORTH OF CREDIT UNIONS

Sec. 301. Prompt corrective action.
Sec. 302. National credit union share insurance fund equity ratio, available assets ratio, and standby premium charge.
Sec. 303. Access to liquidity.

TITLE IV—MISCELLANEOUS PROVISIONS

Sec. 401. Study and report on differing regulatory treatment.
Sec. 402. Review of regulations and paperwork reduction.
Sec. 403. Treasury report on reduced taxation and viability of small banks.

SEC. 2. FINDINGS.

The Congress finds the following:

(1) The American credit union movement began as a cooperative effort to serve the productive and provident credit needs of individuals of modest means.

(2) Credit unions continue to fulfill this public purpose, and current members and membership groups should not face divestiture from the financial services institution of their choice as a result of recent court action.

(3) To promote thrift and credit extension, a meaningful affinity and bond among members, manifested by a commonality of routine interaction, shared and related work experiences, interests, or activities, or the maintenance of an otherwise well-understood sense of cohesion or identity is essential to the fulfillment of the public mission of credit unions.

(4) Credit unions, unlike many other participants in the financial services market, are exempt from Federal and most State taxes because they are member-owned, democratically operated, not-for-profit organizations generally managed by volunteer boards of directors and because they have the specified mission of meeting the credit and savings needs of consumers, especially persons of modest means.

(5) Improved credit union safety and soundness provisions will enhance the public benefit that citizens receive from these cooperative financial services institutions.

SEC. 3. DEFINITIONS.

As used in this Act—

(1) the term ''Administration'' means the National Credit Union Administration;

(2) the term ''Board'' means the National Credit Union Administration Board;

(3) the term ''Federal banking agencies'' has the same meaning as in section 3 of the Federal Deposit Insurance Act;

(4) the terms ''insured credit union'' and ''State-chartered insured credit union'' have the same meanings as in section 101 of the Federal Credit Union Act; and

(5) the term ''Secretary'' means the Secretary of the Treasury.

TITLE I—CREDIT UNION MEMBERSHIP

SEC. 101. FIELDS OF MEMBERSHIP.

Section 109 of the Federal Credit Union Act (12 U.S.C. 1759) is amended—

(1) in the first sentence—

(A) by striking ''Federal credit union membership shall consist of'' and inserting ''(a) IN GENERAL.—Subject to subsection (b), Federal credit union membership shall consist of''; and

(B) by striking '', except that'' and all that follows through ''rural district''; and

(2) by adding at the end the following new subsections:

''(b) MEMBERSHIP FIELD.—Subject to the other provisions of this section, the membership of any Federal credit union shall be limited to the membership described in 1 of the following categories:

''(1) SINGLE COMMON-BOND CREDIT UNION.—1 group that has a common bond of occupation or association.

''(2) MULTIPLE COMMON-BOND CREDIT UNION.—More than 1 group—

''(A) each of which has (within the group) a common bond of occupation or association; and

''(B) the number of members of each of which (at the time the group is first included within the field of membership of a credit union described in this paragraph) does not exceed any numerical limitation applicable under subsection (d).

''(3) COMMUNITY CREDIT UNION.—Persons or organizations within a well-defined local community, neighborhood, or rural district.

''(c) EXCEPTIONS.—

''(1) GRANDFATHERED MEMBERS AND GROUPS.—

''(A) IN GENERAL.—Notwithstanding subsection (b)—

''(i) any person or organization that is a member of any Federal credit union as of the date of enactment of the Credit Union Membership Access Act may remain a member of the credit union after that date of enactment; and

''(ii) a member of any group whose members constituted a portion of the membership of any Federal credit union as of that date of enactment shall continue to be eligible to become a member of that credit union, by virtue of membership in that group, after that date of enactment.

''(B) SUCCESSORS.—If the common bond of any group referred to in subparagraph (A) is defined by any particular organization or business entity, subparagraph (A) shall continue to apply with respect to any successor to the organization or entity.

''(2) EXCEPTION FOR UNDERSERVED AREAS.—Notwithstanding subsection (b), in the case of a Federal credit union, the field of membership category of which is described in subsection (b)(2), the Board may allow the membership of the credit union to include any person or organization within a local community, neighborhood, or rural district if—

''(A) the Board determines that the local community, neighborhood, or rural district—

''(i) meets the requirements of paragraph (3) and subparagraphs (A) and (B) of paragraph (4) of section 233(b) of the Bank Enterprise Act of 1991, and such additional requirements as the Board may impose; and

''(ii) is underserved, based on data of the Board and the Federal banking agencies (as defined in section 3 of the Federal Deposit Insurance Act), by other depository institutions (as defined in section 19(b)(1)(A) of the Federal Reserve Act); and

''(B) the credit union establishes and maintains an office or facility in the local community, neighborhood, or rural district at which credit union services are available.

''(d) MULTIPLE COMMON-BOND CREDIT UNION GROUP REQUIREMENTS.—

''(1) NUMERICAL LIMITATION.—Except as provided in paragraph (2), only a group with fewer than 3,000 members shall be eligible to be included in the field of membership category of a credit union described in subsection (b)(2).

''(2) EXCEPTIONS.—In the case of any Federal credit union, the field of membership category of which is described in subsection (b)(2), the numerical limitation in paragraph (1) of this subsection shall not apply with respect to—

''(A) any group that the Board determines, in writing and in accordance with the guidelines and regulations issued under paragraph (3), could not feasibly or reasonably establish a new single common-bond credit union, the field of membership category of which is described in subsection (b)(1) because—

''(i) the group lacks sufficient volunteer and other resources to support the efficient and effective operation of a credit union;

''(ii) the group does not meet the criteria that the Board has determined to be important for the likelihood of success in establishing and managing a new credit union, including demographic characteristics such as geographical location of members, diversity of ages and income levels, and other factors that may affect the financial viability and stability of a credit union; or

''(iii) the group would be unlikely to operate a safe and sound credit union;

''(B) any group transferred from another credit union—

''(i) in connection with a merger or consolidation recommended by the Board or any appropriate State credit union supervisor based on safety and soundness concerns with respect to that other credit union; or

''(ii) by the Board in the Board's capacity as conservator or liquidating agent with respect to that other credit union; or

''(C) any group transferred in connection with a voluntary merger, having received conditional approval by the Administration of the merger application prior to October 25, 1996, but not having consummated the merger prior to October 25, 1996, if the merger is consummated not later than 180 days after the date of enactment of the Credit Union Membership Access Act.

''(3) REGULATIONS AND GUIDELINES.—The Board shall issue guidelines or regulations, after notice and opportunity for comment, setting forth the criteria that the Board will apply in determining under this subsection whether or not an additional group may be included within the field of membership category of an existing credit union described in subsection (b)(2).

''(e) ADDITIONAL MEMBERSHIP ELIGIBILITY PROVISIONS.—

''(1) MEMBERSHIP ELIGIBILITY LIMITED TO IMMEDIATE FAMILY OR HOUSEHOLD MEMBERS.—No individual shall be eligible for membership in a credit union on the basis of the relationship of the individual to another person who is eligible for membership in the credit union, unless the individual is a member of the immediate family or household (as those terms are defined by the Board, by regulation) of the other person.

''(2) RETENTION OF MEMBERSHIP.—Except as provided in section 118, once a person becomes a member of a credit union in accordance with this title, that person or organization may remain a member of that credit union until the person or organization chooses to withdraw from the membership of the credit union.''.

SEC. 102. CRITERIA FOR APPROVAL OF EXPANSION OF MEMBERSHIP OF MULTIPLE COMMON-BOND CREDIT UNIONS.

Section 109 of the Federal Credit Union Act (12 U.S.C. 1759) is amended by adding at the end the following new subsection:

''(f) CRITERIA FOR APPROVAL OF EXPANSION OF MULTIPLE COMMON-BOND CREDIT UNIONS.—

''(1) IN GENERAL.—The Board shall—

''(A) encourage the formation of separately chartered credit unions instead of approving an application to include an additional group within the field of membership of an existing credit union whenever practicable and consistent with reasonable standards for the safe and sound operation of the credit union; and

''(B) if the formation of a separate credit union by the group is not practicable or consistent with the standards referred to in subparagraph (A), require the inclusion of the group in the field of membership of a credit union that is within reasonable proximity to the location of the group whenever practicable and consistent with reasonable standards for the safe and sound operation of the credit union.

''(2) APPROVAL CRITERIA.—The Board may not approve any application by a Federal credit union, the field of membership category of which is described in subsection (b)(2) to include any additional group within the field of membership of the credit union (or an application by a Federal credit union described in subsection (b)(1) to include an additional group and become a credit union described in subsection (b)(2)), unless the Board determines, in writing, that—

''(A) the credit union has not engaged in any unsafe or unsound practice (as defined in section 206(b)) that is material during the 1-year period preceding the date of filing of the application;

''(B) the credit union is adequately capitalized;

''(C) the credit union has the administrative capability to serve the proposed membership group and the financial resources to meet the need for additional staff and assets to serve the new membership group;

''(D) pursuant to the most recent evaluation of the credit union under section 215, the credit union is satisfactorily providing affordable credit union services to all individuals of modest means within the field of membership of the credit union;

''(E) any potential harm that the expansion of the field of membership of the credit union may have on any other insured credit union and its members is clearly outweighed in the public interest by the probable beneficial effect of the expansion in meeting the convenience and needs of the members of the group proposed to be included in the field of membership; and

''(F) the credit union has met such additional requirements as the Board may prescribe, by regulation.''.

SEC. 103. GEOGRAPHICAL GUIDELINES FOR COMMUNITY CREDIT UNIONS.

Section 109 of the Federal Credit Union Act (12 U.S.C. 1759) is amended by adding at the end the following new subsection:

''(g) REGULATIONS REQUIRED FOR COMMUNITY CREDIT UNIONS.—

''(1) DEFINITION OF WELL-DEFINED LOCAL COMMUNITY, NEIGHBORHOOD, OR RURAL DISTRICT.—The Board shall prescribe, by regulation, a definition for the term 'well-defined local community, neighborhood, or rural district' for purposes of—

''(A) making any determination with regard to the field of membership of a credit union described in subsection (b)(3); and

''(B) establishing the criteria applicable with respect to any such determination.

''(2) SCOPE OF APPLICATION.—The definition prescribed by the Board under paragraph (1) shall apply with respect to any application to form a new credit union, or to alter or expand the field of membership of an existing credit union, that is filed with the Board after the date of enactment of the Credit Union Membership Access Act.''.

TITLE II—REGULATION OF CREDIT UNIONS

SEC. 201. FINANCIAL STATEMENT AND AUDIT REQUIREMENTS.

(a) IN GENERAL.—Section 202(a)(6) of the Federal Credit Union Act (12 U.S.C. 1782(a)(6)) is amended by adding at the end the following new subparagraphs:

''(C) ACCOUNTING PRINCIPLES.—

''(i) IN GENERAL.—Accounting principles applicable to reports or statements required to be filed with the Board by each insured credit union shall be uniform and consistent with generally accepted accounting principles.

''(ii) BOARD DETERMINATION.—If the Board determines that the application of any generally accepted accounting principle to any insured credit union is not appropriate, the Board may prescribe an accounting principle for application to the credit union that is no less stringent than generally accepted accounting principles.

''(iii) DE MINIMUS EXCEPTION.—This subparagraph shall not apply to any insured credit union, the total assets of which are less than $10,000,000, unless prescribed by the Board or an appropriate State credit union supervisor.

''(D) LARGE CREDIT UNION AUDIT REQUIREMENT.—

''(i) IN GENERAL.—Each insured credit union having total assets of $500,000,000 or more shall have an annual independent audit of the financial statements of the credit union, performed in accordance with generally accepted auditing standards by an independent certified public accountant or public accountant licensed by the appropriate State or jurisdiction to perform those services.

''(ii) VOLUNTARY AUDITS.—If a Federal credit union that is not required to conduct an audit under clause (i), and that has total assets of more than $10,000,000 conducts such an audit for any purpose, using an independent auditor who is compensated for his or her audit services with respect to that audit, the audit shall be performed consistent with the accountancy laws of the appropriate State or jurisdiction, including licensing requirements.''.

(b) TECHNICAL AND CONFORMING AMENDMENT.—Section 202(a)(6)(B) of the Federal Credit Union Act (12 U.S.C. 1782(a)(6)(B)) is amended by striking ''subparagraph (A)'' and inserting ''subparagraph (A) or (D)''.

SEC. 202. CONVERSION OF INSURED CREDIT UNIONS.

Section 205(b) of the Federal Credit Union Act (12 U.S.C. 1785(b)) is amended—

(1) in paragraph (1), by striking ''Except with the prior written approval of the Board, no insured credit union shall'' and inserting ''Except as provided in paragraph (2), no insured credit union shall, without the prior approval of the Board'';

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) CONVERSION OF INSURED CREDIT UNIONS TO MUTUAL SAVINGS BANKS.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), an insured credit union may convert to a mutual savings bank or savings association (if the savings association is in mutual form), as those terms are defined in section 3 of the Federal Deposit Insurance Act, without the prior approval of the Board, subject to the requirements and procedures set forth in the laws and regulations governing mutual savings banks and savings associations.

''(B) CONVERSION PROPOSAL.—A proposal for a conversion described in subparagraph (A) shall first be approved, and a date set for a vote thereon by the members (either at a meeting to be held on that date or by written ballot to be filed on or before that date), by a majority of the directors of the insured credit union. Approval of the proposal for conversion shall be by the affirmative vote of a majority of the members of the insured credit union who vote on the proposal.

''(C) NOTICE OF PROPOSAL TO MEMBERS.—An insured credit union that proposes to convert to a mutual savings bank or savings association under subparagraph (A) shall submit notice to each of its members who is eligible to vote on the matter of its intent to convert—

''(i) 90 days before the date of the member vote on the conversion;

''(ii) 60 days before the date of the member vote on the conversion; and

''(iii) 30 days before the date of the member vote on the conversion.

''(D) NOTICE OF PROPOSAL TO BOARD.—The Board may require an insured credit union that proposes to convert to a mutual savings bank or savings association under subparagraph (A) to submit a notice to the Board of its intent to convert during the 90-day period preceding the date of the completion of the conversion.

''(E) INAPPLICABILITY OF ACT UPON CONVERSION.—Upon completion of a conversion described in subparagraph (A), the credit union shall no longer be subject to any of the provisions of this Act.

''(F) LIMIT ON COMPENSATION OF OFFICIALS.—

''(i) IN GENERAL.—No director or senior management official of an insured credit union may receive any economic benefit in connection with a conversion of the credit union as described in subparagraph (A), other than—

''(I) director fees; and

''(II) compensation and other benefits paid to directors or senior management officials of the converted institution in the ordinary course of business.

''(ii) SENIOR MANAGEMENT OFFICIAL.—For purposes of this subparagraph, the term 'senior management official' means a chief executive officer, an assistant chief executive officer, a chief financial officer, and any other senior executive officer (as defined by the appropriate Federal banking agency pursuant to section 32(f) of the Federal Deposit Insurance Act).

''(G) CONSISTENT RULES.—

''(i) IN GENERAL.—Not later than 6 months after the date of enactment of the Credit Union Membership Access Act, the Administration shall promulgate final rules applicable to charter conversions described in this paragraph that are consistent with rules promulgated by other financial regulators, including the Office of Thrift Supervision and the Office of the Comptroller of the Currency. The rules required by this clause shall provide that charter conversion by an insured credit union shall be subject to regulation that is no more or less restrictive than that applicable to charter conversions by other financial institutions.

''(ii) OVERSIGHT OF MEMBER VOTE.—The member vote concerning charter conversion under this paragraph shall be administered by the Administration, and shall be verified by the Federal or State regulatory agency that would have jurisdiction over the institution after the conversion. If either the Administration or that regulatory agency disapproves of the methods by which the member vote was taken or procedures applicable to the member vote, the member vote shall be taken again, as directed by the Administration or the agency.''.

SEC. 203. LIMITATION ON MEMBER BUSINESS LOANS.

The Federal Credit Union Act (12 U.S.C. 1701 et seq.) is amended by inserting after section 107 the following new section:

''SEC. 107A. LIMITATION ON MEMBER BUSINESS LOANS.

''(a) IN GENERAL.—On and after the date of enactment of this section, no insured credit union may make any member business loan that would result in a total amount of such loans outstanding at that credit union at any one time equal to more than the lesser of—

''(1) 1.75 times the actual net worth of the credit union; or

''(2) 1.75 times the minimum net worth required under section 216(c)(1)(A) for a credit union to be well capitalized.

''(b) EXCEPTIONS.—Subsection (a) does not apply in the case of—

''(1) an insured credit union chartered for the purpose of making, or that has a history of primarily making, member business loans to its members, as determined by the Board; or

''(2) an insured credit union that—

''(A) serves predominantly low-income members, as defined by the Board; or

''(B) is a community development financial institution, as defined in section 103 of the Community Development Banking and Financial Institutions Act of 1994.

''(c) DEFINITIONS.—As used in this section—

''(1) the term 'member business loan'—

''(A) means any loan, line of credit, or letter of credit, the proceeds of which will be used for a commercial, corporate or other business investment property or venture, or agricultural purpose; and

''(B) does not include an extension of credit—

''(i) that is fully secured by a lien on a 1- to 4-family dwelling that is the primary residence of a member;

''(ii) that is fully secured by shares in the credit union making the extension of credit or deposits in other financial institutions;

''(iii) that is described in subparagraph (A), if it was made to a borrower or an associated member that has a total of all such extensions of credit in an amount equal to less than $50,000;

''(iv) the repayment of which is fully insured or fully guaranteed by, or where there is an advance commitment to purchase in full by, any agency of the Federal Government or of a State, or any political subdivision thereof; or

''(v) that is granted by a corporate credit union (as that term is defined by the Board) to another credit union.

''(2) the term 'net worth'—

''(A) with respect to any insured credit union, means the credit union's retained earnings balance, as determined under generally accepted accounting principles; and

''(B) with respect to a credit union that serves predominantly low-income members, as defined by the Board, includes secondary capital accounts that are—

''(i) uninsured; and

''(ii) subordinate to all other claims against the credit union, including the claims of creditors, shareholders, and the Fund; and

''(3) the term 'associated member' means any member having a shared ownership, investment, or other pecuniary interest in a business or commercial endeavor with the borrower.

''(d) EFFECT ON EXISTING LOANS.—An insured credit union that has, on the date of enactment of this section, a total amount of outstanding member business loans that exceeds the amount permitted under subsection (a) shall, not later than 3 years after that date of enactment, reduce the total amount of outstanding member business loans to an amount that is not greater than the amount permitted under subsection (a).''.

SEC. 204. SERVING PERSONS OF MODEST MEANS WITHIN THE FIELD OF MEMBERSHIP OF CREDIT UNIONS.

(a) IN GENERAL.—Title II of the Federal Credit Union Act (12 U.S.C. 1781 et seq.) is amended by adding at the end the following new section:

''SEC. 215. SERVING PERSONS OF MODEST MEANS WITHIN THE FIELD OF MEMBERSHIP OF CREDIT UNIONS.

''(a) CONTINUING AND AFFIRMATIVE OBLIGATION.—The purpose of this section is to reaffirm that insured credit unions have a continuing and affirmative obligation to meet the financial services needs of persons of modest means, consistent with safe and sound operation.

''(b) EVALUATION BY THE BOARD.—The Board shall, before the end of the 12-month period beginning on the date of enactment of the Credit Union Membership Access Act—

''(1) prescribe criteria for periodically reviewing the record of each insured credit union in providing affordable credit union services to all individuals of modest means (including low- and moderate-income individuals) within the field of membership of the credit union; and

''(2) provide for making the results of the reviews publicly available.

''(c) ADDITIONAL CRITERIA FOR COMMUNITY CREDIT UNIONS REQUIRED.—The Board shall, by regulation—

''(1) prescribe additional criteria for annually evaluating the record of any insured credit union that is organized to serve a well-defined local community, neighborhood, or rural district in meeting the credit needs and credit union service needs of the entire field of membership of the credit union; and

''(2) prescribe procedures for remedying the failure of any insured credit union described in paragraph (1) to meet the criteria established pursuant to paragraph (1), including the disapproval of any application by the credit union to expand the field of membership of the credit union.

''(d) EMPHASIS ON PERFORMANCE, NOT PAPERWORK.—In evaluating any insured credit union under this section, the Board—

''(1) shall focus on the actual performance of the insured credit union; and

''(2) may not impose burdensome paperwork or recordkeeping requirements.''.

(b) ANNUAL REPORTS.—With respect to each of the first 5 years that begin after the date of enactment of this Act, the Board shall include in the annual report to the Congress under section 102(d) of the Federal Credit Union Act, a report on the progress of the Board in implementing section 215 of that Act (as added by subsection (a) of this section).

SEC. 205. NATIONAL CREDIT UNION ADMINISTRATION BOARD MEMBERSHIP.

Section 102(b) of the Federal Credit Union Act (12 U.S.C. 1752a(b)) is amended—

(1) by striking ''(b) The Board'' and inserting ''(b) MEMBERSHIP AND APPOINTMENT OF BOARD.—

''(1) IN GENERAL.—The Board''; and

(2) by adding at the end the following new paragraph:

''(2) APPOINTMENT CRITERIA.—

''(A) EXPERIENCE IN FINANCIAL SERVICES.—In considering appointments to the Board under paragraph (1), the President shall give consideration to individuals who, by virtue of their education, training, or experience relating to a broad range of financial services, financial services regulation, or financial policy, are especially qualified to serve on the Board.

''(B) LIMIT ON APPOINTMENT OF CREDIT UNION OFFICERS.—Not more than 1 member of the Board may be appointed to the Board from among individuals who, at the time of the appointment, are, or have recently been, involved with any insured credit union as a committee member, director, officer, employee, or other institution-affiliated party.''.

SEC. 206. REPORT AND CONGRESSIONAL REVIEW REQUIREMENT FOR CERTAIN REGULATIONS.

A regulation prescribed by the Board shall be treated as a major rule for purposes of chapter 8 of title 5, United States Code, if the regulation defines, or amends the definition of—

(1) the term ''immediate family or household'' for purposes of section 109(e)(1) of the Federal Credit Union Act (as added by section 101 of this Act); or

(2) the term ''well-defined local community, neighborhood, or rural district'' for purposes of section 109(g) of the Federal Credit Union Act (as added by section 103 of this Act).

TITLE III—CAPITALIZATION AND NET WORTH OF CREDIT UNIONS

SEC. 301. PROMPT CORRECTIVE ACTION.

(a) IN GENERAL.—Title II of the Federal Credit Union Act (12 U.S.C. 1781 et seq.) is amended by adding at the end the following new section:

''SEC. 216. PROMPT CORRECTIVE ACTION.

''(a) RESOLVING PROBLEMS TO PROTECT FUND.—

''(1) PURPOSE.—The purpose of this section is to resolve the problems of insured credit unions at the least possible long-term loss to the Fund.

''(2) PROMPT CORRECTIVE ACTION REQUIRED.—The Board shall carry out the purpose of this section by taking prompt corrective action to resolve the problems of insured credit unions.

''(b) REGULATIONS REQUIRED.—

''(1) INSURED CREDIT UNIONS.—

''(A) IN GENERAL.—The Board shall, by regulation, prescribe a system of prompt corrective action for insured credit unions that is—

''(i) consistent with this section; and

''(ii) comparable to section 38 of the Federal Deposit Insurance Act.

''(B) COOPERATIVE CHARACTER OF CREDIT UNIONS.—The Board shall design the system required under subparagraph (A) to take into account that credit unions are not-for-profit cooperatives that—

''(i) do not issue capital stock;

''(ii) must rely on retained earnings to build net worth; and

''(iii) have boards of directors that consist primarily of volunteers.

''(2) NEW CREDIT UNIONS.—

''(A) IN GENERAL.—In addition to regulations under paragraph (1), the Board shall, by regulation, prescribe a system of prompt corrective action that shall apply to new credit unions in lieu of this section and the regulations prescribed under paragraph (1).

''(B) CRITERIA FOR ALTERNATIVE SYSTEM.—The Board shall design the system prescribed under subparagraph (A)—

''(i) to carry out the purpose of this section;

''(ii) to recognize that credit unions (as cooperatives that do not issue capital stock) initially have no net worth, and give new credit unions reasonable time to accumulate net worth;

''(iii) to create adequate incentives for new credit unions to become adequately capitalized by the time that they either—

''(I) have been in operation for more than 10 years; or

''(II) have more than $10,000,000 in total assets;

''(iv) to impose appropriate restrictions and requirements on new credit unions that do not make sufficient progress toward becoming adequately capitalized; and

''(v) to prevent evasion of the purpose of this section.

''(c) NET WORTH CATEGORIES.—

''(1) IN GENERAL.—For purposes of this section the following definitions shall apply:

''(A) WELL CAPITALIZED.—An insured credit union is 'well capitalized' if—

''(i) it has a net worth ratio of not less than 7 percent; and

''(ii) it meets any applicable risk-based net worth requirement under subsection (d).

''(B) ADEQUATELY CAPITALIZED.—An insured credit union is 'adequately capitalized' if—

''(i) it has a net worth ratio of not less than 6 percent; and

''(ii) it meets any applicable risk-based net worth requirement under subsection (d).

''(C) UNDERCAPITALIZED.—An insured credit union is 'undercapitalized' if—

''(i) it has a net worth ratio of less than 6 percent; or

''(ii) it fails to meet any applicable risk-based net worth requirement under subsection (d).

''(D) SIGNIFICANTLY UNDERCAPITALIZED.—An insured credit union is 'significantly undercapitalized'—

''(i) if it has a net worth ratio of less than 4 percent; or

''(ii) if—

''(I) it has a net worth ratio of less than 5 percent; and

''(II) it—

''(aa) fails to submit an acceptable net worth restoration plan within the time allowed under subsection (f); or

''(bb) materially fails to implement a net worth restoration plan accepted by the Board.

''(E) CRITICALLY UNDERCAPITALIZED.—An insured credit union is 'critically undercapitalized' if it has a net worth ratio of less than 2 percent (or such higher net worth ratio, not to exceed 3 percent, as the Board may specify by regulation).

''(2) ADJUSTING NET WORTH LEVELS.—

''(A) IN GENERAL.—If, for purposes of section 38(c) of the Federal Deposit Insurance Act, the Federal banking agencies increase or decrease the required minimum level for the leverage limit (as those terms are used in that section 38), the Board may, by regulation, and subject to subparagraph (B) of this paragraph, correspondingly increase or decrease 1 or more of the net worth ratios specified in subparagraphs (A) through (D) of paragraph (1) of this subsection in an amount that is equal to not more than the difference between the required minimum level most recently established by the Federal banking agencies and 4 percent of total assets (with respect to institutions regulated by those agencies).

''(B) DETERMINATIONS REQUIRED.—The Board may increase or decrease net worth ratios under subparagraph (A) only if the Board—

''(i) determines, in consultation with the Federal banking agencies, that the reason for the increase or decrease in the required minimum level for the leverage limit also justifies the adjustment in net worth ratios; and

''(ii) determines that the resulting net worth ratios are sufficient to carry out the purpose of this section.

''(C) TRANSITION PERIOD REQUIRED.—If the Board increases any net worth ratio under this paragraph, the Board shall give insured credit unions a reasonable period of time to meet the increased ratio.

''(d) RISK-BASED NET WORTH REQUIREMENT FOR COMPLEX CREDIT UNIONS.—

''(1) IN GENERAL.—The regulations required under subsection (b)(1) shall include a risk-based net worth requirement for insured credit unions that are complex, as defined by the Board based on the portfolios of assets and liabilities of credit unions.

''(2) STANDARD.—The Board shall design the risk-based net worth requirement to take account of any material risks against which the net worth ratio required for an insured credit union to be adequately capitalized may not provide adequate protection.

''(e) EARNINGS-RETENTION REQUIREMENT APPLICABLE TO CREDIT UNIONS THAT ARE NOT WELL CAPITALIZED.—

''(1) IN GENERAL.—An insured credit union that is not well capitalized shall annually set aside as net worth an amount equal to not less than 0.4 percent of its total assets.

''(2) BOARD'S AUTHORITY TO DECREASE EARNINGS-RETENTION REQUIREMENT.—

''(A) IN GENERAL.—The Board may, by order, decrease the 0.4 percent requirement in paragraph (1) with respect to a credit union to the extent that the Board determines that the decrease—

''(i) is necessary to avoid a significant redemption of shares; and

''(ii) would further the purpose of this section.

''(B) PERIODIC REVIEW REQUIRED.—The Board shall periodically review any order issued under subparagraph (A).

''(f) NET WORTH RESTORATION PLAN REQUIRED.—

''(1) IN GENERAL.—Each insured credit union that is undercapitalized shall submit an acceptable net worth restoration plan to the Board within the time allowed under this subsection.

''(2) ASSISTANCE TO SMALL CREDIT UNIONS.—The Board (or the staff of the Board) shall, upon timely request by an insured credit union with total assets of less than $10,000,000, and subject to such regulations or guidelines as the Board may prescribe, assist that credit union in preparing a net worth restoration plan.

''(3) DEADLINES FOR SUBMISSION AND REVIEW OF PLANS.—The Board shall, by regulation, establish deadlines for submission of net worth restoration plans under this subsection that—

''(A) provide insured credit unions with reasonable time to submit net worth restoration plans; and

''(B) require the Board to act on net worth restoration plans expeditiously.

''(4) FAILURE TO SUBMIT ACCEPTABLE PLAN WITHIN TIME ALLOWED.—

''(A) FAILURE TO SUBMIT ANY PLAN.—If an insured credit union fails to submit a net worth restoration plan within the time allowed under paragraph (3), the Board shall—

''(i) promptly notify the credit union of that failure; and

''(ii) give the credit union a reasonable opportunity to submit a net worth restoration plan.

''(B) SUBMISSION OF UNACCEPTABLE PLAN.—If an insured credit union submits a net worth restoration plan within the time allowed under paragraph (3) and the Board determines that the plan is not acceptable, the Board shall—

''(i) promptly notify the credit union of why the plan is not acceptable; and

''(ii) give the credit union a reasonable opportunity to submit a revised plan.

''(5) ACCEPTING PLAN.—The Board may accept a net worth restoration plan only if the Board determines that the plan is based on realistic assumptions and is likely to succeed in restoring the net worth of the credit union.

''(g) RESTRICTIONS ON UNDERCAPITALIZED CREDIT UNIONS.—

''(1) RESTRICTION ON ASSET GROWTH.—An insured credit union that is undercapitalized shall not generally permit its average total assets to increase, unless—

''(A) the Board has accepted the net worth restoration plan of the credit union for that action;

''(B) any increase in total assets is consistent with the net worth restoration plan; and

''(C) the net worth ratio of the credit union increases at a rate that is consistent with the net worth restoration plan.

''(2) RESTRICTION ON MEMBER BUSINESS LOANS.—Notwithstanding section 107A(a), an insured credit union that is undercapitalized may not make any increase in the total amount of member business loans (as defined in section 107A(c)) outstanding at that credit union at any one time, until such time as the credit union becomes adequately capitalized.

''(h) MORE STRINGENT TREATMENT BASED ON OTHER SUPERVISORY CRITERIA.—With respect to the exercise of authority by the Board under regulations comparable to section 38(g) of the Federal Deposit Insurance Act—

''(1) the Board may not reclassify an insured credit union into a lower net worth category, or treat an insured credit union as if it were in a lower net worth category, for reasons not pertaining to the safety and soundness of that credit union; and

''(2) the Board may not delegate its authority to reclassify an insured credit union into a lower net worth category or to treat an insured credit union as if it were in a lower net worth category.

''(i) ACTION REQUIRED REGARDING CRITICALLY UNDERCAPITALIZED CREDIT UNIONS.—

''(1) IN GENERAL.—The Board shall, not later than 90 days after the date on which an insured credit union becomes critically undercapitalized—

''(A) appoint a conservator or liquidating agent for the credit union; or

''(B) take such other action as the Board determines would better achieve the purpose of this section, after documenting why the action would better achieve that purpose.

''(2) PERIODIC REDETERMINATIONS REQUIRED.—Any determination by the Board under paragraph (1)(B) to take any action with respect to an insured credit union in lieu of appointing a conservator or liquidating agent shall cease to be effective not later than the end of the 180-day period beginning on the date on which the determination is made, and a conservator or liquidating agent shall be appointed for that credit union under paragraph (1)(A), unless the Board makes a new determination under paragraph (1)(B) before the end of the effective period of the prior determination.

''(3) APPOINTMENT OF LIQUIDATING AGENT REQUIRED IF OTHER ACTION FAILS TO RESTORE NET WORTH.—

''(A) IN GENERAL.—Notwithstanding paragraphs (1) and (2), the Board shall appoint a liquidating agent for an insured credit union if the credit union is critically undercapitalized on average during the calendar quarter beginning 18 months after the date on which the credit union became critically undercapitalized.

''(B) EXCEPTION.—Notwithstanding subparagraph (A), the Board may continue to take such other action as the Board determines to be appropriate in lieu of appointment of a liquidating agent if—

''(i) the Board determines that—

''(I) the insured credit union has been in substantial compliance with an approved net worth restoration plan that requires consistent improvement in the net worth of the credit union since the date of the approval of the plan; and

''(II) the insured credit union has positive net income or has an upward trend in earnings that the Board projects as sustainable; and

''(ii) the Board certifies that the credit union is viable and not expected to fail.

''(4) NONDELEGATION.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Board may not delegate the authority of the Board under this subsection.

''(B) EXCEPTION.—The Board may delegate the authority of the Board under this subsection with respect to an insured credit union that has less than $5,000,000 in total assets, if the Board permits the credit union to appeal any adverse action to the Board.

''(j) REVIEW REQUIRED WHEN FUND INCURS MATERIAL LOSS.—For purposes of determining whether the Fund has incurred a material loss with respect to an insured credit union (such that the inspector general of the Board must make a report), a loss is material if it exceeds the sum of—

''(1) $10,000,000; and

''(2) an amount equal to 10 percent of the total assets of the credit union at the time at which the Board initiated assistance under section 208 or was appointed liquidating agent.

''(k) APPEALS PROCESS.—Material supervisory determinations, including decisions to require prompt corrective action, made pursuant to this section by Administration officials other than the Board may be appealed to the Board pursuant to the independent appellate process required by section 309 of the Riegle Community Development and Regulatory Improvement Act of 1994 (or, if the Board so specifies, pursuant to separate procedures prescribed by regulation).

''(l) CONSULTATION AND COOPERATION WITH STATE CREDIT UNION SUPERVISORS.—

''(1) IN GENERAL.—In implementing this section, the Board shall consult and seek to work cooperatively with State officials having jurisdiction over State-chartered insured credit unions.

''(2) EVALUATING NET WORTH RESTORATION PLAN.—In evaluating any net worth restoration plan submitted by a State-chartered insured credit union, the Board shall seek the views of the State official having jurisdiction over the credit union.

''(3) DECIDING WHETHER TO APPOINT CONSERVATOR OR LIQUIDATING AGENT.—With respect to any decision by the Board on whether to appoint a conservator or liquidating agent for a State-chartered insured credit union—

''(A) the Board shall—

''(i) seek the views of the State official having jurisdiction over the credit union; and

''(ii) give that official an opportunity to take the proposed action;

''(B) the Board shall, upon timely request of an official referred to in subparagraph (A), promptly provide the official with—

''(i) a written statement of the reasons for the proposed action; and

''(ii) reasonable time to respond to that statement;

''(C) if the official referred to in subparagraph (A) makes a timely written response that disagrees with the proposed action and gives reasons for that disagreement, the Board shall not appoint a conservator or liquidating agent for the credit union, unless the Board, after considering the views of the official, has determined that—

''(i) the Fund faces a significant risk of loss with respect to the credit union if a conservator or liquidating agent is not appointed; and

''(ii) the appointment is necessary to reduce—

''(I) the risk that the Fund would incur a loss with respect to the credit union; or

(II) any loss that the Fund is expected to incur with respect to the credit union; and

''(D) the Board may not delegate any determination under subparagraph (C).

''(m) CORPORATE CREDIT UNIONS EXEMPTED.—This section does not apply to any insured credit union that—

''(1) operates primarily for the purpose of serving credit unions; and

''(2) permits individuals to be members of the credit union only to the extent that applicable law requires that such persons own shares.

''(n) OTHER AUTHORITY NOT AFFECTED.—This section does not limit any authority of the Board or a State to take action in addition to (but not in derogation of) that required under this section.

''(o) DEFINITIONS.—For purposes of this section the following definitions shall apply:

''(1) FEDERAL BANKING AGENCY.—The term 'Federal banking agency' has the same meaning as in section 3 of the Federal Deposit Insurance Act.

''(2) NET WORTH.—The term 'net worth'—

''(A) with respect to any insured credit union, means retained earnings balance of the credit union, as determined under generally accepted accounting principles; and

''(B) with respect to a low-income credit union, includes secondary capital accounts that are—

''(i) uninsured; and

''(ii) subordinate to all other claims against the credit union, including the claims of creditors, shareholders, and the Fund.

''(3) NET WORTH RATIO.—The term 'net worth ratio' means, with respect to a credit union, the ratio of the net worth of the credit union to the total assets of the credit union.

''(4) NEW CREDIT UNION.—The term 'new credit union' means an insured credit union that—

''(A) has been in operation for less than 10 years; and

''(B) has not more than $10,000,000 in total assets.''.

(b) CONSERVATORSHIP AND LIQUIDATION AMENDMENTS TO FACILITATE PROMPT CORRECTIVE ACTION.—

(1) CONSERVATORSHIP.—Section 206(h) of the Federal Credit Union Act (12 U.S.C. 1786(h)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking ''or'' at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new subparagraphs:

''(F) the credit union is significantly undercapitalized, as defined in section 216, and has no reasonable prospect of becoming adequately capitalized, as defined in section 216; or

''(G) the credit union is critically undercapitalized, as defined in section 216.''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''In the case'' and inserting ''Except as provided in subparagraph (C), in the case''; and

(ii) by adding at the end the following new subparagraph:

''(C) In the case of a State-chartered insured credit union, the authority conferred by subparagraphs (F) and (G) of paragraph (1) may not be exercised unless the Board has complied with section 216(l).''.

(2) LIQUIDATION.—Section 207(a) of the Federal Credit Union Act (12 U.S.C. 1787(a)) is amended—

(A) in paragraph (1)(A), by striking ''himself'' and inserting ''itself''; and

(B) by adding at the end the following new paragraph:

''(3) LIQUIDATION TO FACILITATE PROMPT CORRECTIVE ACTION.—The Board may close any credit union for liquidation, and appoint itself or another (including, in the case of a State-chartered insured credit union, the State official having jurisdiction over the credit union) as liquidating agent of that credit union, if—

''(A) the Board determines that—

''(i) the credit union is significantly undercapitalized, as defined in section 216, and has no reasonable prospect of becoming adequately capitalized, as defined in section 216; or

''(ii) the credit union is critically undercapitalized, as defined in section 216; and

''(B) in the case of a State-chartered insured credit union, the Board has complied with section 216(l).''.

(c) CONSULTATION REQUIRED.—In developing regulations to implement section 216 of the Federal Credit Union Act (as added by subsection (a) of this section), the Board shall consult with the Secretary, the Federal banking agencies, and the State officials having jurisdiction over State-chartered insured credit unions.

(d) DEADLINES FOR REGULATIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Board shall—

(A) publish in the Federal Register proposed regulations to implement section 216 of the Federal Credit Union Act (as added by subsection (a) of this section) not later than 270 days after the date of enactment of this Act; and

(B) promulgate final regulations to implement that section 216 not later than 18 months after the date of enactment of this Act.

(2) RISK-BASED NET WORTH REQUIREMENT.—

(A) ADVANCE NOTICE OF PROPOSED RULEMAKING.—Not later than 180 days after the date of enactment of this Act, the Board shall publish in the Federal Register an advance notice of proposed rulemaking, as required by section 216(d) of the Federal Credit Union Act, as added by this Act.

(B) FINAL REGULATIONS.—The Board shall promulgate final regulations, as required by that section 216(d) not later than 2 years after the date of enactment of this Act.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), section 216 of the Federal Credit Union Act (as added by this section) shall become effective 2 years after the date of enactment of this Act.

(2) RISK-BASED NET WORTH REQUIREMENT.—Section 216(d) of the Federal Credit Union Act (as added by this section) shall become effective on January 1, 2001.

(f) REPORT TO CONGRESS REQUIRED.—When the Board publishes proposed regulations pursuant to subsection (d)(1)(A), or promulgates final regulations pursuant to subsection (d)(1)(B), the Board shall submit to the Congress a report that specifically explains—

(1) how the regulations carry out section 216(b)(1)(B) of the Federal Credit Union Act (as added by this section), relating to the cooperative character of credit unions; and

(2) how the regulations differ from section 38 of the Federal Deposit Insurance Act, and the reasons for those differences.

(g) CONFORMING AMENDMENTS.—

(1) AMENDMENTS RELATING TO ENFORCEMENT OF PROMPT CORRECTIVE ACTION.—Section 206(k) of the Federal Credit Union Act (12 U.S.C. 1786(k)) is amended—

(A) in paragraph (1), by inserting ''or section 216'' after ''this section'' each place it appears; and

(B) in paragraph (2)(A)(ii), by inserting '', or any final order under section 216'' before the semicolon.

(2) CONFORMING AMENDMENT REGARDING APPOINTMENT OF STATE CREDIT UNION SUPERVISOR AS CONSERVATOR.—Section 206(h)(1) of the Federal Credit Union Act (12 U.S.C. 1786(h)(1)) is

amended by inserting ''or another (including, in the case of a State-chartered insured credit union, the State official having jurisdiction over the credit union)'' after ''appoint itself''.

(3) AMENDMENT REPEALING SUPERSEDED PROVISION.—Section 116 of the Federal Credit Union Act (12 U.S.C. 1762) is repealed.

SEC. 302. NATIONAL CREDIT UNION SHARE INSURANCE FUND EQUITY RATIO, AVAILABLE ASSETS RATIO, AND STANDBY PREMIUM CHARGE.

(a) IN GENERAL.—Section 202 of the Federal Credit Union Act (12 U.S.C. 1782) is amended—

(1) by striking subsection (b) and inserting the following:

''(b) CERTIFIED STATEMENT.—

''(1) STATEMENT REQUIRED.—

''(A) IN GENERAL.—For each calendar year, in the case of an insured credit union with total assets of not more than $50,000,000, and for each semi-annual period in the case of an insured credit union with total assets of $50,000,000 or more, an insured credit union shall file with the Board, at such time as the Board prescribes, a certified statement showing the total amount of insured shares in the credit union at the close of the relevant period and both the amount of its deposit or adjustment of deposit and the amount of the insurance charge due to the Fund for that period, both as computed under subsection (c).

''(B) EXCEPTION FOR NEWLY INSURED CREDIT UNION.—Subparagraph (A) shall not apply with respect to a credit union that became insured during the reporting period.

''(2) FORM.—The certified statements required to be filed with the Board pursuant to this subsection shall be in such form and shall set forth such supporting information as the Board shall require.

''(3) CERTIFICATION.—The president of the credit union or any officer designated by the board of directors shall certify, with respect to each statement required to be filed with the Board pursuant to this subsection, that to the best of his or her knowledge and belief the statement is true, correct, complete, and in accordance with this title and the regulations issued under this title.'';

(2) in subsection (c)(1)(A), by striking clause (iii) and inserting the following:

''(iii) PERIODIC ADJUSTMENT.—The amount of each insured credit union's deposit shall be adjusted as follows, in accordance with procedures determined by the Board, to reflect changes in the credit union's insured shares:

''(I) annually, in the case of an insured credit union with total assets of not more than $50,000,000; and

''(II) semi-annually, in the case of an insured credit union with total assets of $50,000,000 or more.'';

(3) in subsection (c), by striking paragraphs (2) and (3) and inserting the following:

''(2) INSURANCE PREMIUM CHARGES.—

''(A) IN GENERAL.—Each insured credit union shall, at such times as the Board prescribes (but not more than twice in any calendar year), pay to the Fund a premium charge for insurance in an amount stated as a percentage of insured shares (which shall be the same for all insured credit unions).

''(B) RELATION OF PREMIUM CHARGE TO EQUITY RATIO OF FUND.—The Board may assess a premium charge only if—

''(i) the Fund's equity ratio is less than 1.3 percent; and

''(ii) the premium charge does not exceed the amount necessary to restore the equity ratio to 1.3 percent.

''(C) PREMIUM CHARGE REQUIRED IF EQUITY RATIO FALLS BELOW 1.2 PERCENT.—If the Fund's equity ratio is less than 1.2 percent, the Board shall, subject to subparagraph (B), assess a premium charge in such an amount as the Board determines to be necessary to restore the equity ratio to, and maintain that ratio at, 1.2 percent.

''(3) DISTRIBUTIONS FROM FUND REQUIRED.—

''(A) IN GENERAL.—The Board shall effect a pro rata distribution to insured credit unions after each calendar year if, as of the end of that calendar year—

''(i) any loans to the Fund from the Federal Government, and any interest on those loans, have been repaid;

''(ii) the Fund's equity ratio exceeds the normal operating level; and

''(iii) the Fund's available assets ratio exceeds 1.0 percent.

''(B) AMOUNT OF DISTRIBUTION.—The Board shall distribute under subparagraph (A) the maximum possible amount that—

''(i) does not reduce the Fund's equity ratio below the normal operating level; and

''(ii) does not reduce the Fund's available assets ratio below 1.0 percent.

''(C) CALCULATION BASED ON CERTIFIED STATEMENTS.—In calculating the Fund's equity ratio and available assets ratio for purposes of this paragraph, the Board shall determine the aggregate amount of the insured shares in all insured credit unions from insured credit unions certified statements under subsection (b) for the final reporting period of the calendar year referred to in subparagraph (A).'';

(4) in subsection (c), by adding at the end the following new paragraph:

''(4) TIMELINESS AND ACCURACY OF DATA.—In calculating the available assets ratio and equity ratio of the Fund, the Board shall use the most current and accurate data reasonably available.''; and

(5) by striking subsection (h) and inserting the following:

''(h) DEFINITIONS.—For purposes of this section, the following definitions shall apply:

''(1) AVAILABLE ASSETS RATIO.—The term 'available assets ratio', when applied to the Fund, means the ratio of—

''(A) the amount determined by subtracting—

''(i) direct liabilities of the Fund and contingent liabilities for which no provision for losses has been made, from

''(ii) the sum of cash and the market value of unencumbered investments authorized under section 203(c), to

''(B) the aggregate amount of the insured shares in all insured credit unions.

''(2) EQUITY RATIO.—The term 'equity ratio', when applied to the Fund, means the ratio of—

''(A) the amount of Fund capitalization, including insured credit unions' 1 percent capitalization deposits and the retained earnings balance of the Fund (net of direct liabilities of the Fund and contingent liabilities for which no provision for losses has been made); to

''(B) the aggregate amount of the insured shares in all insured credit unions.

''(3) INSURED SHARES.—The term 'insured shares', when applied to this section, includes share, share draft, share certificate, and other similar accounts as determined by the Board, but does not include amounts exceeding the insured account limit set forth in section 207(c)(1).

''(4) NORMAL OPERATING LEVEL.—The term 'normal operating level', when applied to the Fund, means an equity ratio specified by the Board, which shall be not less than 1.2 percent and not more than 1.5 percent.''.

(b) EFFECTIVE DATE.—This section and the amendments made by this section shall become effective on January 1 of the first calendar year beginning more than 180 days after the date of enactment of this Act.

SEC. 303. ACCESS TO LIQUIDITY.

Section 204 of the Federal Credit Union Act (12 U.S.C. 1784) is amended by adding at the end the following new subsections:

''(f) ACCESS TO LIQUIDITY.—The Board shall—

''(1) periodically assess the potential liquidity needs of each insured credit union, and the options that the credit union has available for meeting those needs; and

''(2) periodically assess the potential liquidity needs of insured credit unions as a group, and the options that insured credit unions have available for meeting those needs.

''(g) SHARING INFORMATION WITH FEDERAL RESERVE BANKS.—The Board shall, for the purpose of facilitating insured credit unions' access to liquidity, make available to the Federal reserve banks (subject to appropriate assurances of confidentiality) information relevant to making advances to such credit unions, including the Board's reports of examination.''.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. STUDY AND REPORT ON DIFFERING REGULATORY TREATMENT.

(a) STUDY.—The Secretary shall conduct a study of—

(1) the differences between credit unions and other federally insured financial institutions, including regulatory differences with respect to regulations enforced by the Office of Thrift Supervision, the Office of the Comptroller of the Currency, the Federal Deposit Insurance Corporation, and the Administration; and

(2) the potential effects of the application of Federal laws, including Federal tax laws, on credit unions in the same manner as those laws are applied to other federally insured financial institutions.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit a report to the Congress on the results of the study required by subsection (a).

SEC. 402. REVIEW OF REGULATIONS AND PAPERWORK REDUCTION.

Section 303 of the Riegle Community Development and Regulatory Improvement Act of 1994 (12 U.S.C. 4803) is amended to read as follows:

''SEC. 303. REGULAR REVIEW OF REGULATIONS AND PAPERWORK REDUCTION.

''(a) REVIEW.—During the 1-year period following the date of enactment of the Credit Union Membership Access Act, each Federal banking agency and the National Credit Union Administration shall, to the maximum extent possible and consistent with the principles of safety and soundness, statutory law and policy, and the public interest—

''(1) conduct a review of the regulations and written policies of each such agency—

''(A) to streamline and modify those regulations and policies in order to improve efficiency, reduce unnecessary costs, and reduce the paperwork burden for insured depository institutions; and

''(B) to remove inconsistencies and outmoded and duplicative requirements; and

''(2) work jointly to make uniform all regulations and guidelines implementing common statutory or supervisory policies.

''(b) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of the Credit Union Membership Access Act, each agency referred to in subsection (a) shall submit a report to Congress detailing the progress of the agency in carrying out this section and making recommendations to the Congress on the need for statutory changes, if any, that would assist in the effort to reduce the paperwork burden for insured institutions.''.

SEC. 403. TREASURY REPORT ON REDUCED TAXATION AND VIABILITY OF SMALL BANKS.

The Secretary shall, not later than 1 year after the date of enactment of this Act, submit a report to the Congress containing—

(1) recommendations for such legislative and administrative action as the Secretary deems appropriate, that would reduce and simplify the tax burden for—

(A) insured depository institutions having less than $1,000,000,000 in assets; and

(B) banks having total assets of not less than $1,000,000,000 nor more than $10,000,000,000; and

(2) any other recommendations that the Secretary deems appropriate that would preserve the viability and growth of small banking institutions in the United States.

PRIVILEGE OF THE FLOOR

Mr. SARBANES. Mr. President, I ask unanimous consent that Dean

Shahinian of our committee be allowed on the floor of the Senate during consideration of this bill.

The PRESIDING OFFICER (Mr. ALLARD). Without objection, it is so ordered.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mr. D'AMATO. Mr. President, I ask unanimous consent that staff of the Committee on Banking, Housing, and Urban Affairs be permitted access to the floor during consideration of this bill.

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

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mr. D'AMATO. Mr. President, today, we consider H.R. 1151, the Credit Union Membership Access Act, which is critical legislation. It is legislation necessary to preserve the ability of all Americans to join the credit union of their choice, and to ensure that 73 million Americans who are currently members of a credit union in no way have their membership status jeopardized.

Credit unions work, Mr. President. They work for working families, they work for the little guy. And in their hour of gravest need, it is time for Congress to work for them. I urge my colleagues to support this legislation as enthusiastically as our friends in the House did—by an overwhelming vote of 411–8. I am confident that we will act to preserve the rights of all Americans to join credit unions now and into the future.

Mr. President, this legislation was crafted in response to a Supreme Court ruling that was decided on a very narrow legal point, handed down on February 25 of this year. That ruling placed 20 million Americans in immediate jeopardy and tens of millions of others of being kicked out of the credit unions they belong to. Who are these Americans? They are small business employees and small business owners, low- and moderate-income earners, farmers, laborers, church members—the hard-working American men and women who have a right to affordable financial services as much as anyone else.

For decades, the American dream has been made a reality by credit unions. These cooperatives reach out to individuals, associations and communities who have had the door slammed in their faces by other financial institutions. Make no mistake about it, Mr. President, the economy, while strong today, the economy—such that people can get loans for a variety of reasons—may not always be that strong. I hope it is. But if history is any reminder of what may be in the future, there will be difficult times.

It has always been the credit union that has given to the little guy, the forgotten middle class—I don't mean little in terms of size and not as a pejorative, but indeed I am talking about the backbone of this country—the opportunity to look his or her neighbor in the eye, who knows that they are good and who knows they will work to pay back that loan, as opposed to somebody 2,000 miles away who doesn't even see that person, who gets an application, who views it in terms of what the income is or the fact that the person is out of work, or the fact that the person has a small farm and is running against tough times and says, no, and turns them down.

It has traditionally been the credit union neighbor, knowing a neighbor employee, working next to his co-employee, recognizing their needs, making that money available so they can send their kid to school. It is one of the great strengths of this country, and it gives us economic diversity, it gives people choice, and it provides competition.

There are those who do not like competition, who set up a whole series—almost a canard as to, ''Oh, no; credit unions are a problem.'' They are a problem, because they give people affordable opportunities to borrow at the lowest rates, because they don't pay income taxes. Why? They are not paying dividends out to people. Where do those moneys go? Those moneys go so that additional loans are available to their members. I love it. I think it is great. I think it really is Americana at its best.

During good and prosperous times, we should not turn away and we should not create conditions that make it difficult, if not impossible, for them to serve the needs of our neighbors and our friends, and people in all of our communities.

Mr. President, it is not good enough to say, ''I am going to vote for a credit union bill,'' and then attempt to fix a whole series of measures aimed at impeding the credit unions from doing their job. There are going to be some of my good friends and colleagues who are going to come here and say, ''We want to make it possible for others in the financial services area to recognize that we love them and we care for them,'' et cetera.

There are going to be a number of amendments that are going to be put forth. Some of these amendments, and one in particular, one that would attempt to remove the Community Reinvestment Act from the obligation of community banks—if that is passed, that will spell a veto of this bill.

I am not suggesting to you we shouldn't help community banks. I want to help them. Indeed, our President who presides today has come forth. I want to commend the Senator from Colorado for some very creative, long overdue actions to help community banks in the most positive way by seeing to it that they do not have unfair tax burdens placed upon them, by seeing that they have the opportunity to expand their board of directors or their shareholders, the number of shareholders, without falling into another taxable area.

There are things we can do and should be doing. But we shouldn't be attempting to do them, in my opinion, on this bill because it clouds the issue of whether or not we are going to give credit unions the opportunity to continue to serve their people.

Let me suggest this. Our Senate bill goes much further than the House bill to ensure the safety and the soundness of credit unions through tougher, more detailed provisions requiring a system of prompt, corrective action for federally insured credit unions.

This is not a giveaway. This is not the same bill that came from the House. It is improved. It is tougher on them and fairer on them. We sat down and negotiated with them. We said to them that we are not going to place at risk the FDIC insurance for the American taxpayer. They agreed.

The system is be patterned after the prompt corrective action provisions of the Federal Deposit Insurance Act. This is a different bill from the one that comes from the House. It is aimed at protecting our taxpayers.

The Senate bill also includes for the first time capital requirements for all federally insured credit unions, including a risk-based capital requirement for complex credit unions. Together, these provisions represent the most significant legislative reform of credit union safety and soundness since 1970 when the National Credit Union insurance fund was created.

We have included the enhanced safety and soundness provisions upon the recommendation of the Treasury Department following an extensive Treasury Department study placed in legislation by our colleague, Senator BENNETT. These are basic, prudent approaches to successfully manage any financial institution that Congress has already applied to banks and thrifts. In the long run, it is the American taxpayer that we protect by assuring that credit unions reach and attain high levels of capital, or face restrictions with respect to their operations.

Credit unions, no matter how small or how large, need a sufficient capital buffer to handle unexpected downturns in the economy and subsequent losses. The capital requirements in this bill will see to it that those goals are achieved.

We all know how important prevention is, along with legislative oversight, when dealing with financial institutions. Credit unions are no different from other financial institutions when it comes to prevention and oversight.

There are those who will say you are going in and giving to the masses. No. We responded to their legitimate concerns that they can continue business. But we have tougher end requirements as it relates to sound operation and oversight and the ability to close those down who may not be meeting their obligations.

In 1991, the GAO issued an extensive study which detailed the recommendations for corporate credit union investments and capital ratios that were later adopted. These recommendations were also adopted by the NCUA.

The failure of Cap Corp. in 1995 raised specific concerns about the interest rate risk that corporate credit unions were taking. Our committee held hearings in early 1995 and later reported out a bill, S. 883. In 1997, NCUA issued a comprehensive revision of the rules governing corporate credit unions to address concerns arising from the failure of Cap Corp.

Mr. President, credit unions all over are now in solid shape, as concluded in the exhaustive study done by Treasury last year. The new safety and soundness provisions, as recommended by the Treasury Department, will further strengthen insured credit unions across the country and, in so doing, protect our taxpayers.

Our legislation also goes much further than the House in placing for the first time significant restrictions on member business loans. We are going to hear something about that. We are going to hear that we should restrict loans that credit unions can make. While the House bill simply puts a freeze on current regulations and requires a study, our bill places statutory limits on the amount of total business loans available for credit unions.

This is not a bill crafted to please all. This is a bill crafted to permit credit unions to do that which they do best—to make those loans, those personal loans to their members, and, yes, to meet the needs of the small businessmen.

In the Senate bill, the total amount of outstanding member business loans of a federally insured credit union cannot exceed 12.25 percent of the assets of the credit union. Credit unions that become undercapitalized—that is, less than 6 percent of their net worth—are prohibited from making new commercial loans that would result in an increase in the total amount of member business loans outstanding. Credit unions that presently exceed the member business loan limits will be given 3 years in which to come into compliance.

Mr. President, this is a pretty tough loan limitation, the first time. It is not in the House bill—never had any limitations on business loans. There are going to be some who genuinely feel that should be curtailed even further. I would suggest to go further would really do violence to the ability of almost 200 of the Nation's 1,500 credit unions that make these loans available today. It is unintended mischief that will take place if that legislation passes. I say ''unintended,'' Mr. President. Notwithstanding unintended, the consequences will not be fair and will be disruptive.

These restrictions on business lending in our bill are real and they are meaningful, and together with the expanded safety and soundness provisions in title III of the bill, we will ensure that credit union business lending does not present any safety and soundness concerns. In a July 13 letter to the majority leader, Secretary Rubin has stated Treasury's position that the prompt corrective action in capital standard provisions in the bill represent an adequate response to any safety and soundness concerns about credit union business lending.

Furthermore, I have a copy of the statement of the administration policy dated July 22, 1998, which states that there is no safety and soundness basis for additional business loan requirements.

I ask unanimous consent that Secretary Rubin's letter and the Statement of the Administration Policy be printed in the RECORD.

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

DEPARTMENT OF THE TREASURY,
Washington, DC, July 13, 1998.

Hon. TRENT LOTT,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR TRENT: I appreciate your scheduling H.R. 1151, the Credit Union Membership Access Act, for Senate floor action beginning July 17. I am writing to urge expeditious Senate passage of the bill—as approved by the Banking Committee on April 30—without any extraneous amendments.

In revising the statute governing federal credit unions' field of membership, the bill would protect existing credit union members and membership groups, and remove uncertainty created by the Supreme Court's AT&T decision.

The bill's safety and soundness provisions would represent the most significant legislative reform of credit union safety and soundness safeguards since the creation of the National Credit Union Share Insurance Fund in 1970. The bill would institute capital standards for all federally insured credit unions, including a risk-based capital requirement for complex credit unions. It would create a system of prompt corrective action—specifically tailored to credit unions as not-for-profit, member-owned cooperatives. It would also take a series of steps to make the Share Insurance Fund even stronger and more resilient.

These reforms involve little cost or burden to credit unions today, yet they could pay enormous dividends in more difficult times.

The bill rightly reaffirms and reinforces credit unions' mission of serving persons of modest means. Section 204 would require periodic review of each federally insured credit union's record of meeting the needs of such persons within its field of membership. This requirement is flexible, tailored to credit unions, and will impose no unreasonable burden. It rests on the Congressionally mandated mission of credit unions and on the benefits of federal deposit insurance. Such deposit insurance gives credit union members ironclad assurance about the safety of their savings, and thus helps credit unions compete for deposits with larger, more widely known financial institutions (just as it helps community banks and thrifts). Section 204 is particularly appropriate in view of how the bill liberalizes the common bond requirement and thus facilitates credit unions' expansion beyond their core membership groups.

Finally, I would like to comment on the safety and soundness of credit unions' business lending. Credit unions may make business loans only to their members, and cannot make loans to business corporations. Under the National Credit Union Administration's regulations, each business loan must be fully secured with good-quality collateral, the borrower must be personally liable on the loan, and business loans to any one borrower generally cannot exceed 15 percent of the credit union's reserves. Credit unions' business loans have delinquency rates that are comparable to those on commercial loans made by community banks and thrifts, and charge-off (i.e., loss) rates that compare favorably with those of banks and thrifts. We believe that existing safeguards—together with such new statutory protections as the 6 percent capital requirement, the risk-based capital requirement for complex credit unions, and the system of prompt corrective action—represent an adequate response to safety and soundness concerns about credit unions' business lending.

We look forward to working with you and other Senators to secure expeditious passage of a clean bill.

Sincerely,

ROBERT E. RUBIN,
Secretary of the Treasury.

STATEMENT OF ADMINISTRATION POLICY

H.R. 1151—CREDIT UNION MEMBERSHIP ACCESS ACT

The Administration strongly supports Senate passage of H.R. 1151, as approved by the Senate Banking Committee, without extraneous or controversial amendments. The full Senate should reject amendments rejected at the Banking Committee mark-up, such as the amendment that would substantially weaken the Community Reinvestment Act by exempting certain banks from the Act's requirements. If H.R. 1151 were presented to the President with such an amendment, the Secretary of the Treasury would recommend that the President veto the bill.

The Senate Banking Committee version reflects a careful balancing of important goals: (1) protecting existing credit union members and membership groups; (2) removing uncertainty created by the Supreme Court's AT&T decision; (3) facilitating credit union expansion beyond core membership groups in appropriate circumstances, such as when necessary to meet the needs of underserved areas; (4) reforming credit union safety and soundness safeguards, by instituting capital standards and a risk-based capital requirement, as well as further strengthening the Share Insurance Fund; and (5) reaffirming and reinforcing credit unions' mission of serving persons of modest means. The Administration strongly opposes any efforts to upset this balance by stripping the bill of any of these important provisions.

Specifically, Section 204 would require periodic review of each Federally-insured credit union's record of meeting the needs of such persons within its membership. This requirement is flexible, tailored to credit unions, and will impose no unreasonable burden. It rests on the Congressionally mandated mission of credit unions and on the benefits of Federal deposit insurance. Inclusion of Section 204 is particularly important to keeping credit unions focused on their public mission in view of how the bill liberalizes the common bond requirement.

In addition, the Administration sees no safety and soundness basis for an amendment that would limit the ability of credit unions to make business loans to their members. Existing safeguards, coupled with the new capital and other reforms in the bill, are sufficient to protect against any safety and soundness risk from member business lending.

PAY-AS-YOU-GO-SCORING

H.R. 1151 would affect direct spending and receipts; therefore it is subject to the pay-as-you-go requirements of the Omnibus Budget Reconciliation Act of 1990. The Administration's preliminary estimate is that H.R. 1151 would have a net budget cost of zero.

Mr. D'AMATO. We need to act expeditiously on this legislation. I am deeply grateful to the Senate majority leader for making this time available so that we can go forward. Make no mistake about it, without the ability to add new members and new groups, the credit union movement would be fatally injured.

I am convinced that we are going to move in a prompt way and that the legislation will pass by an overwhelming margin. Why? Because it is the right thing to do. It is the right thing to do for 73 million Americans who now belong to credit unions, for the 20 million Americans whose current credit union membership is threatened, and for the 675 million Americans and small businesses who may be shut out, prevented from joining a credit union in the future. I certainly urge my colleagues to support and expeditiously act on this important legislation.

Mr. President, before I yield the floor, I would be remiss if I did not thank my colleague, the ranking member of the Banking Committee, Senator SARBANES, the distinguished senior Senator from Maryland, for his outstanding contribution and leadership in helping to craft this legislation and to bring it to this point in a totally bipartisan fashion. We would not be here positioned to go forth on this legislation were it not for his outstanding leadership and that of a dedicated bipartisan staff, might I add, on the minority side. They have done an absolutely fabulous job in bringing us to this point.

I yield the floor.

PRIVILEGE OF THE FLOOR

Mr. SARBANES. Mr. President, I ask unanimous consent that Patience Singleton and Loretta Garrison, staff members, be allowed privileges of the floor.

The PRESIDING OFFICER (Mr. DEWINE). Without objection, it is so ordered.

Mr. SARBANES. Mr. President, first I want to thank my colleague, Chairman D'AMATO, for his kind words and to underscore the very effective leadership which the chairman has exercised in bringing this legislation to this point. This bill came out of the committee on a vote of 16 to 2. We had very strong support within the Senate Banking, Housing, and Urban Affairs Committee, and I have been pleased to be able to work closely with the chairman in trying to craft this legislation.

We had, as usual, outstanding contributions by members of the staff on both the Republican and the Democratic sides, and we are most appreciative to them for the many long hours they have put in on this legislation.

The time is now to straighten out the credit union challenge which was posed by the Supreme Court decision. This legislation passed the House of Representatives in the beginning of April by a vote of 411 to 8. The Senate Banking Committee, after holding two hearings on the issue, marked up the legislation on April 30 and reported it with amendments to the full Senate by a vote of 16 to 2. Since April 30, we have been looking for an opening on the Legislative Calendar in order to take the matter up in the Chamber, and the majority leader has provided this opening.

If I could have the attention of the majority leader, I would like to ask, it is my understanding the intention now is to do the opening statements—I know that Senator SHELBY and others have amendments—and begin debate on the amendments, continue that on Monday afternoon beginning at about 1 o'clock, and any votes that would transpire in relationship to the amendments which have been offered would occur beginning about 6 o'clock Monday evening?

Mr. LOTT. Mr. President, if the Senator will yield, we would have to begin those votes a little earlier than that, probably at 5:30. It would be partially driven by how many votes we have. If we just had one vote lined up, for instance, we could begin about 5:45. If we have two or three, we would have to begin at 5:30 in order to get the voting sequence completed by 6:30.

So that is what we are up against. We are trying to accommodate Senators coming in late and Senators who have to leave after 6:30. But the hope is that you would have two or three amendments ready to be voted on Monday afternoon beginning around 5:30, with the understanding that if we need to hold that first vote a little while for Senators coming in with a close plane connection, we would be prepared to do that, and then have the vote probably on the Shelby amendment and final passage Tuesday morning at 9:30.

I discussed that with Senator DASCHLE, and he and I worked on trying to accommodate Senators' schedules on all sides. I believe, if you could go ahead and get debate on all amendments today and Monday, then we could have one or two or three votes Monday afternoon, sometime between 5:30 and 6, probably not later than 5:45, and then the last two votes Tuesday morning.

Mr. SARBANES. As I understand it, some people will be scrambling to be here. I think if we didn't start before 5:45, or if we let that first vote run a little bit——

Mr. LOTT. A little bit, except Senators have to leave at 6:30, and I am one of them, and that is the schedule I am particularly interested in.

Mr. SARBANES. Of course, the Senator could make the beginning of the last vote and leave.

Mr. LOTT. As long as I am out of here at 6:30, everything will be fine.

Once again, I know we have had to work late, but we have made good progress on the appropriations bills. This is a good bill. But I still think the Senate should work during the day and be home with their families at night. That is a novel idea that I still advocate, so I am going to be with my wife eating supper Monday night at 7 o'clock. Good luck before then. But we will try to accommodate everybody, including my favorite lady in the world.

Mr. SARBANES. I just want to underscore the intention is, and we have every reasonable expectation that, we are going to be able to complete this bill finally by Tuesday morning and do a good deal of it by Monday evening.

In addition to the broad bipartisan support for this legislation in the Congress, it is strongly supported by the administration. Senator D'AMATO has already placed in the RECORD a letter that Secretary Rubin, our very able Secretary of the Treasury, sent to the majority leader and to the minority leader urging expeditious Senate passage of the bill without any extraneous amendments. Of course, the amendments are the important issue that we will be considering over the next few days.

President Clinton has personally indicated his support for this legislation, urging the Senate to pass the bill without weighing it down with extraneous and controversial amendments that would seriously jeopardize the legislation. H.R. 1151 is also supported by a very diverse range of groups in the community including the Consumer Federation of America, the Seniors Coalition, the National Farmers Union, National Educational Association, Americans for Tax Reform, the American Small Business Association, AFL–CIO, and the National Urban Coalition.

The broad support for this legislation suggests the important role credit unions play in our economy. Since the founding of the first credit union in the United States in 1909, almost a century ago, credit unions have served as a way for people of average means, without easy access to credit, to pool their savings in order to make loans to fellow credit union members at competitive interest rates.

Mr. President, the impetus for H.R. 1151 came from a Supreme Court decision earlier this year. In a 5 to 4 decision, the Court held that under the Federal Credit Union Act a federally chartered credit union may only have a single common bond of occupation. This overturned a policy of the National Credit Union Administration, the regulators of the credit unions, first adopted in 1982, which permitted multiple groups each having a separate common bond to be part of a single Federal credit union.

The consequence of that Supreme Court decision is to prohibit the formation of multiple group credit unions. Even if the lower courts, in implementing the Supreme Court decision, permit existing multiple group credit unions to stay in business and to accept members from their current groups, employees from the large majority of

companies in the United States will find their future opportunities to become a member of a Federal credit union seriously constrained by the Supreme Court's decision.

The National Credit Union Administration generally does not permit groups with less than 500 employees to start a credit union because it is judged the group is not broad enough or numerous enough to support a credit union in a safe and sound manner. The only way for employees of these companies to join a credit union is if the companies affiliate with existing credit unions. So, if new multiple bond credit unions are prohibited, this will no longer be possible and millions of Americans may be denied the opportunity to join a credit union. This outcome is clearly undesirable, in my view, and is, of course, the basis for the broad bipartisan support for enacting this legislation.

This legislation would first grandfather existing multiple group credit unions and allow them to add members from their current groups. In addition, it would permit Federal credit unions to have multiple groups, each of which, after the first group, has a common bond of occupation or association and has less than 3,000 members. The bill would also give the National Credit Union Administration the power to authorize credit unions to add additional groups if it finds the groups cannot safely establish and operate a credit union on their own. The Credit Union Administration could also permit a Federal credit union to add a person or organization located in a local community, neighborhood, or rural district that it has determined is underserved by other depository institutions.

But, in order for a Federal credit union to accept additional membership groups, the NCUA would have to find that the credit union is adequately capitalized, has adequate managerial or financial resources, and has a satisfactory examination record. The legislation directs the Credit Union Administration to encourage the formation of separately chartered credit unions whenever practicable and consistent with safety and soundness.

In addition to addressing the membership issue, this legislation requires significant new safety and soundness standards for Federal credit unions. These new requirements are based on recommendations contained in a carefully prepared study of credit unions by the Treasury Department conducted at the direction of the Congress and submitted last year.

Earlier, in legislation, the Congress directed the Treasury Department to study credit unions and to submit a report to the Congress. A good deal of what is contained in this legislation reflects the outcome of that study.

The bill imposes, for the first time, statutory capital standards on Federal credit unions. The bill requires an insured credit union to have a net worth ratio of 7 percent to be ''well capitalized'' and 6 percent to be ''adequately capitalized.'' A credit union with a net worth ratio of less than 6 percent would be ''undercapitalized,'' at 4 percent it would be ''significantly undercapitalized,'' and at 2 percent ''critically undercapitalized.'' The legislation provides a system of prompt corrective action which requires the National Credit Union Administration to take a series of progressively more stringent measures if the credit union falls below the ''adequately capitalized'' level. Each insured credit union that is undercapitalized would be required to submit an acceptable net worth restoration plan to the NCUA. Until that plan is approved, the credit union generally would not be permitted to increase its average total assets. If an insured credit union becomes critically undercapitalized according to the standards I mentioned earlier, the NCUA would be required to liquidate the credit union, appoint a conservator, or take such other action as it determines could better achieve the purpose of protecting the credit union insurance fund.

I have taken a few moments to dwell on these provisions because I think they are quite important. They have generally not been involved in the debate that has led up to considering the measure on the floor, but I think Members need to appreciate the very important safety and soundness provisions contained in this legislation. This is a major step in ensuring financial stability in the credit union industry. It has led the Secretary of the Treasury, in the letter which he sent to the leadership, to make this statement. I just want to quote this paragraph from Secretary Rubin's letter:

> The bill's safety and soundness provisions would represent the most significant legislative reform of credit union safety and soundness safeguards since the creation of the National Credit Union Share Insurance Fund in 1970. The bill would institute capital standards for all federally insured credit unions, including a risk-based capital requirement for complex credit unions. It would create a system of prompt corrective action—specifically tailored to credit unions as not-for-profit, member-owned cooperative. It would also take a series of steps to make the Share Insurance Fund even stronger and more resilient.
>
> These reforms involve little cost or burden to credit unions today, yet they could pay enormous dividends in more difficult times.

We worked closely with the Treasury in considering the provisions that were in the legislation. I think this is a major step forward. I really commend this aspect of the legislation to my colleagues as they consider the overall bill.

Furthermore, this bill imposes, for the first time, a limit on commercial lending by credit unions. No such limit currently exists. The bill provides that a credit union would be generally limited in its member business loans to no more than the lesser of 1.75 times the minimum net worth required for well-capitalized credit unions—namely 7 percent—or 1.7 times its actual net worth. This would put a limit on member business loans for a well-capitalized credit union at approximately 12.25 percent of its total loans. Loans of less than $50,000 would be excluded—that is an operating practice currently—and we would continue to adhere to that.

Many credit unions are chartered for or have a history of making business loans to their members. Members of a specialized vocation—farmers, fishermen, taxi drivers and so forth—would not be subject to this limit.

Furthermore, this legislation imposes, for the first time, a modest but meaningful community obligation with respect to reinvestment in insured credit unions, which has been carefully tailored to the membership-based nature of credit unions. It would require the National Credit Union Administration to prescribe criteria for periodically reviewing the record of each insured credit union in providing affordable credit union services to all individuals of modest means, including low- and moderate-income individuals, within the field of membership of the credit union, and provide for making such results publicly available.

The bill also directs the National Credit Union Administration, in evaluating any insured credit union under this requirement, to focus on the actual performance of the credit union and not to impose burdensome paperwork or recordkeeping requirements. We think this is a modest but important step in paying attention to the needs of low- and moderate-income individuals, and thereby making access to credit more broadly available.

In conclusion, let me just say this is a very carefully developed and balanced piece of legislation. As I said, the committee held two extensive hearings on the matter. It worked very carefully over the provisions that have been included in the legislation and brought here before the Senate. This legislation seeks to make credit union membership accessible while strengthening the safety and soundness of federally insured credit unions and encourages them to meet the financial service needs of all of their members.

I strongly urge the support of this legislation by my colleagues. I strongly urge my colleagues to reject extraneous amendments that may be offered to the legislation that may complicate or jeopardize its enactment. We now need to move this legislation forward.

I think a very careful package has been put together here. The credit union movement supports the legislation as reported by the committee. The administration supports the legislation as reported by the committee. I respect, obviously, the motivation of my colleagues who intend to offer amendments, but I can only point out that those amendments would greatly complicate our efforts to move this legislation to final passage and signature into law by the President. I very much hope my colleagues can back the work that

was done by the committee in bringing this matter to the Senate floor.

I, again, thank Chairman D'AMATO for his skillful work in developing the legislation to this point and bringing it to the floor of the Senate.

Mr. President, I yield the floor.

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, let me add my voice to those who have congratulated Senator D'AMATO and Senator SARBANES for this bill. I believe we have put together a good bill. I think it is a dramatic improvement over the House bill. It does, for the first time, in an effective manner begin to look at capital requirements and safety and soundness, and, in doing so, it will dramatically improve the quality and regulation of credit unions all over the country. I think those who are part of the credit union movement want people to know that their deposits are safe, sound, insured, regulated and protected in the savers' interest.

Second, the bill, for the first time, begins to put appropriate limits on the amount of business loans that credit unions can make. There are those who believe, and I happen to be one of them, that credit unions were chartered to provide consumer credit to their members as part of a cooperative effort. A dramatic movement of credit unions into commercial lending would circumvent the whole intent of the credit union movement, and in my opinion, it would be a negative factor on the progress of the credit union movement. In this bill, we for the first time set limits on the amount of credit union assets that can go into commercial loans. That is a very positive step.

We deal with the common bond issue, and we settle once and for all the principle that every American ought to have the right to join a credit union—not any credit union—but join a credit union within an appropriate field of membership. it my view, and I believe that we achieve this with this bill, that it should be possible for every American citizen to find an appropriate field of membership by which he or she can associate with others, and have the opportunity to join a credit union and to affiliate with that credit union if they choose to do it.

Those are the positive things about this bill. I am a strong supporter of the bill. I intend to vote for this bill, but there is one provision in the bill to which I am very strongly opposed.

In this bill, for the first time ever, we begin to have the Federal Government direct credit unions as to how they will use their members' money. In this bill, for the first time ever, we begin the process of telling credit unions that the government is going to allocate some of a credit union's resources to promote a ''public purpose,'' even though it may not be the purpose of credit union members. I believe that not only is this very bad and dangerous public policy, but I think the logic of it is totally inapplicable to credit unions and the credit union movement.

The name—it is a wonderful sounding name for a program that has nothing to do with any one word in the name—is Community Reinvestment Act. In this bill, for the first time ever, we apply in three different ways this Federal mandate and credit allocation to credit unions.

Let me explain why, despite all the arguments you can make on the merits or demerits of the Community Reinvestment Act, why it does not belong on this bill.

Credit unions are voluntary, private associations. They are nonprofit organizations. They are tax-exempt organizations. They represent a collective effort of members to pool their savings with a common objective. They pool their savings and they lend to each other, the members of the credit union. In doing so, they perform a cooperative credit function. In many cases, they provide credit that would not be available, certainly at rates that would not be available, in many cases, to the consumer.

They are not in the business of promoting any broad, general purposes, such as the general welfare of the country or the community. They are small, private associations that are organized for the purpose of promoting the welfare of their members. The whole purpose is to pool nickels, dimes and dollars to build a cash base that can be lent to members for things such as buying a new car or new truck, buying a new tractor.

The objective of the credit union is to promote the interest of credit union members. It is not a for-profit organization, and there is no logic to applying to it a provision of law where the Government adds an additional mandate that the credit unions should direct the money of those members to support some end other than the well-being of the people who put up the money in the first place.

Let me explain how this works, and I want to read you some language—in my mind, shocking language—that has been included in this bill in the House, and language that I believe should be removed.

In the bill, the House has set up this requirement for a Federal mandate and capital allocation that goes by the name of community reinvestment. I will talk in a moment as to why this provision has nothing to do with community or reinvestment.

This bill mandates that credit unions conform to this Federal capital allocation. Here is how it is defined, and here is basically how it works:

In three different places, we have a reference to it in the bill. The first way that the bill would measure whether a credit union is complying with this Federal mandate allocating their members' hard-earned money is on page 58 in new section 215. In subsection (b), it is set out that credit unions have to comply with this community reinvestment, and that in doing so, they will be regularly evaluated by the Federal Government, and their record will be looked at to see if the credit union is ''providing''—I want you to remember, that is ''ing''—''. . . providing affordable credit union services to all individuals of modest means . . . within the field of membership of the credit union. . . .''

In other words, in this section, the Federal Government will evaluate whether or not this credit union, in making loans, in allocating the money of the people who have joined the credit union, is providing affordable services—and I don't know how you define ''affordable.'' I think I know how you define ''providing;'' you test whether they are actually doing it, although I could imagine some very interesting and intrusive methods of testing that the regulators might conjure up. But the test of ''providing'' can be a very rigorous test, since the standard is not whether the credit union is offering its services, it is not whether they are trying to do it. They are required to do it. They are to be ''providing''—you are evaluating whether they are ''. . . providing affordable credit union services to all individuals of modest means . . . within the field of membership of the credit union.''

You need to understand, field of membership and membership are two different things. A credit union considers itself successful if it is able to get about 20 percent of the people who could join that credit union to join it. So that in any field of membership, normally about 80 percent of the people in the field of membership who were invited to join the credit union, who were invited to put up their money, said ''No, I don't want to join your credit union; I don't want to put my money into your credit union.'' But the first provision of this bill requires that the credit union, to comply with this law on Federally mandated capital allocation, must be ''. . . providing affordable''—and where are these terms defined? Nowhere—''credit union services to all individuals of modest means . . . within the field of membership.''

Now, I do not believe we ought to be forcing credit union members, who put up their own money, to provide services to people that had an opportunity to join the credit union but decided not to join it. I think that violates the whole spirit of the credit union movement because a credit union is a cooperative, and if you want credit union services, you join the credit union. You participate in putting up the capital and you apply for loans or services from the credit union.

The second evaluation has to do with community credit unions. And those are credit unions that serve an entire community. This second provision requires that credit unions are ''meeting''—not trying to meet—and please note, the law does not say that you ''offer'' services, that you offer ''affordable'' services, whatever that means, to

all people of modest means within your field of membership. The law requires that you ''provide'' it.

Now, the second reference is, that you are ''meeting the credit needs and credit union service needs of the entire field of membership of the credit union.'' That is on page 59—''the entire field of membership. * * *''

So again, you are in a community. This little credit union is providing services to people in a town with 5,000 people; roughly 20 percent of those people have joined the credit union. But this law requires that they provide ''affordable'' services—whatever that means—to people who did not even join the credit union. How can that be right? Clearly, in my opinion, it cannot be right.

Now, the third case, very similar to the first, except the language gets even more grandiose. Imagine writing a Federal law where you can threaten the deposit insurance of a credit union and put it completely out of business. If it does not have Federal deposit insurance, it is not going to be able to operate. This law applies to both Federal credit unions and State credit unions, as long as they receive Federal deposit insurance.

Listen to this language. You have regulation to see if the credit union is ''satisfactorily''—satisfactorily, mind you—''providing,'' ''affordable''—I do not know how you define these terms. I have discussed ''providing.'' The credit union is actually doing it. It is not ''offering'' services; it is ''providing'' them, services are being accepted and received, not just offered. ''Satisfactorily'' is an undefined term, satisfactory to whom? ''Affordable'' is undefined and undefinable —that the ''credit union is satisfactorily providing affordable credit union services to all individuals of modest means within the field of membership of the credit union,'' whether or not they join the credit union in the first place.

Mr. President, this provision does not belong in this bill. This provision is piracy. This provision came about because we have a crisis in the credit union movement because of the court ruling, a crisis which requires congressional action. And what those in the House, who put this provision in the bill, have, in essence, said is, that in order to resolve your crisis, you have to pay tribute. And the tribute you have to pay is that we are writing a provision of law which says that every year you will be evaluated by a group of Federal bureaucrats who will determine whether you are satisfactorily providing affordable credit union services to people who are not even members of the credit union. And then they will publish their findings.

Now, what does this produce? What this produces is a situation where you literally—I am going to use some strong language here; and I mean every word of it—this produces a situation where literally you have professional protesters who extort resources from banks, and if this bill passes unchanged, they will be extorting resources from credit unions. Here is how it works. And I am going to give you some examples. And you are going to be shocked by these examples.

What happens is that periodically you have this evaluation that is made public, and whether or not the evaluation is satisfactory, you have a group of people who show up from various organizations to tell you how to use your resource for their benefit. ACORN is very active in this effort, and there are many other organizations, it is a growing industry—they show up at the bank and they say, ''You're not meeting your CRA requirements. And here are some things we want you to do. And if you'll do these things, then we will say that you're meeting these requirements, and we will stop protesting for now.''

It works like this. You have a bank who may have a perfect record on CRA requirements, but they want to merge with another bank. Even though they may have never had anything other than an exemplary rating, protesters can enter the process and challenge the merger on the grounds of community reinvestment and cost the banks millions of dollars because of the delays that their protests cause.

Now, let me give you two examples of where this has occurred.

The first I will refer to happened in 1989 in California. And let me say, Mr. President, it is hard to get banks to talk about this. I recently spoke to the CEO of a major Fortune 500 company, and I mentioned to him an effort I am supporting, an effort Senator SHELBY is undertaking to provide CRA relief for small community banks. When I mentioned CRA, he said, ''It's extortion.'' If I called him up and asked, ''Could I use your name?'' how many people who are being extorted want their name used? They do not. They are afraid to have their name used. When a CEO of a Fortune 500 company in America is afraid to say his mind publicly, to expose extortion, something is wrong in America.

Now, let me give you my examples and offer my amendment, and then we will debate this again on Monday.

In 1989, California First Bank wanted to merge with Union Bank. But when they sought to merge, opposition was lodged under the CRA provisions of banking law, and in order for these protests to be withdrawn so that delays could be ended and the merger could go forward, here is what California First Bank agreed to: One, to increase purchases from women and minority-owned vendors to 20 percent of purchases within the next 5 years. Second, they agreed to give charitable contributions, cash grants, not loans, in the amount of 1.4 percent of income in 1989 and 1.5 percent of income in 1990.

Now, I do not know this, but if I were a U.S. attorney in that district, I would go look and see if they gave those contributions to the groups that protested the merger. That would be a very interesting inquiry.

Next, California First Bank committed that 60 percent of the employees placed in middle and senior management positions within the next 5 years would be minorities and women. And finally, they committed to appoint three minority and women directors.

That is what they had to do in order to get the right to merge with another bank. Now, listen to this next one.

Sumitomo Bank of California—now I do not know, but I guess that Sumitomo Bank is a Japanese affiliate. I think it is relevant because I want you to put yourself in this position. Let us assume that an Ohio bank had opened an affiliate in the Dominican Republic and that some government agency there had said that, ''You are not meeting your CRA requirements.'' And then they published that, and then a group of people came to the bank and said, ''We want you to do some things so that we then will tell the government that you are meeting these requirements.'' Let's see what the things were that our Government in effect forced this bank to do. Let me read to you what they did.

No. 1, $500 million was committed to CRA-related loans. No. 2, the bank committed to spend 2 percent of income on charity, nonprofit organizations, with two-thirds of the money going to inner-city development, this being cash, grant money. No. 3, the bank committed to appoint minority board members. No. 4, the bank agreed to appoint a paid five-member minority advisory board to consult with management. And, No. 5, the bank agreed to give 20 to 25 percent of outside contracts to minority-owned vendors.

Now if that happened to an Ohio bank operating in the Dominican Republic, what would you call it? I would call it extortion. That is what I would call it. I would call it extortion, or maybe even expropriation, a taking of private property.

Now, how does something like that happen? How it happens is that we let people write into law provisions like ''satisfactorily providing affordable services,'' which no one can define, nobody knows what it means, and if you have to comply—a regulator that is willing to let protest groups file objections to banks merging, for example, by simply the ability to hold that merger up—they are able to extort resources.

Now, I could go on for quite a while and add to the list. For example, when Bank One wanted to merge with First Chicago. But what do you think happened when they filed that merger? What happened was, they had a group of protesters who showed up, who filed a boilerplate objection which could be drawn up in 15 minutes by any lawyer who deals in this area. I am sure the bank president said, ''Well, we have an exemplary CRA record.'' The protestors said, ''We have objected to your merger.''

So weeks go by, time goes by, and this is the Woodstock Institute that objected in Chicago—I better be careful to get the name right—yes, in Chicago, the Woodstock Institute objected. So what happens in such cases? The bank ends up allocating the resources of its stockholders in order to eliminate the objection just to be able to move forward with its business.

Now, let me read a quote to just show the arrogance of these people who we are empowering under these laws. Forgive me if I get a little excited about it, but it is the kind of practice I hate worst. This comes from the proposed merger of NationsBank and Bank of America. They have received outstanding CRA grades, but in spite of their unprecedented $350 billion CRA packages of loans and services to inner cities, et cetera, CRA activists are raising protests against the merger. One of the activist leaders has said the following—remember, this is about banks that have exemplary CRA records, at least according to the Government regulators who regulate this activity. These banks have exemplary records. But here is what the protester said, ''We will close down their branches and ensure they fail in California.'' That is what they said. ''We will close down their branches and ensure they fail in California. This is going to be a street fight and we're prepared to engage in it.''

Do you know what this reminds me of? This reminds me of a little immigrant storeowner. He and his wife and three children are running a little store, and these great big hoods come knock on his door. They come in and say, ''Somebody could do you some harm. There might be people who could come and break in your store, steal your goods. They might beat you up; they might break your arm. But I will tell you what we will do. If you will pay us 5 percent of what you earn in this store, we will see that nobody comes and breaks your arm.''

That is what this reminds me of. That is exactly what this reminds me of.

Now, I don't like the fact that it is going on. Some day I will get rid of it. Some day this is going to be gone. I intend to speak out on this for so long with such great passion that in good time Congress is ultimately going to rise up and stop this. That is not likely to happen here today, but some day it will happen.

What I don't want to do is, I don't want to start this business with credit unions. Now, I am sure that we are going to hear from someone who will say credit unions don't support this amendment. Well, the credit unions have been told, ''You support the Gramm amendment, and maybe your bill won't get passed. You support this amendment, and maybe the President won't sign your bill. You support this amendment, and maybe it will mean endless delays.'' Now, that is like saying to someone sticking a gun to your temple, saying, ''You feel good about things, don't you?''

We will vote on this amendment on Monday afternoon.

I don't want credit unions to have to be evaluated on whether or not they are providing satisfactory, affordable services to people who didn't even join the credit union.

AMENDMENT NO. 3336

(Purpose: To strike provisions requiring credit unions to use the funds of credit union members to serve persons not members of the credit union)

Mr. GRAMM. Mr. President, as a result of not wanting that to happen, I send this amendment to the desk to strike these provisions, and I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Texas [Mr. GRAMM] proposes an amendment numbered 3336.

Mr. GRAMM. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

Strike section 204 of the bill and renumber the sections accordingly, and beginning on page 45, line 24, strike all through page 46, line 4, and redesignate subparagraph (E) and (F) on page 46 as subparagraphs (D) and (E), respectively.

Mr. GRAMM. Mr. President, it is my understanding this will be the first vote we have on Monday. It is also my understanding that there will probably be an hour set aside so each side will have 30 minutes to debate the amendment. Rather than stay around today and debate it, I will use my 30 minutes on Monday.

I thank my colleagues for their indulgence. This is an important amendment. We ought not to add these onerous CRA provisions to credit unions, which are investor owned, which are set up as cooperatives to serve the people who are members.

Imagine, for example, in New York, where you have a credit union that was set up so cabdrivers could save their money and lend it to one another, and the loans, then, would be made to buy a Medallion so somebody could own their own cab.

Now, with CRA, the Federal Government comes in and says, ''Hey, how many loans have you made to people who aren't members of your credit union who could have been—they are in your field of membership, but they didn't choose to join your credit union; how many Medallions have you helped them buy?''

So Joe Brown, who put money into the credit union for 15 years, finally gets to the point where he thinks he can buy his Medallion, but because of this provision, the credit union has to take Joe's money and lend it to somebody who never joined the credit union, never wanted to be in the credit union.

If you can defend that, good luck.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. JOHNSON. Mr. President, I rise to address the overall issue of the legislation before the Senate, H.R. 1151.

I want, first, to commend Chairman D'AMATO and the ranking member, Senator SARBANES, for their help in this legislation getting to the floor in a timely fashion.

I will not address the issue raised by my colleague from Texas. I know there are others who will want to talk about that at much greater length.

There is an underlying legitimate debate there about whether an industry that benefits from Federal insurance, Federal regulation assuring that industry's stability and long-term viability, should, in turn, have to commit itself to making investments back into its own community or not. That debate can go forward. But I want to talk briefly about the underlying bill.

As we all, I think, understand, following the Supreme Court's decision earlier this year, the credit union membership of some 20 million credit union members all across America has been in some jeopardy. There was initially legislation offered in the other body that was designed simply to overturn the Supreme Court decision. The other body chose not to do that. Nevertheless, they did reach a compromise bill that passed in April on an overwhelmingly vote of 411–8.

Following that debate, and passage of that legislation, the Senate Banking Committee took up our version of credit union legislation, with the understanding that prompt action was in fact needed. But again, rather than simply choosing to overturn the Supreme Court decision and rather than simply choosing to pass the legislation passed in the House, the Senate Banking Committee crafted its own version, strengthening significantly the language of that original H.R. 1151.

Now, there is a compromise involved here. Most Members in this body, and many Americans, are members of both credit unions and banks. It is important that they both be viable, strong contributors to our national economy. It has always been—and it is the nature of compromises—that some will go away not entirely satisfied, but, on the other hand, we can reach that balance that will allow both the banking and credit union industries to go forward in a fair and competitive fashion. That certainly, at least, is the goal of this legislation.

So in the course of crafting this bill, we were able to arrive at bipartisan agreements on the level of restraint on expansion of credit unions that ought to be put into legislative language. There are some who would rather have no restraint whatsoever; others would rather have much greater restraint on what definition of ''common bond'' is used. We did reach a level of restraint in our legislation that, for the first time, now exists. I think perhaps, most

importantly, the Senate Banking Committee adopted the Treasury Department's recommendations on safety and soundness.

I think one of the greatest concerns all of us have had in this body is to make sure that if we are going to have an industry that is growing and prosperous, that it have underlying regulatory safety and soundness provisions that are really necessary for its long-term viability and for the confidence of the American consumers—not to mention the confidence the taxpayers ought to be able to have that they will not be called upon at some future time to bail out an industry that may have failed for lack of adequate safety and soundness provisions. I think one of the most important parts of the Senate response to the crisis that we have faced this year is stronger safety and soundness provisions and the adoption of the Treasury's recommendations.

The committee also took up the issue of restraint on commercial lending—or member business loans, as they are sometimes referred to—which now, for the first time, is in place. Again, there are those who would have much more severe restrictions and those who would have no restrictions and ask why any restrictions ought to exist over and above our safety and soundness standards. But this compromise was reached, and I think it is one that is supported by the credit union industry and is supported by the consumer groups as well. And the Senate committee chose to retain language on CRA—or ''CRA-light'' as it is sometimes referred to—that was instituted by the other body when they took up H.R. 1151.

Again, there are those who would like to see a much more rigorous, aggressive approach to CRA taken, and there are those who are simply philosophically disinclined to support any kind of CRA, even though this ''light'' version is simply a direction to the regulator of credit unions to come up with some assurance that, in fact, credit unions are investing in their local communities, which certainly has always been the case, although now there are larger credit unions with billions of dollars of capital, and some question is raised there. In any event, this is a provision that is accepted by the industry.

We need a strong banking industry and we need a strong credit union industry. They both have legitimate, important roles to play in the provision of credit across America. In my State of South Dakota, with some 700,000 citizens, almost 200,000 of them belong to credit unions. We have historically a long track record of utilization of cooperative ventures, whether it is our rural electric, telephone co-ops, or other agricultural cooperatives across the State. We have that long tradition, one that has contributed significantly to affording more options, a greater level of economic prosperity, to a great number of people across rural America.

Mr. President, I ask unanimous consent that a letter in support of this legislation from the National Farmers Union and a letter from the National Rural Electric Cooperative Association be printed in the RECORD.

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

NATIONAL FARMERS UNION,
Washington, DC, June 23, 1998.

Re Credit Union Membership Access Act.

Hon. TIM JOHNSON,
Member of the U.S. Senate,
Washington, DC.

DEAR SENATOR JOHNSON: I am writing on behalf of the 300,000 members of the National Farmers Union (NFU) to urge you to support H.R. 1151, the Credit Union Membership Access Act, which will restore an open field of membership to credit unions. In addition, we urge you to oppose the Hagel-Bennett amendment which would make it more difficult for farmers and ranchers to obtain loans from their credit unions.

Farmers, ranchers, and rural citizens around the country are facing tough times right now due to low commodity prices. The Hagel-Bennett amendment would unnecessarily restrict credit unions from making loans to their members for business purposes, and will worsen the difficult situation farmers, ranchers and rural citizens now face.

During our 95th annual convention, NFU members affirmed their support for credit unions: ''We are unalterably opposed to any proposal that seeks to curtail services by credit unions to their members under the false guise of regulatory reform or financial soundness. Such proposals are especially discriminatory against rural credit unions which provide agricultural credit services. We pledge our support to the credit union movement in its efforts to combat the anti-competitive regulatory tactics undertaken by other segments of the financial services industry.''

We urge you to pass this important legislation, without adoption of the Hagel amendment.

Sincerely,

LELAND SWENSON,
President.

NATIONAL RURAL ELECTRIC
COOPERATIVE ASSOCIATION,
Arlington, VA, July 15, 1998.

Hon. TIM JOHNSON,
U.S. Senate,
Washington, DC.

DEAR SENATOR JOHNSON: On behalf of the over 30 million Americans who currently receive electricity from rural electric cooperatives, we strongly urge you to vote in favor of H.R.1151, the Credit Union Membership Act, without any amendments.

It is vitally important that certainty be brought to the nation's credit unions and their members. For many Americans credit unions are their only source for affordable banking and credit services.

H.R.1151 represents an excellent balance among the competing financial interests and deserves to be enacted before the August recess. The House passed this measure by an overwhelming majority of 411–8 and the Senate Banking Committee reported the bill out in a 16–2 vote.

H.R.1151 has broad bipartisan and constituent support. Please pass this legislation.

Thank you for your consideration.

Sincerely,

GLENN ENGLISH,
Chief Executive Officer.

PRIVILEGE OF THE FLOOR

Mr. JOHNSON. Mr. President, I ask unanimous consent that Scott Swanjord, a staff member of mine, may have floor privileges during this debate.

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

Mr. JOHNSON. Mr. President, we have minimal time remaining in this 105th Congress. The schedule is full. We have virtually the entire budget still to do, and other key issues are facing us. Frankly, we cannot afford to have this legislation held up with vetoes, veto threats, with ongoing, never-ending negotiations. So I think it is very important that we move forward with this legislation.

A veto threat has been issued by the White House. If the CRA provisions are taken out—the ''CRA-light'' provisions—we will lose our bipartisanship, and it is a provision that is supported by the industry itself. It would appear to me that we need to move forward expeditiously with this legislation. We will be taking up bank regulatory relief legislation later on this coming week perhaps. There will be other vehicles in which to debate some of these extraneous matters dealing with the banking industry and, peripherally, the credit union industry. But I think it would be a mistake for us to be caught up in too many side issues on the underlying bill here.

There is an absolute urgency that we move this bill forward. If we do not, the membership of some 20 million Americans will, in fact, be in very real and very great jeopardy. So with the legislation that passed 411–8 in the House, passed the Senate Banking Committee by a 16–2 vote, it would be my hope that this coming week we could conclude debate on this bill, obviously, with the adequate consideration of well-intended amendments, hopefully limited in number, but then get this bill in its current form onto the President's desk for signature.

I yield the floor.

Mr. SHELBY addressed the Chair.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SHELBY. Mr. President, something was said just a minute ago about the threat of a veto by the President. I have heard this a lot on different bills. But I know the process should work. Especially when you have a principle that you believe in and that you know is right, you should not step aside because someone intimates that they might veto it. That is part of the legislative process.

Mr. President, having said that, later in the debate—probably Monday when we get back—I will be offering an amendment to the bill dealing with the Community Reinvestment Act, or CRA. My proposed amendment would authorize a small bank exemption from the Government-mandated credit requirements of the Community Reinvestment Act, which Senator GRAMM from Texas so eloquently talked about earlier this morning. Community banks, as you well know, as a Senator and present Presiding Officer, by their

very nature, serve the needs of their community.

They do not need a burdensome, government mandate to force them to allocate credit or originate profitable loans. Make no mistake about it. Community banks would not exist very long if they didn't take care of the whole community; and they do.

Since H.R. 1151 increases the competitive advantage credit unions have over banks, we feel this amendment is necessary to reduce the inequities in this area and allow our small community banks to better meet the needs of consumers.

Nine members of the Banking Committee sponsored a small bank exemption amendment to H.R. 1151 in the committee markup. The amendment resulted in a tie vote of nine to nine. The nine members of the committee that supported the amendment felt so strongly about the small bank exemption, that all nine members signed a statement of additional views to the committee report, which is unusual.

Let me say from the start, CRA is a tax on community banks, CRA raises the costs of inputs to banks by increasing their regulatory burden and compliance costs. In addition, CRA forces banks to make loans according to a federal quota, increasing the risks, and therefore the costs, of borrowing to consumers. Make no mistake about it, the Community Reinvestment Act raises the cost of borrowing through higher loan rates and punishes savers in the form of lower savings rates. Congress I believe should adopt policies that lowers the cost of borrowing, and my amendment would do that.

I would also point out that the federal government does not know the demand for loans any better than the local banker. CRA preempts the free market lending criteria of community banks and imposes the judgment of federal bureaucrats. CRA is government mandated credit allocation, the form of credit allocation that has proven disastrous most recently in east Asia. We have an opportunity to reduce the scope of government mandated credit allocation with this amendment, and I urge my colleagues to do so.

I want to revisit, and give a little history contextually.

HISTORY

When the Community Reinvestment Act was introduced in 1977, the bill's chief sponsor and chairman of the Banking Committee, William Proxmire stated:

> The authority to operate new deposit facilities is given away, free, to successful applicants even though the authority conveys a substantial economic benefit to the applicant. Those who obtain new deposit facilities receive a semi-exclusive franchise to do business in a particular geographic area. The Government limits the entry of other potential competitors into that area if such entry would unduly jeopardize existing financial institutions. The Government also restricts competition and the cost of money to the bank by limiting the rate of interest payable on savings deposits and prohibiting any interest on demand deposits.

Senator Proxmire later said:

> The regulators have thus conferred substantial economic benefits on private institutions without extracting any meaningful quid pro quo for the public.

REVIEW

The central premise on which Senator Proxmire bases his justification for ''extracting any meaningful quid pro quo'' may have existed in 1977, but absolutely does not exist today. Taken one at a time, each and every claim Senator Proxmire used to justify CRA in 1977 is no longer applicable today. Let us go through them one at a time:

Chartered institutions ''receive a semi-exclusive franchise to do business in a particular geographic area.''

Congress passed the Reigle-Neal Interstate Banking and Branching Efficiency Act of 1994, which allowed one bank to acquire another bank in any other state, thus subjecting small community banks to the competition of acquisition hungry megabanks.

Senator Proxmire also said:

''Government limits the entry of other potential competitors.''

That was in 1977.

Clearly this is not the case. The underlying bill, H.R. 1151 does not limit, but dramatically increases the entry of potential competitors.

The bill essentially says that credit unions can serve every group in a community—making them the same as community banks.

Senator Proxmire said in 1977 regarding CRA justification:

''Government also restricts competition and the cost of money to the bank by limiting the rate of interest payable on savings deposits and prohibiting any interest on demand deposits.''

This is no longer true.

The Depository Institutions Deregulation and Monetary Control Act of 1980 phased out the interest rate ceilings on savings deposits and introduced Negotiable Orders of Withdrawals (NOW Accounts) that allowed the payment of interest on demand deposits to consumers.

PROXMIRE PREMISE NO LONGER EXISTS

Twenty-one years later, the ''substantial economic benefit'' to which Senator Proxmire refers no longer exists. Since the benefit no longer exists, neither should the Government mandate of credit allocation. Congress should lift this mandate off small community banks.

REGULATORY BURDEN

According to a recent Federal Reserve study, entitled, ''The Cost of Banking Regulation: A Review of the Evidence,'' regulatory costs account for up to ''13 percent of noninterest expenses'' of banks. That is a lot of money. In addition, the study concluded that ''(A)verage compliance costs for regulations are substantially greater for banks at low levels of output''—in other words, smaller banks—''than for banks at moderate or high levels of output''—or larger banks.

This regulatory burden is borne out in the efficiency rate of banks. As you can see by the chart, small banks are less efficient than large banks.

Banks with less than $250 million in assets have an efficiency ratio of 63 percent versus that of large banks over $250 million with an efficiency ratio of 60.5 percent. These inefficiencies translate into a lower return on equity for small banks. Large banks have a return on equity of 14.4 percent versus 11.3 percent for small banks. This means the average large bank has a return on equity 27 percent greater than small banks.

EXEMPTION OF BANK ASSETS

Contrary to what opponents of the amendment would have you believe, the small bank exemption would not ''gut'' CRA.

Banks with less than $250 million in assets account for less than 12 percent of bank assets nationwide. Thus, 88 percent of bank assets are concentrated in banks with over $250 million in assets and would still be subject to CRA, assuming that the Shelby amendment is adopted.

I have a chart that will help put that into perspective for my colleagues. Although there are 8,110 small banks below $250 million in assets, those banks account for only $593 billion in combined assets. That means small banks account for 11.7 percent of bank assets nationwide.

However, one bank—BankAmerica, the new bank resulting from the merger of NationsBank and BankAmerica—possesses assets of $570 billion or 11.3 percent of total bank assets. Thus, one financial giant holds assets nearly as big as that of all 8,110 small banks across America. That begs the question, why do we have to burden 8,110 small community banks that only account for such a small portion of CRA monies? The vast majority of bank assets are concentrated in the large, billion dollar megabanks that can more easily shoulder the burden.

SMALL BANKS SERVE COMMUNITIES

Small community banks have an excellent record of serving their communities. Since over half of all banks and thrifts below $250 million have only one or two branches, they really have no other place to go but to their community to do business. Of the 8,970 small banks and thrifts, only nine—.1 percent—received a ''substantial noncompliance'' CRA rating in 1997. In addition, small banks have a better record with regard to the most common type of community-based lending—real estate lending.

Banks under $250 million had a real estate lending to assets ratio of 37 percent in 1997 versus 23.9 percent for large banks over $250 million.

FAIR LENDING LAWS

The small bank exemption from CRA is not about discrimination. The following fair lending laws will still apply, including: The Fair Housing Act of 1968 which prohibits discrimination on the basis of race, color, religion, sex, national origin, familial status

and handicap in all aspects of the housing industry; the Equal Credit Opportunity Act of 1974 which prohibits creditors from discrimination based on race, color, religion, national origin, sex, marital status, age, or receipt of public assistance; and the Home Mortgage Disclosure Act of 1975 which requires banks to keep current records of its mortgage lending activity.

Any assertion that small banks do not serve their communities rings hollow. Small banks must serve their communities if they want to survive. Any claim of discrimination also rings hollow given the fair lending laws that apply to all lenders.

CONCLUSION

In conclusion, Mr. President, the Community Reinvestment Act was introduced in 1977 by Senator Proxmire under the premise that banks receive a ''substantial economic benefit.'' That benefit does not apply today as we enter the 21st century.

The small bank exemption from CRA would go a long way in helping reduce the costs and risks of mandated credit allocation. CRA is not only a bad law for banks, but it is also a bad law for consumers. CRA forces banks to underwrite risky loans because they find that preferable to being terrorized and vandalized by so-called community groups that extort money from banks. As a result, consumers around this country are being forced to subsidize this terrorist activity in the form of higher loan rates, lower savings rates and a lower return on equity.

Mr. President, I ask my colleagues to support this very important amendment on behalf of the small community banks around America but, more importantly, every bank customer who walks in to get a loan and is forced to subsidize this government mandated credit allocation.

I yield the floor.

Ms. MOSELEY-BRAUN addressed the Chair.

The PRESIDING OFFICER. (Mr. GORTON). The Senator from Illinois.

Ms. MOSELEY-BRAUN. I thank the Chair.

Mr. SARBANES. Mr. President, will the Senator from Illinois yield me just 2 minutes without losing her right to the floor?

Ms. MOSELEY-BRAUN. Certainly.

Mr. SARBANES. Mr. President, before the Senator from Alabama leaves the floor—because this is going to turn into a very interesting debate, and I want to make clear the parameters of it, obviously—he sent out a letter quoting Senator Proxmire. I am sure he is a good former trial lawyer, and he would anticipate that we would go and read all of the Proxmire statement from which he was making selections which were reflected on the chart that he just showed us.

Now, from that Proxmire statement, the very one containing these selections which the Senator says is his rationale for supporting the Community Reinvestment Act, and from which the Senator allegedly shows that the rationale no longer applies—although I disagree with even that assertion—let me read to you. I will read the next sentence, which didn't appear on the Senator's chart, I regret to say.

Mr. SHELBY. If the Senator will yield——

Mr. SARBANES. Let me make the point, and then I would be happy to yield.

The next sentence said:

> The Government provides deposit insurance through the FDIC and the FSLIC with a financial backup from the U.S. Treasury.

''The Government provides deposit insurance through the FDIC and the FSLIC with a financial backup from the U.S. Treasury.''

That wasn't quoted as a rationale why it is reasonable to expect financial institutions to look after the needs of their community—because they are getting a very important Government support in the deposit insurance.

Now, Senator Proxmire made the statement in 1977. To prove his statement, in the 1980s, and to underscore the meaningfulness of the public benefits provided to federally insured financial institutions during the S&L crisis, the GAO report says that ''the direct and indirect cost to the United States taxpayers of resolving the savings and loan crisis, namely delivering on this insurance which is provided to them, was $132 billion—$132 billion—''and that does not include the interest expenses associated with financing the direct costs of the crisis which would drive the figure even higher.''

So, please, with all respect to the former chairman of the Senate Banking Committee, if we are going to start doing selections out of his statements, certainly we should include what I regard as the most important single rationale that he put there:

> The Government provides deposit insurance through the FDIC and the FSLIC with a financial backup from the U.S. Treasury.

Now, that comes right out of the CONGRESSIONAL RECORD of January 24, 1977, which is what the Senator said in the letter he sent to Members he was quoting from. But, unfortunately, for the purposes of clarity in debate, that provision was not cited. Of course, that is the very provision that became applicable in the 1980s when we had the S&L crisis, and we delivered to the tune of $132 billion in order to honor the deposit insurance requirements. Obviously, without the deposit insurance requirements, you wouldn't have these industries. They are absolutely dependent on them to provide a basic level of financial stability and consumer confidence.

So I appreciate the Senator yielding, but I thought it was important to get that on the RECORD at this point, although we will bring it up again in the debate later on.

The PRESIDING OFFICER. The Senator from Illinois.

Ms. MOSELEY-BRAUN. Mr. President, I thank the Senator from Maryland for shedding light on this debate, because I think it is very important that this debate be put in context and that the whole story be told. The truth is that this debate, reduced to its essentials, really does relate to a fundamental philosophical difference. Either you are for the politics of conflict and anger and ''I got mine, too bad for you,'' or you understand and appreciate the value of a politics based on cooperation, on finding common ground, and in recognizing that, as Americans, we are all in this together.

The fact of the matter is, the CRA is not extortion, as, apparently, it was called on this floor this morning. It is a perfect example of coming up with a construct that allows financial service institutions to do good while doing well. I think it is very important for the listening public to understand that this gives money away to no one. These institutions are not giving away money. They are not losing money. They get back every cent. In fact, the loss ratio, to the extent that we have studies on this, the loss ratio for banks doing business under the Community Reinvestment Act is no different. Banks have done no more poorly while under CRA. The Community Reinvestment Act simply provides access to capital for underserved communities. There are those of us who think that is a good thing for America, that that helps everybody, that everybody benefits when we do not have whole sectors of our country, rural areas, inner-city areas—when we don't have whole sectors of our country cut off from capital flows.

I was going to rise in opposition specifically to the amendment by the Senator from Alabama to this credit union bill. But, really, my remarks have to be directed, I think, at both of the pending amendments, both the amendment of the Senator from Alabama, as well as the amendment of the Senator from Texas.

Before I speak specifically on the amendment, however, I think it is important to say what a strong supporter I am of the underlying bill, H.R. 1151. I commend and congratulate the Senator from New York as well as the Senator from Maryland for their very good work in resolving the issues that are reflected by the Credit Union Membership Access Act, which was reported out of our Banking Committee by a vote of 16 to 2. The fact is this, the underlying legislation, responds to a ruling by the U.S. Supreme Court that, frankly, terrified a number of people that they would lose their ability to participate in credit unions. Certainly this legislation will put an end to those fears.

I believe credit unions play such an important role in the panoply of financial institutions in our country precisely because we have to have ways to make certain that ordinary citizens will be able to access credit and capital, will have someone they can put a face on, who is in the neighborhood,

who is part and parcel of the community. Those values, associated with financial institutions, is just as important for our country as making certain that our big banks and our big institutions can compete internationally. We have to do both. We have to have the focus and the attention paid to Main Street, to little towns and communities, to parents who want to send their kids to college, to somebody who wants to borrow for a car, somebody who wants to borrow for a house or whatever their immediate needs are. We have to have those kinds of opportunities in our system of financial institutions or financial services, as well as the big banks and the institutions capable of competing with the European and other industrialized nation's banks that can aggregate huge amounts of capital.

So I think making certain the credit unions are strong and secure and able to provide access to capital and credit for citizens is a very, very important thing, and, again, I strongly support the effort by the Senator from New York and the Senator from Maryland in hammering out the basis of H.R. 1151, and I support it.

Having said that, I want to talk specifically about the amendment of the Senator from Alabama as well as, more generally, about the conversation from the Senator from Texas. I sat here, frankly, when my blood wasn't boiling over some of the conversation—actually the Senator from Alabama has a more soothing tone so he doesn't get your blood up as much as might otherwise happen. But it occurred to me it was really important in this debate to tell the listening audience and the general public what actually is going on here, because so much information has been left out of the conversation so far.

In the first instance, it is important to understand what the Community Reinvestment Act is not. Let's start there. CRA is not ''fair lending.'' It has nothing to do with race as a specific thing. It is not that. It has to do with geographic distribution of capital, so it relates to communities more than anything else, not so much to individuals. That is important to keep in mind as we talk about CRA, because this debate will continue into next week.

The second point I think is important to make, again in terms of what CRA is not, CRA is not a giveaway. Every penny comes back—or at least as much as to any other lending institution. It is about loans. It is not a mandated interest reduction. It is not requiring financial institutions go into social work. CRA is not charity.

As the Senator from Maryland pointed out, the taxpayers put up the money, really, for deposit insurance. We also have a tax exemption with regard, at least, to the credit unions. There are bankers, frankly, who are more than a little annoyed that credit unions have almost a 30 basis point advantage because of the tax exemption that they enjoy. But the tax exemption has been there precisely because we want to make certain that individuals, people in communities, have a chance to go into their neighborhood credit union or credit union associated with their job and borrow money for college or whatever. So there is a basis point advantage that the credit unions get.

The taxpayers, all of us, all Americans who pay taxes, help make that possible. That happens any time you create a tax exemption from something that ought otherwise be taxed. If we say we are going to tax everything from here to here, from A to D, but we are going to exempt this little part C to D and say, ''Because you are doing something we like, we are not going to tax you for that,'' that tax exemption, then, has to be made up by everybody else, right? So it becomes what we sometimes call a tax expenditure. When you take something out of A to D, that little part has to be made up if you have to get to D, and that is what happens if we provide for tax exemptions generally. Everybody chips in; everybody participates.

It should be for that reason, if nothing else, that we recognize that when you talk about policy like this, it really does matter, it really does come down to recognizing we are all in this together, that we all have an investment, that we all share in these policies, and that finding the place for cooperation and common ground makes a lot more sense for our country than, again, finding the points of conflict, of anger, and of ''I got mine, too bad for you.''

Another thing CRA is not, it does not have an explicit credit allocation criteria. There are no bureaucrats. This is another one of the old saws that just get people's blood boiling, ''Oh boy, those nasty Federal bureaucrats telling us what to do.'' There are no bureaucrats telling the credit unions, the banks or anybody else, how to do their jobs. It is a results-oriented kind of legislation.

And, in fact, there are, since the 1995 amendments, simply three separate criteria: A lending test evaluates whether or not a bank has a record of meeting the credit needs of its local community. Boy, is that awful. Has the bank met the credit needs of its local community.

An investment test evaluates how well a bank satisfies the credit needs of its local neighborhoods through qualified community investments that benefit the assessment area. Another horrendous extortion we were hearing about a minute ago.

Finally, a service test that evaluates how well the needs of the community are being met by the bank's retail delivery systems.

All of these things go into defining what CRA is about. Again, it is no bureaucrat telling somebody on the front end how to do it, but it is assessing whether or not the decisions were made in the private sector in an appropriate way that would achieve results.

Another thing that CRA is not is sanctions. Again, this gets to the inflammatory language we heard on the floor about extortion and a gun to the head and all the rest of it. There are no sanctions for poor performance, no explicit sanctions.

What it does is, the regulators will take an institution's CRA ratings into account in making evaluations with regard to their attempts to expand or merge or otherwise change the way they do business. What you have here then is a modest attempt to provide the basis for community reinvestment, and even that is under attack, again, I think, by some shopworn and already, hopefully, discredited politics that I don't believe the American people care to hear anymore. It is fighting yesterday's battles all over, or, as Yogi Berra would say, ''It's deja vu all over again.''

The amendment of the Senator from Alabama seeks to exempt fully 86 percent of our Nation's banks—that is to say, those with under $250 million in assets—from the provisions of the Community Reinvestment Act. This is not the first time he has offered this amendment. In 1995, this very amendment was considered as part of a banking regulatory relief bill. At that time, the Community Reinvestment Act regulations were undergoing revision to make them less burdensome and more effective for banks and customers and consumers and communities. The amendment was unnecessary and counterproductive then. It is even more so now. In addition to failing to relate to anything having to do with the current reality, it fails to make the case that it will help effectuate the goals of the Community Reinvestment Act.

The attempt to describe the CRA as overly burdensome to banks is not true, has not been true, it is not true. Frankly, the banks themselves have stepped forward to tell us that they believe the CRA is a positive thing that allows them to do good and to do well.

Let me share for a moment some of the comments by members of the banking industry.

Alan Morris, commissioner of banks for the Commonwealth of Massachusetts, Division of Banks and Loan Agencies:

> I would like to dispel any myths which may still exist about CRA, myths which abound not only among some bankers but among many regulators and community groups. CRA makes good business sense. Of the many bank failures which occurred in Massachusetts over the last 3 years, I can assure you that not one is attributable to a bank making too many CRA loans. We tend to forget, after all, that sound loans to people in businesses in an institution's own local community is what CRA is all about. The false assumptions by some that low and moderate income persons are not deserving of or cannot use banking services is harmful to the communities, the institutions and the economy.

Again, this is something that affects us all. If we don't have capital flows going to all parts of our country, it is

kind of like not having blood circulate to your feet. You can either get the blood circulating to your feet, or you can cut it off, or you can walk around in pain and misery. We can decide we are going to look at abandoned communities with boarded-up houses, with no jobs, where people cannot access capital and credit, or we can do something to get the blood pumping into those communities. And that is what the Community Reinvestment Act does.

Another banker talking about CRA:

My message is simple: Community reinvestment in low and moderate income communities is good and profitable business.

Again, doing good and well at the same time.

Nora Brownell, senior vice president, corporate affairs, Meridian Bank Corporation:

I want to reiterate the Community Reinvestment Act offers all of us an opportunity to address major economic development and service issues in our environment today.

The question becomes, What battle are we fighting here? What is going on? Why are we fighting a battle that doesn't exist? Why are we creating an ersatz crisis, or why are we coming up with an ersatz solution in search of a problem if the bankers don't think a problem exists, if the credit unions are happy with the bill as it is?

I point out the letter from the credit union—what is the quote—they are happy with the bill ''as passed by committee.'' ''As passed by committee'' does not mean either the amendment by the Senator from Alabama or the amendment by the Senator from Texas.

If the credit unions like the bill as it is, if the bankers aren't upset with the Community Reinvestment Act, what then are we talking about and why are we talking about it? I submit to you, I say to my colleagues, that the reason we are talking about it is that some people like to energize conflict and anger as a part of their politics; that some people like to have people mad at each other, because when they get people mad at each other, then they can get their voters particularly angry and their supporters particularly annoyed, and out of that annoyance, they wind up getting political power. That is what I think all of this really comes down to.

I don't mean to be nasty, and I don't mean to be discourteous to any of my colleagues, but it is just stunning to me that we continue to have a debate about the burdensome nature of the Community Reinvestment Act when the banks themselves aren't complaining about it.

To say they are not complaining about it because they are scared, because there is a gun at their head, really—that then suggests they are not only not being burdened but they are too cowardly to talk about it. I don't think any of the people who run these institutions are afraid to speak up for their own interests, particularly bankers. This institution has never been known not to listen to bankers. If bankers wanted to complain about something, they could have brought it to the attention of this committee and this institution. They certainly have the power and clout and have never been too shy in other regards when they needed something—when they needed bailing out, when they needed support. This institution has been very responsive to bankers, and I suggest they have not been afraid to show their faces and complain about the Community Reinvestment Act.

Let's talk a little bit about the history of the CRA. The CRA was passed in 1977 to combat what was called the ''redlining'' of certain neighborhoods. Redlining refers to the practice of—in some instances, people actually found evidence where red lines were drawn on maps to indicate areas that were off limits for lending.

The goal of the CRA is to encourage banks to meet the credit needs of their entire communities, including low- and moderate-income areas—nothing more, nothing less. This obligation had its roots, frankly, in the Banking Act of 1935 which required banks to meet the convenience and needs of their communities, and that, of course, was reiterated in the Bank Holding Company Act of 1956 and, of course, the bank charters themselves.

CRA is not new, really, in that regard. There is precedence in other existing laws with regard to the intent of making certain that banking and that the access to capital and credit are evenly and equitably distributed throughout all communities.

The CRA does not require any banks to make bad loans. It only asks them to explore good loan possibilities in their entire market area. CRA opens new markets and allows banks, again, to do good while doing well.

Now, it is critical, again, to keep in mind what it is and what it is not. It is not an effort to treat banks as if they were arms of the Government. It does not set up banks and financial institutions as social service agencies. It is not about treating them as an equivalent of a Government grant. This is not giving money away to anybody. It is not a credit allocation. It is not forcing somebody to give credit to a particular group or particular community in a particular way. And it certainly is not about minorities.

I certainly hope that nobody gets away with demonizing the Community Reinvestment Act on the basis of race, or demonize it, frankly, on the basis that it is for inner-city communities because it is not. It is about communities all over the country, and particularly in rural communities. Actually, rural communities in some instances are more challenged than our inner-city and urban areas in terms of getting access to capital and credit.

It is especially important to preserve the CRA obligations for rural banks when often they are the only game in town for credit purposes. Several years ago, our Banking Committee held some CRA oversight hearings and we discovered cases of small banks in which the service area consisted of two towns, each with a population of about 10,000. The bank in that case was found to be in substantial noncompliance with CRA because its loan portfolio consisted of only 5 percent of the total assets of the bank.

Now, again, 5 percent—you say, how could that happen? You have a bank in a little town. Why would it give only 5 percent of its loans in the town? Well, in some instances the investments are in Treasuries and other things like that which wind up being more profitable for the bottom line, but it certainly does not serve the interests of the community. And that is not where banking laws—again, going back to 1935—that is not where the banking laws want to take us. Frankly, that does not in any way reflect or relate to or in any way show support back for the kind of support that taxpayers and citizens overall give to these financial institutions.

The last time the efforts were made to exempt small banks from the CRA—I am speaking specifically to the amendment by the Senator from Alabama—there was an article that appeared in the Madison Capital Times in Wisconsin. It is ''Bank measure bad for farms.'' Referring to that amendment, the very same amendment, this article, ''Bank measure bad for farms'' presents the view of a concerned rural resident who was concerned about the unpainted barns and boarded-up rural businesses that she saw in her community.

I ask unanimous consent to have this article printed in the RECORD.

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

[From the Madison Capital Times, July 20, 1995]

BANK MEASURE BAD FOR FARMS

(By Margaret Krome)

Earlier this week I drove past unpainted barns and boarded up rural businesses on my way to a meeting. Like many city dwellers, I fretted about the health of farms I passed and small towns I drove through, but felt powerless to help.

However, we urbanites can protest policies that actively harm rural communities. One such proposal is before Congress right now. It would gut a major safeguard for money borrowers, the Community Reinvestment Act.

As in all communities, rural citizens need credit. When farmers, other small businesses, and rural citizens deposit their money in their local bank, they do so both to protect their funds and with the hope that when they want to start a new business or bring a new family member into their farm operation, the local bank will, in turn, lend them money.

But sometimes banks, and especially many rural banks, establish a very different pattern, where local lending takes a lower priority than making more assured investments, like federal government securities. Thus, such banks drain local resources outside of the very localities that support them, making it that much harder for local citizens to get credit.

The Community Reinvestment Act was passed in 1977 to make banks more responsive to the credit needs of the community they serve. The measure provides that before a bank can expand, be bought, merge with another, or make other changes in business structure, its record of community reinvestment is reviewed.

If community members voice dissatisfaction with how the bank has met local needs, or if the bank's local lending rate is consistently low, it triggers a regulatory yellow light. Before the bank's plans can proceed, it must respond to citizen concerns.

When M&I Bank proposed to buy out Valley Bank holdings in 1993, for example, citizens in southwestern Wisconsin held meetings to raise concerns about lending practices in that 10-county region. Without ever becoming a formal challenge, the process resulted in M&I's working with the community to increase agricultural and small businesses.

Despite such successes, now comes H.R. 1858, the ''Financial Institution Regulatory Relief Act of 1995,'' to the rescue of oppressed bankers everywhere. In three simple swipes, it effectively eviscerates the CRA.

First, it removes a citizen's or community group's ability to challenge a bank's application for expansion based on its prior CRA performance.

Second, it outright exempts banks with less than $100 million in assets from CRA regulations, which especially hurts rural areas, where such banks are located. In fact, under H.R. 1858, CRA provisions would not apply in 34 of the state's 72 mostly rural counties.

Finally, and incredibly, it allows banks between $100 and $250 million in assets to ''self-certify'' their CRA compliance . . . as if any bank would ever be motivated to do otherwise.

The banking community's complaint that meeting CRA regulations is too costly is unconvincing, given record profits that Wisconsin banks have registered in recent years. Granted, CRA-related paperwork for some banks has been considerable at times, but after a 2-year regulatory reform process, even those problems were addressed in April with greatly lessened reporting requirements and a streamlined examination process for small banks.

The ''reforms'' in H.R. 1858 are not designed to relieve banks of onerous reporting requirements. They appear to be poorly disguised efforts to grant banks a carte blanche to invest local monies in whatever ways best suit their private profit-making interests.

There's nothing wrong with making a profit, but in rural areas, where often there's little competition among banks, it's wrong to revoke one of the few accountability measures citizens have.

Historically, banking officials hold all the cards during any local lending negotiation. The CRA shifts that power balance by giving citizens a forum to air concerns about a bank's pattern of lending.

If rural communities are to regain the vitality their citizens deserve, they need true help an meaningful solutions. Permitting banks free rein in the name of regulatory relief is not one of them.

Ms. MOSELEY-BRAUN. The author stated in the article:

As in all communities, rural citizens need credit. When farmers, other small businesses, and rural citizens deposit their money in their local bank, they do so both to protect their funds and with the hope that when they want to start a new business or bring a new family member into their farm operation, the local bank will, in turn, lend them money.

But sometimes banks, and especially many rural banks, establish a very different pattern, where local lending takes a lower priority than making more assured investments, like Federal Government securities. Thus, such banks drain local resources outside of the very localities that support them, making it that much harder for local citizens to get credit.

She goes on—by the way, I do not know how many people who are listening to me now got a chance to hear the earlier comments about the nasty Federal Government, but, again, here this lady is saying they are taking money out of home localities in rural communities and investing them in Federal Government securities.

She goes on to describe how the Community Reinvestment Act spurred one bank in particular to increase its commitment to agricultural and small businesses. And I quote. She says:

. . . in rural areas, where often there is little competition among banks, it's wrong to revoke one of the few accountability measures citizens have.

Mr. President, I believe that she is exactly right. Even if banks under $250 million represent a small percentage of total banking assets, they still represent 100 percent of options for many small town residents.

To go back to the article, the author also writes:

If rural communities are to regain the vitality their citizens deserve, they need true help and meaningful solutions. Permitting banks free rein in the name of regulatory relief is not one of them.

In addition to the article that I just mentioned, I would like, Mr. President, to have printed in the RECORD a letter. This letter, which I received yesterday, expresses strong opposition to the amendment by the Senator from Alabama.

It asserts that:

Rural Americans need the tools of the Community Reinvestment Act to ensure accountability of their local lending institutions. It is needed to prevent rural banks from abandoning their commitment to serve millions of Americans living in smaller low- and moderate-income communities.

This letter, by the way, is signed by 11 groups: The Center for Community Change, the Center for Rural Affairs, the Federation of Southern Cooperatives, the Housing Assistance Council, the Intertribal Agriculture Council, Iowa Citizens for Community Improvement, National Catholic Rural Life Conference, National Family Farm Coalition, National Farmers Union, National Rural Housing Coalition, and the Rural Coalition.

I ask unanimous consent that letter be printed in the RECORD.

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

JULY 23, 1998.

DEAR SENATOR: On behalf of the undersigned organizations representing rural Americans, we are writing to express our strong opposition to legislative efforts to weaken the coverage of the Community Reinvestment Act (CRA). Our understanding is that Senator Shelby plans to offer an amendment to H.R. 1151, the credit union legislation, that is scheduled for floor action. In addition, Senator Gramm plans to offer an amendment that strikes provisions, in H.R. 1151 that would ensure that credit unions provide services to all individuals of modest means within their field of membership.

The Shelby amendment would exempt banks under $250 million in assets from CRA coverage. This affects over 85% of banks nationally. For citizens in Iowa, Kansas, Minnesota, Montana, Nebraska, and Oklahoma, 95% of the banks would be exempt.

Rural Americans need the tools of the Community Reinvestment Act to ensure accountability of their local lending institutions. It is needed to prevent rural banks from abandoning their commitment to serve the millions of Americans living in smaller low and moderate-income communities. Unfortunately, small commercial banks do not automatically reinvest in their local communities. This is documented by national data on reinvestment trends and loan to asset ratios for banks across the country. 50% of small banks have a loan-to-deposit ratio below 70%, with 25% of these having levels less than 58%. The data for 1997 reveals that banks under $100 million in assets received 82% of the substantial non-compliance ratings.

We strongly urge you to oppose these amendments to H.R. 1151. The Shelby amendment ignores the important regulatory changes since 1995 that have significantly reduced the paperwork and reporting issues for small banks. The Gramm amendment will strike an important provision from the bill that for the first time would require credit unions to meet the financial services needs of their entire field of membership.

A vote against these amendments will help meet the credit demand of millions of family farmers, rural residents, and local businesses. Thank you for considering our concerns.

Sincerely,

Center for Community Change; Center for Rural Affairs; Federation of Southern Cooperatives; Housing Assistance Council; Intertribal Agriculture Council; Iowa Citizens for Community Improvement; National Catholic Rural Life Conference; National Family Farm Coalition; National Farmers Union; National Rural Housing Coalition; Rural Coalition.

Ms. MOSELEY-BRAUN. In addition, I have received many letters from community groups and other concerned citizens who oppose this amendment.

I must point out that, again, in 1995, when this amendment was proposed before, letters were sent in opposition by the Save CRA Coalition and others. Unlike many of the special interest groups around here in Washington, frankly, that group's name lets you know exactly what it stands for. The Save CRA Coalition was established to defeat the amendment of the Senator from Alabama when it was previously offered.

The letter they sent, opposing the weakening of the CRA, was signed by 2,181 State and local government organizations, for-profit businesses, community groups, unions, farm groups and faith-based organizations from every State in the country, the District of Columbia, Puerto Rico, and the Virgin Islands, by the way, including a number of organizations from Alabama and Texas.

Now, I am going to ask that the letter be printed in the RECORD also. I am not intending to filibuster, and I know that some of my colleagues are here on the floor wanting to speak, but there is a long, long list of organizations which are very, very recognizable that I hope my colleagues have a chance to take a look at to see the breadth and the level of opposition to the amendment by the Senator from Alabama and the opposition to weakening the CRA.

I hope that also every Member of the Senate will have occasion to at least review the names of the organizations in their own State with regard to opposition to this amendment. My own State, what, it is three pages—Illinois has page 9, page 10, and on to page 11. They are just names in a single space of organizations in opposition to that amendment. And I am sure if I were to take Missouri or Delaware or any of the other States, they would be an equally long list. I hope my colleagues will familiarize themselves—or New York—will familiarize themselves with the names of the organizations that, again, are against weakening the Community Reinvestment Act.

However, I ask unanimous consent that the letter itself be printed in the RECORD, but not the names of the organizations who signed the letter because that would take up too much space in the RECORD.

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

SAVE THE CRA COALITION,
Washington, DC, September 7, 1995.

Hon. ALPHONSE D'AMATO,
U.S. Senate, Washington, DC.

DEAR SENATOR D'AMATO: The following state and local governments organizations, for-profit businesses, community groups, unions, farms groups, and faith-based organizations oppose legislative changes in S. 650 and H.R. 1858 that weaken the Community Reinvestment Act (CRA). CRA ensures that creditworthy borrowers have access to the American system of commerical credit. It has given banks an incentive to discover profitable lending and investment opportunities in rural, suburban and urban communities. Congress does not need to revise this effective law.

Preservation of CRA is vital to the work of community developers and small business nationwide, CRA has been the catalyst for important local alliances among financial institutions, local businesses, nonprofits, and state and local governments. It has led to hundreds of thousands of modest-income families becoming first-time home owners, generated new capital for small businesses and small and mid-size family farms, and made financing available for local economic development projects. Additionally, CRA has spurred the creation of innovative mechanisms for providing credit such as revolving loan funds and consortia.

We recognize the value of making CRA a more performance-based system rather than a process of documentation, however federal regulators have addressed this issue. On April 19, 1995, the four bank regulatory agencies issued final rules making CRA compliance more effective. The process of revising these regulations covered two years of intense deliberation; public hearings involving hundreds of bankers, community groups and local officials; and nearly 14,000 written comments from banks and other organizations nationwide. We strongly believe that the regulations agreed to by the nation's financial regulators effectively address whatever weaknesses banks have complained about in CRA's administration and thereby bolster its successes.

Proposed ''regulatory relief'' legislation (S. 650 and H.R. 1858) would stifle local community efforts by exempting an overwhelming majority of banks and allowing the rest to abandon their commitments to millions of Americans in low- and moderate-income communities. In addition to provisions that explicitly modify the Community Reinvestment Act, other provisions in this legislation deter community reinvestment efforts by abolishing constructive channels for community input in decisions regarding bank mergers and other corporate expansions, and eliminating critical data collection requirements that enable objective assessments of bank performance.

Since its enactment in 1977, CRA has attracted more than $60 billion worth of investments in low- and moderate-income communities around the country, and stimulated local economies. Every dollar spent in community-based development circulates through the economy an estimated five times through vendors, suppliers, subcontractors and related workers.

In light of the success of the CRA, we urge you to strike provisions within S. 650 and H.R. 1858 that weaken the CRA and to oppose any efforts to cripple this critical law.

Sincerely,

2,181 Organizations.

Ms. MOSELEY-BRAUN. One of the reasons that CRA has such broad support is very simple. It does not force banks to make bad loans. It encourages them to examine unexplored markets in their service area, and it, again, allows a financial institution to do good while doing well simultaneously. They make money on these loans.

My favorite CRA story is about one banker who said that he hated the CRA, but he did not think it was burdensome. What he hated was the fact that other banks did it, too. Other banks were complying with CRA. He had discovered years ago—it was kind of a market rating situation—he discovered years ago that there were many cash-poor but credit-worthy customs out there. And he had previously been the only one issuing loans in certain low- and moderate-income areas in low- and moderate-income neighborhoods.

So now with CRA in place, he was forced to compete where he had once enjoyed a monopoly. And so he was annoyed, if you will, that his monopoly over the areas that had not had access to capital and credit, except via him—that that monopoly was now opened up because other institutions were beginning to engage in those communities, because and by virtue of the Community Reinvestment Act.

Again, he had learned a lesson that many bankers are now learning. Because of CRA, community reinvestment is the best way to do good while doing well simultaneously. And CRA is profitable for banks. In a survey conducted by the Federal Reserve Bank of Kansas, 98 percent of banks found that their CRA activities were profitable.

Many others agree with the Kansas City study. Most major banks, including NationsBank and Bank of America, have reiterated their commitment to the CRA. As I recall, when we last had a hearing in the Banking Committee, some bankers testified in favor of keeping CRA intact. In fact, I was delighted at a hearing we had of the Banking Committee. Secretary Rubin had previously come out in support of the CRA, but I actually put the question to Chairman Greenspan, who is acknowledged as the guru of financial everything, I guess, and Chairman Greenspan reiterated or spoke to his support of the CRA, which I was absolutely delighted about.

I will give an earlier statement of Chairman Greenspan:

When conducted properly by banks which are knowledgeable about their local markets, CRA can be a safe, sound, and profitable business. CRA has prepared financial institutions to discover new markets that may have been underserved before.

I see a number of my colleagues standing and looking at me. I think this means I am talking too long. I don't mean to filibuster this issue. I just want to say I believe I have spoken to the issue. There are facts and figures I would like to share with my colleagues, but I know we will have another opportunity to do that because we will have this issue come up again on Monday.

Suffice it to say that expanding the Community Reinvestment Act to the credit unions, which apparently the Senator from Texas doesn't like very much, is not something which has the credit unions themselves riled up. They like the bill we passed out of committee. They don't want to have that amendment. They want to see us go forward with H.R. 1151.

With regard to the CRA-gutting attempt, taking out 85 percent of CRA activity that the Senator from Alabama would suggest, I submit that also is an amendment that the credit unions don't want to see on this bill because it is too important to them.

With regard to just an overall appeal to my colleagues, let me suggest that to find a solution like these two are suggesting in search of a problem does not do justice to the level of the cooperation that we have seen in this Congress, and particularly with this Banking Committee, that CRA gives us an opportunity to find common ground, to work together, and to work together for the good of our entire country. The alternative is an appeal to conflict and anger which I think is beneath the Senate. I hope my colleagues will join me in opposing both of these amendments.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. D'AMATO. Mr. President, I propound a unanimous consent request: That the pending Gramm amendment be temporarily set aside; I further ask that at 4:30 p.m. on Monday, July 27, the Senate resume consideration of the

Gramm amendment, with 1 hour for debate equally divided prior to a motion to table; I further ask that the tabling vote occur at 5:30 p.m, with no second-degree amendments in order to the amendment prior to the vote.

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

Mr. D'AMATO. I believe my colleague from Connecticut has a brief statement. I believe he has asked our other colleagues that he be recognized.

Mr. DODD. Let me thank my colleagues who are here, and I will keep these remarks brief. I thank my colleagues from Colorado, North Carolina, and Missouri.

Briefly, Mr. President, let me, first of all, extend my compliments to the distinguished chairman of the Banking Committee and the ranking member, Senator D'AMATO and Senator SARBANES, for their excellent leadership in bringing this bill on credit unions to the floor. This is a very, very important piece of legislation. I think most of my colleagues who have followed this debate hoped we wouldn't have had to come to the floor with a credit union bill. But as a result of Supreme Court decisions, we have been forced to act, and to act expeditiously in this Congress. In fact, as a result of a letter drafted by the chairman, several others, and myself, we have asked the court not to initiate their decision so that there would be time for us legislatively to respond to the Supreme Court decision.

This is not just any other bill we are bringing up that may or may not have some importance on the Legislative Calendar. It is critical that before this Congress adjourn this piece of legislation be considered and adopted and signed into law if we are going to provide the kind of relief that must be sought as a result of the AT&T credit union decision.

Again, my compliments to the leadership of Senator DOMENICI, Senator SARBANES, and other members of the Banking Committee, who voted 16–2, I think was the vote, that brought this bill to the floor of the U.S. Senate.

It is critically important. Why is it important? It is important because if we are going to see members of credit unions forced to leave their credit unions as a result of the AT&T credit union decision, the resulting loss of those members could cause a credit union to become insolvent. That is the problem here, and that in itself would create a drain on the taxpayer-backed deposit insurance fund.

So, it is very, very important we not allow those credit unions to run the risk of losing its membership as a result of that decision or our inability to act and then causing these credit unions to fail around the America. None of that will happen, obviously, if we move to adopt the legislation.

I point out that in the House, the other body, they adopted the legislation, I think, something like 411–8. It was overwhelmingly adopted. I am confident that will be the case here, as well. We will get a good, strong vote provided we don't get sidetracked on some side issues. Whether they have merit or not, there will certainly be other vehicles in the minds of some people, but the idea we would allow it to be attached to this, running the risk—you run the risk of having this credit union legislation collapse. If that does happen, then the resulting consequences of that collapse will have to be borne by those who try to take advantage of this vehicle to add extraneous matters. That is very, very clear to credit union members all across the country.

This is an opportunity for us to act on this bill. I have strong views about the amendment of our colleague from Alabama on CRA. I am opposed to what he wants to do. I know there are Members who strongly agree with what he wants to do. But also I will tell you that if you allow that provision to be added to this bill, you are going to cause this bill to fall. If that is the case, then the resulting consequences, I think, are terribly predictable.

I am not going to necessarily, today, engage in the debate on the Shelby amendment on the CRA, Community Reinvestment Act, except to say that I know in my State of Connecticut for the literally thousands of members of credit unions, the millions in the State of New York and California and elsewhere all across this country who are watching this debate, knowing if this bill falls because of a desire of some to come up with an amendment here that has some appeal, I think the transparency of the efforts will be quite obvious that, in fact, it is really not the issue of CRA.

There are those who, frankly, want to kill this bill, who don't like the credit union bill but don't really want to take it on directly and so will offer an extraneous amendment, hopefully, that might just narrowly get adopted, the bill collapses, and you have been able to sort of smuggle the destruction of this important piece of legislation through. It is extremely important that we deal with this bill in as clean a fashion as possible, no matter how appealing some of these amendments may be. So that is important.

The second question obviously we want to still address is whether or not we want the maximum possible number of Americans to have the choice of joining a credit union. I think people ought to be free to make that choice of joining a credit union. The overwhelming majority of credit unions provide affordable financial services to working families all across this country.

Let me draw one theme that has been raised during consideration of the bill—that is whether credit unions have lost their mission of serving middle-income Americans and families of modest means, which was written into the original act. The question surfaced because of a campaign of misinformation, in my view, prompted by some industries that compete with credit unions. During the Banking Committee hearing of these issues, back in March, one banking industry representative stated that ''credit union membership had become so compromised that membership was being offered to members of wealthy country clubs.'' I am not making up this example. This one actually happened.

Needless to say, those who support credit unions were very upset about that allegation because it would run contrary to the thrust of what credit unions are supposed to do. We examined that allegation and it is was true, in fact, that there were wealthy country club memberships.

What they fail to tell you is that the people being solicited to join the credit union were the cooks, janitors, groundskeepers, and others. They weren't members of the country club, they worked at the country club. Yet, if you listened to the allegation, you assumed it was people who paid significant fees to join the club, rather than employees. That is the sort of misinformation that is going on to try to destroy this bill and this important credit union organization across the country.

The average credit union is still very small in size. It is limited by the number of people they serve. In my State of Connecticut—an affluent State, a strong middle class State—the average size of a credit union as an institution is $16 million in assets. In fact, if you take all the assets of all of my credit unions in Connecticut and total them up, they don't equal the assets of one of my 10 largest banks in the State of Connecticut. I know that is not true in every State, but in Connecticut, which is a fairly affluent State and has an aggressive, strong credit union organization, total assets of all of my credit union members don't equal the size of any one of the 10 largest banks.

In fact, assets of all the 11,392 federally insured credit unions was $327 billion, or less than the size of Chase Manhattan Bank or Citibank. The asset size of the 11,452 federally insured banks is $5.2 trillion, compared to $327 billion for all the credit unions. So the notion that somehow this is some great threat to commercial banking in this country, I think, is unwarranted, it is not credible at all. Small banks and thrifts are threatened in many ways in this country, but I suggest that they are much more threatened by aggressive banking giants like NationsBank than by any credit union. The loss of banking services in many communities that I visited has much more to do with aggressive takeovers and consolidations practiced by large national financial institutions or large regional institutions than it does competition from credit unions. That is the least of these smaller banks' and community banks' threats.

The facts show that while credit unions have experienced modest growth since the implementation of

the multiple common bond, that growth is dwarfed by the growth in the banking industry.

Ultimately, the complaints of the bank and thrift industry boil down not so much to a loss of market share but to the fact that credit unions offer customers a pretty good deal. They offer customers higher interest rates on savings and checking, as well as lower interest rates on credit cards and certain kinds of loans; credit unions don't charge their customers a fee for every conceivable type of transaction. We have reached a point in the banking industry where seeking out a new fee income has replaced seeking out new loan business as the way to make profits.

Not only are banks generating $3 billion a year in ATM fees—a subject matter that the chairman of the committee cares deeply about—$3 billion a year in ATM fees in excess of their costs, but some banks even started charging customers for using a deposit slip at branches, or for having the temerity to actually call a live person—if you can ever find one—on the phone during normal business hours.

While the banks claim that credit unions offer a better deal because they don't pay taxes, that is also a fiction. Credit unions have no access to capital markets to raise funds; they keep the capital needed to stay in business only through retained earnings. That is vastly different from what the banks do. Moreover, the banks also don't acknowledge the many tax advantages they enjoy, such as being able to write off billions in taxes every year for loan losses that never occur, or for receiving a tax credit for any minimal premium they must pay toward maintaining taxpayer-guaranteed deposit insurance.

Credit unions are nonprofit organizations that put their earnings into both creating capital and keeping costs down for their customers, the actions that were precisely envisioned by Congress in establishing the Federal credit unions of 1934.

So, Mr. President, I think there is an important role that our credit unions play. There is good, healthy competition out there. Let me end where I began. That is, I urge my colleagues—those of you who truly care about allowing the Supreme Court decision to be dealt with legislatively—there is only one window where we are going to get a chance to do this. Even if you find yourself attracted to a standing-alone provision on the CRA issue—which I don't, but some do—even if you are slightly attracted to that amendment, by supporting that amendment you will bring down this bill, and then people are going to understand what happened here.

So I certainly endorse and support the comments of our colleague from Illinois, Senator CAROL MOSELEY-BRAUN, who speaks eloquently on the issue of the Community Reinvestment Act—the strength of it, how well it has worked, and how well it is working in reaching sectors of our society that have been too often in years past denied access to financial services in our country. I think it would be a mistake to jeopardize this credit union bill, which has come out of our committee with such a strong vote and such a strong vote in the other body.

I think on Monday we can certainly do a great deal to relieve the anxiety and fears of literally millions of people across the country who utilize credit unions for their financial security and their futures. They are going to be terribly disappointed in this body if we get involved in extraneous matters and bring this bill down. So over the weekend, I urge that members of credit unions across the country certainly let their Members of Congress know how important this bill is to them and how important it would be to keep off amendments that could destroy our ability to pass this legislation.

I thank my colleagues for their graciousness. I compliment the chairman and Senator SARBANES for their fine work on this bill.

Mr. FAIRCLOTH addressed the Chair.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. FAIRCLOTH. Mr. President, I rise in support of H.R. 1151. Credit unions have played an important role in our financial system. They have given a helping hand and a hand-up to millions of Americans whom it otherwise would not have been available to. Nearly 70 million Americans are members of credit unions. I consider myself a strong supporter of credit unions. We have over 195 in my State, including the second largest in the Nation. Over 2 million people in North Carolina are members of credit unions. I do not believe that we should limit their access to credit, and it is the principal reason I support the credit unions in this bill. We have to protect and preserve credit unions for the future.

Mr. President, this bill is not without controversy. This bill started out as a court case in my home State. The case went to the Supreme Court that began in North Carolina and was decided against the credit unions.

Now, there has been a lot of heated conversation about this legislation. Some of what has been said is correct, but a large part of it has been incorrect.

Very simply, this is what it would do. This legislation would allow multiple groups, each with their own common bond, to be part of one credit union. The Federal Credit Union Act of 1934 was unclear on this point. But beginning in 1982, the National Credit Union Administration has allowed groups to be part of a credit union. The real question is whether Congress will support the policy that has, in effect, been the law since then, since the 1980s. I have to conclude that the Congress will, but they are only going to do it with some limitations.

Essentially, this is why we have to change the law.

And let me say, the changing marketplace has changed the banking world too. Glass-Steagall—the bank law that separates banks and securities firms has almost no meaning in today's society. In fact, it is little adhered to.

Mr. President, the workplace has changed dramatically since 1934. The era of working for one company, with one occupation, with one skill—for all of one's life is gone. Technology and global markets have forever changed our way of life.

These changes mean that a one group credit union will have difficulty surviving in today's day and age.

Banks used to not have banks outside their own States, and primarily within their own community. Banks used to be able to sell insurance in only towns of 5,000 people. Now they are limited to the United States.

We need to update our bank laws as well—and I hope and anticipate that we can do that.

And I have not stood in the way of the bank regulators that have had to update our laws through executive action, rather than the Congress acting.

And I think the same view is reasonable with respect to credit unions.

But—as I said—there should be some limitations—and there are limitations in this bill.

Credit unions do not pay taxes. I am adamantly opposed to taxing credit unions.

The answer to this problem is not to impose taxes on credit unions. The answer is to reduce taxes for small banks. That is why Senator ALLARD and I introduced legislation yesterday to make tax law changes to help community banks.

We need to reduce regulation for small banks—that is why I will vote for Senator SHELBY's amendment to remove CRA for community banks.

We do not need to punish credit unions to help small banks—I think we should simply help small banks.

Let me also say this.

We have done a number of things to change and reform the credit union industry.

This bill is not without tough provisions for the credit union industry and some of them are pretty tough provisions.

We have limited commercial loans to be made by credit unions to 12 percent of their assets. Before now, there was no limit. And there was only a study in the House bill.

We have required the NCUA to charter separate credit unions where possible.

We have limited the use of geographic charter credit unions to a ''defined'' community—so that there cannot be abuses in the chartering of geographic credit unions.

Finally, we have imposed prompt corrective action on credit unions—and we have essentially established minimum net worth requirements for credit unions.

So there are many reforms to the industry that have not been discussed by the opponents of this bill.

Mr. President, let me just say again—this is an important bill to keep credit unions going into the future and into the 21st century.

If we don't pass this bill—it is uncertain if people can continue to join credit unions. And there is the possibility that persons could lose their right to be a member of a credit union. The district court has not yet decided how this case will be implemented.

It is simply wrong to suggest that if we don't pass this, that given benign neglect, it will probably go away. It will not. We have to pass this bill so that current members are assured of keeping their status.

Mr. President, I thank you and urge pass passage of the bill. But let me comment also on the two pending amendments.

First, I support Senator GRAMM's amendment.

It makes absolutely no sense to put CRA on credit unions. Credit unions are member organizations to begin with. The very nature of credit unions is to lend to their members. To put CRA on it is redundant, and ridiculous.

The provisions in the H.R. 1151 is redundant, as I said, and is, frankly, absurd. Anybody that has looked at it knows it.

I strongly support Senator GRAMM's amendment. We do not need CRA for credit unions. We need to reduce the burden for small banks. Every bank that I have talked to has a problem with the CRA. It is too subjective. There are too few definitive standards. Small banks spend an inordinate amount of their time and money complying with Federal law when their lending is almost totally local.

I support Senator SHELBY's amendment because CRA makes no sense for small banks. Small banks can't survive, if they don't lend in their community. That is what CRA says they need to do. But for a small bank, where else does it lend if it is not in its community?

That was the purpose of the CRA to begin with. It simply is not today viable. To take deposits and lend in a small community is what community banks do.

The Senator's amendment exempts 8,000 banks. But they account for only 11 percent of the assets of the industry. In fact, these 8,000-plus banks have roughly the same amount of assets as one of our North Carolina banks. It is not an unreasonable amendment. Small banks are shrinking, they are disappearing, and the more burden we put on them the less there will be.

Just as I don't think credit unions threaten big banks, I don't think exempting small banks from CRA is a threat to the CRA.

The SHELBY amendment only exempts 11.7 percent of the assets of the banks of this country.

As I said, we have one bank in North Carolina with roughly the same amount of assets.

Mr. President, I thank you. I yield the floor.

Mr. ALLARD addressed the Chair.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. ALLARD. Mr. President, I rise in support of H.R. 1151.

First, I want to begin by thanking Chairman D'AMATO for skillfully steering the Credit Union Membership Act through the Senate Banking Committee and onto the Senate floor.

It has been a pleasure to work with both him and his staff on this Senate Banking Committee. That also is speaking in behalf of my staff also. We have been very appreciative of their work in helping us with our issues and what you are doing for credit unions.

I am pleased to support this credit union bill in the Banking Committee, and I am pleased to continue to support it now.

I have always been a supporter of the credit union movement. The main reason I have been supportive is because I felt that any competition among financial institutions is vitally important. And, obviously, the credit unions provide the customer another choice out there; another way of meeting his banking and financial needs.

During my years in the Colorado State Senate I worked closely with the Colorado Credit Union League and the numerous credit unions and members that we have in Colorado.

I have been pleased to continue my work with the Colorado Credit Unions as a member of the Senate Banking Committee.

Mr. President, there are 185 credit unions in Colorado. There are 1,321,000 credit union members in Colorado.

And the credit unions hold nearly $7 billion in assets in Colorado.

Credit Unions play a vital role in our communities. They provide an opportunity for groups of people to join together and pool their assets.

Credit Unions are run by their members. Those members make loans and help each other to get ahead and build a prosperous life for their families and for their communities.

Let me turn to several provisions in the Credit Unions bill.

I am particularly supportive of the new capital requirements and the ''prompt corrective action'' requirements that we put in the bill during our deliberations in the Senate Banking Committee. That is because I feel so strongly that we need to work to make sure that our financial institutions remain safe and sound.

I have always felt that we were particularly blessed to be serving in the Senate particularly during a time when our economy is doing very well.

As much as I would like to hope that our economy continues to prosper, history has shown us that periodically there are fluctuations in our economy; there are good times and there are bad times. If we do not make good decisions today to assure safety and soundness, it is going to create problems in the future. So that is why I have been so pleased with the safety and soundness provisions that we have added to H.R. 1151. These provisions are vital to protect credit union members. We want the credit union members' movement to remain strong and well capitalized.

Let me turn to the issue of taxation. From the beginning of this debate, I have opposed the taxation of credit unions. They are collective organizations. They are not-for-profit businesses. They pool their assets. Their gains go back to the members as assets. They also go back to their members as interest, and that interest is taxable to the credit union members. As I said earlier, credit unions exist to help their members, and consequently I do not believe that credit unions should be taxed. I have been concerned with the tax and regulatory burden that remains on small financial institutions, whether they are banks or credit unions. Consequently, I will support elimination of the Community Reinvestment Act. I support lifting the CRA burden on small financial institutions, and I support reducing the tax burden on small banks.

I raised this issue during the Banking Committee's hearing last month on the proposed financial modernization legislation. We need to do something to make certain that our small community banks can remain viable. We do not want those banks to drown in the burden of regulation and taxation.

At the time of the hearing I had brought up a question about subchapter S corporations and independent banks, and, graciously, the chairman says, ''You know, I think maybe you are on to something. We ought to continue to pursue that.'' Consequently, because of the strong support from the chairman in trying to give tax relief to small banks, I put together some legislation. This has all resulted because a small, independent banker from my State of Colorado decided to share with me some ideas he had about S corporations and how we could help small banks through the Tax Code.

So the chairman was very receptive to those concerns. He said, ''Well, let's work on it.'' We worked on it. We have introduced some legislation that will be helpful to small bankers in Colorado and throughout the country.

It has become very clear that small banks do want something done with their subchapter S corporations. The subchapter S provisions of the Internal Revenue Code reflect the desire of Congress to eliminate the double tax burden on small business corporations.

Subchapter S has been liberalized a number of times, and most recently in 1996. Yesterday, I introduced legislation that will expand and improve subchapter S of the Internal Revenue Code, and this is S. 2346. I am joined in this effort by Senators D'AMATO, FAIRCLOTH, HAGEL, ENZI, BENNETT, MACK, SHELBY, and GRAMS. This legislation contains several provisions that will make the subchapter S election more widely available to small businesses in

all sectors. It also contains several provisions of particular benefit to community banks that may be contemplating a conversion to the subchapter S.

Financial institutions were first made eligible for the subchapter S election in 1996. This legislation builds on and clarifies the subchapter S provisions applicable to financial institutions.

As Congress considers credit union legislation and financial modernization legislation, it is important that we explore ways in which we can ensure that the tax and regulatory burden on our community banks remains reasonable. This S corporation legislation is reflective of that desire, and we will now begin working with the Senate Finance Committee to see if we can get this legislation in a bill this year.

Section 403 of this credit union bill will require the Secretary of the Treasury to submit a study to Congress within 1 year that will make legislative recommendations on how Congress can reduce and simplify the tax burden on small banks. I hope the Treasury Department will be endorsing this S corporation legislation.

It seems to me that it is one of the better ways to reduce the tax burden on small banks. In the last several months, there has been considerable conflict between banks and credit unions. They both play a vital role in our communities. I hope that in the coming months we can produce legislation that will strengthen credit unions as well as community banks, and I support the bill.

I thank the members of the committee, particularly the chairman, for their support of H.R. 1151, and look forward to swift passage. I am particularly pleased to serve on this committee because of the cooperation and sincere desire in that committee to make sure that we have strong financial institutions and that we have competition out there, which I think is the real answer to a lot of our problems.

I yield the floor, Mr. President.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from New York.

Mr. D'AMATO. Mr. President, let me just take a brief moment because I know the Senator from Missouri has been anxiously waiting to seek the floor.

I thank my colleague from Colorado, a member of our Banking Committee, as well as the Presiding Officer, for their support not only in this endeavor as it relates to the credit unions but for our overall legislative efforts. Indeed, I believe that Senator ALLARD has offered in a most constructive way an opportunity to begin to give to the small business entrepreneur, and in this case the small community bank, an opportunity to create meaningful competition, to allow retained earnings to be held to avoid double taxation, and to make a very positive impact on financial modernization that will lead to greater competition and in the long run will expand the economy and the tax base for individual small banks, and as a result, benefit all of our citizens. This effort is not only a worthwhile endeavor, it is one that all of us should seek to support, Republicans and Democrats alike.

Let me simply say this because I feel compelled to do so. I understand the frustrations of many of my colleagues as we debate the question of CRA and whether or not it should be a factor for small banks, whether it should be continued, or whether it should be modernized. Indeed, I think we should take a closer look at this issue, as Senator ALLARD has in terms of coming forth with his legislative proposal which addresses tax relief.

The CRA amendment regarding small banks is a broad brush, shotgun approach for those who would support the effort of dealing with this issue in the context of a very important legislative matter. It beclouds the issue. Addressing this important matter of CRA for small banks now does not help in attempting to see to it that we remove barriers from honest competition, barriers that maybe should be removed and that we should address. But, I repeat, to bring it up in this form with the limited time that we have this Session will be disruptive to the overall effort.

I ask all of my colleagues, my Republican colleagues in particular, and even those who have signed on and indicated support of the effort of the Senator from Alabama to help community banks, not to undertake it at this time. It actually distracts from the merits of their argument. It will prevent considering their concerns carefully and analyzing what can be done to ease these burdens, to assess if they really are burdensome and if so, in what way. So I am going to appeal to my colleagues—I appeal to them today; I will appeal to them on Monday—this is not the time to be going forward seeking relief that we will not have the opportunity to act on in any event. It will fracture our efforts on the credit union bill. It will at the least, the very least, bog down this effort. The House of Representatives will not accept the bill with this amendment. If they do accept it, then what will happen is that the bill will be a vetoed. Now what are we accomplishing? Why do we want to confuse whether or not we are really supporting credit unions with this attempt at dealing with another unrelated issue? That will only serve to hurt our efforts for credit unions.

This Senator intends to support the motion of Senator GRAMM of removing the CRA provisions from this credit union bill. But my gosh, if we are going to begin reaching far back through existing laws, without doing so in a meaningful way, then what I suggest what we are doing is purely mischief making. We want to be loved by all. We want to make everyone happy. I understand that. That is the nature of those in politics. But there comes a time when we have to take a stand and do what is right. Sometimes you can't have the adoration of all. Better to have the respect and to do what is right.

I will be urging that of my colleagues, and particularly those who have concerns about the application of CRA on the community banks. Let's do what is right.

I yield the floor.

Mr. BOND addressed the Chair.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. BOND. Mr. President, I ask unanimous consent to proceed 5 minutes as if in morning business to introduce a piece of legislation.

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

(The remarks of Mr. BOND pertaining to the introduction of S. 2354 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Mr. D'AMATO. Mr. President, I think, as much as we will be returning on Monday to resume debate and consideration of the credit union legislation, which is so important, and which I believe will be adopted overwhelmingly, I urge any of my colleagues who might want to make statements that we will be available to receive those statements at this point. If not, it seems to me we will then be moving, at the request of the majority leader, to adjourn until Monday.

So I am going to suggest the absence of a quorum and hope if there are any of my colleagues who would like to make their statements now, opening statements or observations, that they would do so within the next 5 to 10 minutes.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. SARBANES. 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. SARBANES. Mr. President, I will be very brief. I know we, in effect, have concluded the debate today with respect to the credit union bill, but there were some comments made earlier about the CRA aspects of this legislation, and I want to put this in the RECORD.

First of all, let me make it very clear, the CRA that is being applied to the credit unions is not the Community Reinvestment Act. It is a provision drafted especially for the credit unions, and it is designed to ensure that they pay full attention to the field of membership. I think it is a reasonable provision. I hope it will stay in the bill.

I know that the Senator from Texas is trying to strike it, but, of course, he is against any CRA, any version of CRA anywhere and at any time. I disagree very strongly with that. We will have

an extended debate on the effort to exclude some banks from CRA.

There is really a basic philosophical difference. We see the CRA as bringing people into the mainstream of economic life and involving them in our economic process. I have spoken to many bankers who support CRA. They think it has produced good results. Federal Reserve Chairman Greenspan has said:

> The essential purpose of the CRA is to try to encourage institutions who are not involved in areas where their own self-interest is involved, in doing so. If you are indicating to an institution that there is a forgone business opportunity in an area X or loan product Y, that is not credit allocation. That, indeed, is enhancing the market.

That is Chairman Greenspan.

It is being portrayed by its opponents as sort of a mandatory credit allocation. It certainly is not that. It is an effort to ensure a reasonable amount of money goes back into the community.

A number of banks have issued statements in support of CRA. They say it has increased their focus on their lending performance. In fact, the Bank of America said:

> Over the past several years, Bank of America, in partnership with community organizations, has developed CRA lending into a profitable mainstream business.

And that is really what we are trying to achieve—a profitable mainstream business.'' These institutions receive deposit insurance, and I earlier indicated the importance of that to the workings of the industry and the fact we had to produce hundreds of billions of dollars in the S&L crisis in order to deliver on that promise.

There was a problem with CRA over bookkeeping, recordkeeping, and so forth. Secretary Rubin led a major effort to revise the Federal regulations. This extended over a 12- to 18-month period. All groups were involved—the bankers, the community groups, academics, the administration. In effect, Members of the Congress were drawn into the process, and, in the end, very, very significant changes were made. As a consequence, I think many of the defects that earlier were argued against CRA were taken care of. Much of the regulatory overburden I think was removed.

The argument was made that these small banks hold only a fraction of the assets. The fact is that in 30 States, over 80 percent of the banks would be affected by the Shelby amendment. In other words, it would exclude 80 percent of the banks; in 6 States, over 95 percent; in 9 other States, over 90 percent; and the remainder, the other 15 States, over 80 percent.

Most of these are rural States, and there seems to be a perception that CRA benefits only the urban areas of our country. However, rural areas, no less than urban areas, are affected by it. We received a letter from a coalition of rural and farm groups, including the National Farmers Union, the National Family Farm Coalition, the National Rural Housing Coalition, and the Federation of Southern Cooperatives, in opposition to the small bank exemption for CRA.

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:

JULY 23, 1998.

DEAR SENATOR, On behalf of the undersigned organizations representing rural Americans, we are writing to express our strong opposition to legislative efforts to weaken the coverage of the Community Reinvestment Act (CRA). Our understanding is that Senator Shelby plans to offer an amendment to H.R. 1151, the credit union legislation, that is scheduled for floor action. In addition, Senator Gramm plans to offer an amendment that strikes provisions in H.R. 1151 that would ensure that credit unions provide services to all individuals of modest means within their field of membership.

The Shelby amendment would exempt banks under $250 million in assets from CRA coverage. This affects over 85% of banks nationally. For citizens in Iowa, Kansas, Minnesota, Montana, Nebraska, and Oklahoma, 95% of the banks would be exempt.

Rural Americans need the tools of the Community Reinvestment Act to ensure accountability of their local lending institutions. It is needed to prevent rural banks from abandoning their commitment to serve the millions of Americans living in smaller low and moderate-income communities. Unfortunately, small commercial banks do not automatically reinvest in their local communities. This is documented by national data on reinvestment trends and loan to asset ratios for banks across the country. 50% of small banks have a loan-to-deposit ratio below 70%, with 25% of these having levels less than 58%. The data for 1997 reveals that banks under $100 million in assets received 82% of the substantial non-compliance ratings.

We strongly urge you to oppose these amendments to H.R. 1151. The Shelby amendment ignores the important regulatory changes since 1995 that have significantly reduced the paperwork and reporting issues for small banks. The Gramm amendment will strike an important provision from the bill that for the first time would require credit unions to meet the financial services needs of their entire field of membership.

A vote against these amendments will help meet the credit demand of millions of family farmers, rural residents, and local businesses. Thank you for considering our concerns.

Sincerely,

Center for Community Change, Center for Rural Affairs, Federation of Southern Cooperatives, Housing Assistance Council, Intertribal Agriculture Council, Iowa Citizens for Community Improvement, National Catholic Rural Life Conference, National Family Farm Coalition, National Farmers Union, National Rural Housing Coalition, Rural Coalition and the United methodist Church, General Board of Church and Society.

Mr. SARBANES. Mr. President, I will quote a portion of this letter:

> Rural Americans need the tools of the Community Reinvestment Act to ensure accountability of their local lending institutions. It is needed to prevent rural banks from abandoning their commitment to serve the millions of Americans living in smaller low- or moderate-income communities. Unfortunately, small commercial banks do not automatically reinvest in their local communities.

It is a strong view that CRA has really brought investment back into the communities and that this has redounded to everyone's advantage, including—including—the advantage of the banks.

We think that CRA has been remarkably effective in encouraging both large and small banks to look closely at market opportunities in all of the areas which they serve and in building a better relationship between the banks and the community. The result has been billions of dollars in market-rate profitable loans in urban and rural communities that historically have had difficulty in gaining access to credit.

That is the basic, bottom-line message, and it is a very good message. It is a very good message for the country.

I very much hope that as my colleagues think through this issue, they will appreciate the benefits that flow from CRA and reject the Shelby amendment, which would exclude banks under $250 million in assets—which, as I indicated, are the overwhelming number of banks in the country—and reject the Gramm amendment which seeks to eliminate a modest provision in the credit union bill that would require the credit unions to take a look at how they are serving their field of membership in their community, a provision which, I might note, the credit unions have indicated they accept. In fact, their stated position to us is that they support this bill as reported from the committee.

Mr. President, I yield the floor.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. D'AMATO. Mr. President, I must say that in the areas in which my ranking member, friend and colleague, Senator SARBANES and I have worked on in the Banking Committee, we have shared rather similar positions on—well, just about 80 or 90 percent of the issues we have addressed, whether it be on housing issues or mass transportation issues or issues regarding financial services. Indeed, I almost reluctantly come to the conclusion that this is not the appropriate time to undertake expanding CRA activities by prescribing them for credit unions. And just as I have cautioned my colleagues and friends—most of them on the Republican side—that if we are to look at the benefits, and maybe some of the effects that are not beneficial which could be the unintended consequences of a well-intentioned law—and I have no doubt it is well-intentioned—it is my opinion, overall, that CRA has been beneficial in attempting to ensure that financial institutions that accept deposits from a particular area or community, direct some of those financial activities back into that community.

Now, let us not kid ourselves. I think we are disingenuous if we would suggest that all institutions are sure to

meet both a financial and moral commitment and balance both. Some of these financial institutions have to be conscious of their stockholders and conscious of doing business in our very competitive society. And I think that we would be less than candid if we were not to recognize that there have been institutions over the years that have directed their investment activities with almost a singular purpose—to bring to the bottom line the greatest profits that they can possibly derive, without attempting to help a community, to derive an investment strategy or portfolio that would only give them the highest possible return.

I think it was as a result of looking at activities where communities and banks were gathering deposits from communities and giving little, if any, back and, indeed, engaged in the practice of redlining—and there have been studies, these practices are documented. The Federal Reserve Bank of Boston conducted a study that documented redlining practices in Boston, Massachusetts. And that is unfortunate, it is an outrage. But those are the facts.

Consequently, Congress came forth and passed legislation—and it is the law of the land—that directs credit allocation to these areas that heretofore were not receiving it, whether they be the rural areas or whether they be in the inner cities. But let us not kid ourselves. Redlining was taking place, and it is, again, disingenuous for any of our colleagues to suggest that it was not.

Maybe we should provide an opportunity for some of the smaller institutions that have an exemplary record—and indeed I am very conscious of the statements made in the 1997 Federal Reserve report, that there were only nine—only nine out of the thousands of community banks that were cited for inadequate investment, not meeting the goals of CRA. That is a great, great record. Maybe we could find a solution where there is a less frequent accounting or reporting process that would ease the burden, particularly for institutions that have demonstrated that they do care, that they have a concern, and that they meet their social responsibility. That is why CRA came about—to see to it that it was not just to get the highest yield every time, because Congress said, ''We insure these, and we think there should be some effort made at allocating credit, yes, in communities that might not otherwise be as attractive for investment purposes.''

That is what we are talking about. That is how CRA came about. So while I am sympathetic to the unintended burdens that may have been created, I also am appreciative of the fact that there have been billions of dollars as a result of this program that have been invested in rural areas, in rural America, and in urban centers that may not have otherwise benefitted from investment. This practice has, in turn, created profits, jobs, opportunity and hope for Americans that otherwise wouldn't be.

Having said that, I am arguing on one side why we should not at this time be looking to simply wipe out CRA legislation affecting community banks. I am willing to discuss this matter, willing to hold hearings and willing to go forward and examine, What alternative solutions can ease burdens that may exist? But by the same token, regarding CRA-like implications for credit unions, I just believe it is wrong. We are talking about groups of people, cooperatives, who come together by their very nature.

When we look at this matter more closely—Monday, I intend to look at the profile of the credit union member. I have to tell you, they meet the description when we try to encourage making available moneys and resources and to see to it, whether it be the community banks or all the financial institutions, that they become involved. And that is why they have come together. Their very profile, absolutely in terms of demographics, in terms of per capita income, meets the needs that we have tried to establish overall through CRA.

I believe it is absolutely counterproductive to say to the very people of these cooperatives—nonprofit institutions, have moneys that go right back into that institution; it is their capital, not the individual who earns more, or takes out more, or a stockholder—that we then place this requirement on them when it has never been demonstrated to be necessary. Indeed a letter from the NCUA attests to that fact. I will just read part of this letter. It was written to Phil Bechtel, chief counsel for the Senate Banking Committee, June 1, 1998, signed by Robert Loftus, director of Public Congressional Affairs.

It says, ''Our investigations have not produced any evidence''—any evidence—''that credit unions are guilty of redlining or other discriminatory practices.''

Given that history, let us move forward—I support this legislation, but I believe that the Senator from Texas is right in moving to strike this provision. I also strongly believe that, to those of my colleagues who want to give regulatory relief to the small banks and community banks, as well intentioned as they are, their efforts will absolutely do nothing but delay, bring about more confusion, and the charges that in their attempt to do provide relief to small banks, what they are really doing is trying to defeat this legislation. I think whether it is an unintended consequence or not, that is exactly how it is going to be portrayed. And I will say on the floor to my colleagues: Recognize what you are doing, recognize that you want to be loved by all.

I think that the point can be made. I think we can fight for regulatory relief. There are times and places to do it. But this is not the time nor the place. If this was the last boat going out of town, then fine, we would do it. I think there are a couple other areas where I could suggest that my colleagues address this issue of relief for small banks, if they really want to see this legislation enacted. And it would be appropriate to undertake that, but not here, and not on this credit union bill.

I see the distinguished chairman of the Finance Committee is here, and I know he wants to speak to this bill.

I yield the floor.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. I thank the distinguished Senator from New York for yielding to me. I congratulate him and his colleague, Senator SARBANES, for bringing this legislation before us.

I want to take this opportunity to restate my support for Delaware's credit unions. As we all know, months ago, a Supreme Court decision placed the viability and future of credit unions in limbo. For that reason, I am particularly pleased that the Senate will be voting next week on H.R. 1151, a bill to ensure credit unions will be able to add new member groups.

Mr. President, I support credit unions because I know how vital they are to the financial health of thousands of Delaware families and businesses. These nonprofit member-run institutions are unique. Their sole purpose is to provide financial services to their members at the best rates and under the most favorable conditions possible.

Savvy consumers know that credit unions are often a great option. Their ATM fees are reasonable or nonexistent; single-digit credit card interest rates are common at credit unions; and your child's first savings account won't face a monthly low-balance fee. I don't think I mentioned, I say to my distinguished Senator from New York, you can also set up a Roth IRA.

All Senators have undoubtedly heard from the thousands of credit union members in their States. Their message is one of self-sufficiency and of low-cost, low-fee consumer-based financial services. Credit unions are good for families, good for businesses, and they are good for Delaware.

H.R. 1115 is necessary for these valuable institutions to thrive.

Again, I want to thank the chairman of the Banking Committee and the ranking member for their role in bringing this legislation to this point. I look forward to voting for this legislation next Monday.

Mr. D'AMATO. Mr. President, let me thank the distinguished chairman of the Finance Committee for his help and his work. Indeed, he and his staff are working on important legislation with Senator ALLARD, and I believe the Presiding Officer and others have signed on to give some tax relief to the small community banks.

The Senator and his staff have been most cooperative in helping to move it forward. I hope we would even have an opportunity to do something this year.

Mr. ROBERTS. Mr. President, notwithstanding all the advice we have received from Senator SARBANES and Senator D'AMATO in regard to how world banks make their loans or don't, and what is in the minds of country bankers all throughout the Nation, and without CRA we simply wouldn't have ever made a loan in rural America, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. ROBERTS). Without objection, it is so ordered.

Mr. KENNEDY. Mr. President, I support H.R. 1151, the Credit Union Membership Access Act, but I strongly oppose the amendments being offered by Senator GRAMM and Senator SHELBY. Credit unions have a distinguished history of providing affordable financial services to America's low- and moderate-income communities. This legislation will help them continue to do that.

It is ironic that we are now debating the issue of whether banks and credit unions should serve low- and moderate-income communities and to reinvest in the communities in which they receive deposits. Massachusetts has 317 credit unions, at 1.7 million members. They have had community reinvestment obligations for many years, and they have done an excellent job of meeting needs of consumers at all income levels. Massachusetts credit unions are a model for the Nation. The vast majority of banks take their community reinvestment obligation seriously in meeting these obligations.

The Massachusetts Bankers Associations, whose member banks are doing excellent work in community reinvestment, does not support the Shelby amendment. Institutions which have received outstanding ratings, like Bank of Boston and Citizens Bank, are using the Community Reinvestment Act to provide profitable lines of business.

Senator SHELBY's amendment to eliminate the Community Reinvestment Act for 85 percent of the banks would eliminate an important source of affordable credit and financial services from low- and moderate-income families who are bankable. Massachusetts banks do not support this amendment, and I urge my colleagues to oppose it.

Senator GRAMM's amendment would say to credit unions who are being granted expanded power, they have no obligation to serve members of modest means. Both these amendments are bad policy.

In this period of sustained economic growth, it is vital that all families have the opportunity to obtain credit in order to buy a home, start a small business, or send a child to college. The Community Reinvestment Act has a long history of success. Since 1992, it has helped banks to extend over $800 billion in loans for housing, small businesses, economic development and local communities across the Nation.

As many have said, there is no capitalism without capital. We should oppose any effort to reduce access to credit which families need in order to buy a home, to start or expand a business, and send their children to college. The Community Reinvestment Act is not charity. It creates a positive obligation for banks to reinvest in communities from which they receive deposits. It is good business and it helps communities, businesses, and families nationwide; requiring similar investments by credit unions is good policy.

I urge my colleagues to pass this important piece of legislation and to oppose these two amendments. It hurts all those who want a better future for themselves and their families, and it hurts our inner cities and rural communities who are rebuilding. Most of all, they reverse 20 years of successful reimbursement in our neighborhoods, and it deserves to be defeated.

MORNING BUSINESS

Mr. D'AMATO. Mr. President, I ask unanimous consent there now be a period for the transaction of routine morning business with Senators permitted to speak for up to 10 minutes each.

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

Mr. KENNEDY. I ask unanimous consent to be able to proceed for 15 minutes.

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

Mr. KENNEDY. I ask the Chair to let me know when I have 3 minutes remaining.

PATIENTS' BILL OF RIGHTS

Mr. KENNEDY. Mr. President, since the Republican leadership plan on the Patients' Bill of Rights was introduced a week ago, we have been holding meetings and forums with doctors and nurses and patients to explore the critical issues that must be addressed if a Patients' Bill of Rights is to be worthy of the name.

In each case, the message has been the same. The problems created by HMOs and managed care are pervasive in our health system. Every doctor and patient knows that. Too often, managed care is mismanaged care. Every doctor and patient knows that medical decisions that should be made by doctors and patients are being made by insurance company accountants, and every doctor and patient knows that profits, not patients' care, have become the priority of too many health insurance companies.

And at each of the forums we have held, the message from doctors and nurses and patients has been the same: Pass the bipartisan Patients' Bill of Rights. Reject the Republican leadership plan; it leaves out too many critical protections and it leaves out too many patients. Even the protections it claims to offer are full of loopholes. It is a program to protect industry profits, not patients.

One of the most critical issues that needs to be addressed in legislation is the right of people with serious illnesses, like cancer, to get the high-quality specialty care they need. If the conventional treatments fail, they should have the opportunity to participate in clinical trials that offer them hope for improvement or a cure, and that can contribute to finding a better treatment for future patients. Our legislation provides for these rights; the Republican plan does not.

Yesterday, we heard from Dr. Casimir, a distinguished Texas oncologist. Dr. Casimir talked about some heartbreaking stories of cancer patients whose HMOs delay and deny access to specialty care, often until it is too late. She said that when she gets a patient whose cancer progressed substantially from the initial diagnosis to the time they are allowed to receive specialty care, she often flips to the front of the chart, and 9 times out of 10, the insurer is an HMO. Every centimeter a cancer grows can mean the difference between a good chance at life and the likelihood of death. Every centimeter represents potentially devastating and avoidable pain, suffering and sometimes the death of a patient. Dr. Casimir's message was clear: Pass the Patients' Bill of Rights so that more patients will not die needlessly.

Today, we heard from Dr. Bruce Chabner, a distinguished clinical oncologist and cancer researcher. This is what the doctor had to say:

> My name is Bruce Chabner and I am a medical oncologist and cancer researcher. I am here to support the Patients' Bill of Rights that would require HMOs and insurance companies to support clinical research. I would like to explain briefly the role of insurance coverage in research. Most of the costs in clinical research are associated with the cost of discovery. Laboratory experiments in the development of new treatments are supported by the Government grants, by industry, and by institutional commitments by hospitals and medical schools.
>
> These contributions provide the hundreds of millions of dollars that lead to new treatments and new hope to millions of our patients with cancer. However, the clinical treatment of these patients requires support for the routine care associated with these clinical trials. The only source of such support for routine care costs is health insurance and HMO contributions.
>
> This is the final step in proving that a new treatment or a new device actually works in people. Without this step, research is meaningless and has no impact on people, nor does it save lives. We are not asking the insurance companies and HMOs to support the vast effort to discover new treatments or to bring them to the clinics. We are not asking for support for the cost of analyzing data and support during the clinical trials. We are only asking them to continue support for the patients' care costs.

I am sure that every Member of Congress who is faced with the awful dilemma of cancer would want this kind of continued support for their family members. The research provides the only hope our patients have of conquering this disease and the only hope our society has for curing cancer.

Now, I just want to mention this one more time, Mr. President. Under our Patients' Bill of Rights, we are guaranteeing the specialty care and clinical trials. For example, if your family or you were affected by cancer, you would not only be able to go to an oncologist, but you would be able to go to one of the great cancer centers that we have in this country to be able to get treatment. You would be able to get the specialty care that you need. If you believe you are being denied that particular care, you are able to go in to have an internal appeal and an external appeal, which must be responded to promptly. But you will get it; we guarantee it, under the Patients' Bill of Rights.

We guarantee that you will be able to participate in a clinical trial if it is medically necessary—if your doctor says it is medically necessary. Clinical trials can be the source of enormous hope for millions of Americans who are afflicted by cancer. There are 47,000 women who die each year from breast cancer, and there is extraordinary research that is taking place that offers great hope for millions of women.

Under this proposal, under the Patients' Bill of Rights, we are guaranteeing that if it is medically proven, you can get into a clinical trial. What kind of financial burden does this place on an HMO? Does it say to the HMO, well, you are going to have to pay all of these additional expenses? Absolutely not. The clinical trial is being paid for by the medical center; the clinical trial is being paid for by the pharmaceutical company; the clinical trial is being paid for by the financial strength of the particular clinical center.

The only thing that the HMO would have to pay for is routine services—do we understand that?—which they would otherwise be required to pay. Those that oppose this provision say, well, if you require that they get clinical trials, it is going to bankrupt the HMO. That is preposterous, that is wrong, that is deceptive, and that is a critical misinterpretation of our legislation.

As our distinguished clinical researchers pointed out today, once again, the kind of treatment that is necessary for these clinical trials is provided by the center, not by the patient or the HMO. The only requirements by the HMO would be routine care. Quite frankly, the HMO would be obligated to provide routine care in any event. So that does not adversely impact the HMO financially. Still, we have the reluctance and resistance to guarantee this in the Patients' Bill of Rights. I don't understand it. That is one of the reasons we ought to have a debate on this issue.

How many Members in this body know the allocation of expenditures on clinical trials? I doubt if there are 5 or 10. I cannot understand why any Member of the Senate is saying not do it if it is medically necessary, because the HMO is not going to be burdened with substantial additional costs. That isn't the way it works.

As I mentioned, 47,000 women die every single year. There are these clinical trials that are taking place in the great medical centers all over this country. And if a doctor says he believes, based upon the type of clinical trial and the kind of need that you are facing—to a woman that has been biopsied in her breast, and where a tumor is present—there is an opportunity and likelihood that you might survive, we believe that ought to be available. That is the best medical practice. Insurance companies were providing that protection for years before we had the HMOs. This wasn't even an issue for years and years, Mr. President. Now it is. And the principal reasons that the cancer oncologists and the cancer organizations support our proposal is because they see the fact that HMOs are denying this kind of treatment.

Mr. President, we had Ms. Stekley, who was the head of clinical research at the Lombardi Center out here in Washington, D.C. She said that 80 percent of their administrative time is spent arguing with the HMOs to let people into their clinical trials—not because they are profiting financially, but because they believe that they can help the people, from a health point of view—80 percent of their administrative time. This person was almost in tears saying, ''Senator, we can help people survive, and it isn't going to cost the HMO any additional resources. Your proposal does the trick.''

What is possibly wrong with having that particular inclusion in any protection for a Patients' Bill of Rights? I cannot understand it, Mr. President. I cannot believe that we don't have a full opportunity to debate this issue in this body on this one issue, and that we will not be successful. It is enormously important to do two things: One, to have a guarantee that you can have a specialist; and, two, if it is medically recommended, you can have a clinical trial based upon medical evidence. And if you do not, then you are going to get a speedy right of appeal. And you contrast that with the top researchers who testified just yesterday, how they look at their patients, and have seen the various tumors that have grown day by day, week by week, month by month, and seeing the chance of these women's survival declining dramatically—because of what? Because of two things.

The PRESIDING OFFICER. The Senator has 2 minutes 52 seconds.

Mr. KENNEDY. I thank the Chair.

For two things: Because they were late getting to a specialist, and because they were excluded from any opportunities for the clinical trials.

The HMOs thought they could handle it. The HMOs thought they had someone on their panel who could handle this particular kind of cancer, even though right down the street there was a major international center that specialized in this very program.

Under the Republican program, access to clinical trials is not guaranteed—it isn't even an appealable item. Even if it were, will the appeal be established by an independent group? No. It will be established by the HMO. They name the people whom this will be appealed to. Then, if that person is harmed with grievous bodily injury, or death, under our Republican program there is no remedy.

Mr. President, this is the kind of issue that we ought to have an opportunity to debate. We just took one provision today with regard especially to clinical trials. We had a few others. But the time has moved on and I will wait for another time.

I thank the Chair. I yield the floor.

Mr. BYRD addressed the Chair.

The PRESIDING OFFICER. The distinguished Senator from West Virginia is recognized.

Mr. BYRD. Mr. President, I have listened with great interest to the speech by Mr. KENNEDY, and I look forward to hearing him speak on further decisions on this subject.

And I wish to thank the distinguished Senator from Minnesota, Mr. GRAMS, who has stated that his speech today might last 40 minutes, and he was very considerate to ask me how long I would be speaking. And he suggested that I proceed with my remarks ahead of him, because he would want to speak for about 40 minutes. I think it is most gracious and considerate of the Senator, and I thank him. And his good deeds will be repaid in kind at some future date.

Mr. KENNEDY. Mr. President, will the Senator yield?

Mr. BYRD. Yes.

Mr. KENNEDY. I, too, want to thank my friend and colleague from West Virginia, because the Senator heard that I wanted to address the Senate on this matter, which I considered of some importance, and was willing to accommodate my schedule as well, for which I am very grateful. It is typical of the great thoughtfulness that all of us have understood to be a part of the Senator from West Virginia but which we are reminded about so frequently. I thank the good Senator for his generosity and for his thoughtfulness.

Mr. BYRD. Mr. President, I thank my friend from Massachusetts. I am merely repaying a good deed that he did for me a week or so ago when he allowed me to go ahead of him. And by virtue of his doing so, when I completed my remarks and other Senators got recognition, Senator KENNEDY had to wait still longer. Well, I thank all Senators. And this is one of the things that makes it a joy to serve in this body.

Mr. President, what is the order?

The PRESIDING OFFICER. The general orders are that speeches are limited to 10 minutes.

Mr. BYRD. Mr. President, I may need a little longer than 10 minutes. I ask unanimous consent that I may speak not to exceed 15 minutes.

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

Mr. BYRD. I may not use that much time.

MIXED SIGNALS FROM THE PENTAGON

Mr. BYRD. Mr. President, one week ago today, a small ceremony took place in the Pentagon at which the three senior leaders of the United States Army unveiled a series of posters depicting each of the seven core values of the Army. They are noteworthy values—Loyalty, Duty, Respect, Selfless-Service, Honor, Integrity, Personal Courage. They send a strong message to the world about the values that shape America's fighting forces.

Three days later, Defense Department officials sent a very different message from the Pentagon regarding core values when they took the wraps off a proposal that would relax the military code of honor concerning adultery. According to the news accounts I have read, Secretary Cohen is expected to propose within the next few weeks a new approach to dealing with cases of adultery in the military that would limit prosecutions—limit prosecutions—and ease automatic penalties.

Mr. President, I respectfully ask, what on earth has gotten into the leadership of the Defense Department?

Each of our services is founded on a set of bedrock principles. I have just recited the Army's. For the U.S. Navy and Marine Corps, the core values are honor, courage, and commitment. The core values of the Air Force are integrity, service, and excellence.

These values form the moral guideposts for the men and women of America's armed forces.

Whether we are talking about the Army, Navy, Air Force, or Marines, we are talking about a group of exceptional individuals in whom we as a nation place extraordinary trust and from whom we exact exceptional standards of courage, leadership, and moral conduct.

These standards, demanding though they are, have served our nation well for more than two hundred years. They are the virtues that undergirded the American Revolution and helped General George Washington's Army endure the bitter winter at Valley Forge. They are the principles that elevated the American Civil War from a duel between states to a crusade that cemented the unity of a nation. They are the values that guided our troops to victory over the most evil power of the twentieth century—the forces of Adolph Hitler—during World War II.

Honor, Duty, Respect, Integrity, Courage and Commitment make up a noble list. This roster of virtues is one that our men and women in uniform have, from this nation's founding, embraced with pride.

I admire the dedication of our military forces. I admire their willingness to hold themselves to a higher standard. I believe that the core values they embody are as important as all the skills and training and equipment this nation can marshal in making America's armed forces mighty and powerful, the best in the world. That has always been the way with American military forces. We saw in World War II the most powerful, the mightiest armed force in the world, the best armies that ever walked the earth.

And so I ask again, what on earth has gotten into the leadership of the Department of Defense?

Mr. President, I am pleased to note that the Marine Corps has responded to the call to lower the bar on adultery with the equivalent of Brigadier General Anthony McAuliffe's response to the Germans' demand to surrender during the Battle of the Bulge. In a word, ''Nuts!''

And so I salute the Marine Corps for taking that stand.

Let me just say that again. I think it needs to be said, and I hope that the Secretary of Defense will hear me.

I am pleased to note that the Marine Corps has responded to the call to lower the bar on adultery with the equivalent of Brigadier General Anthony McAuliffe's response to the Germans' demand to surrender during the Battle of the Bulge. In a word, ''Nuts.''

God bless the Marines. God bless the Marine Corps. And God bless that word ''Nuts,'' because that is the response of the Marine Corps.

For a service whose motto, *Semper Fidelis,* means ''Always Faithful,'' the Marine Corps' unwillingness to compromise its core values is commendable. I salute the Marine Corps. I hope that the leadership of the Army, Navy, and Air Force will follow suit. At a time when the reputation and the morale of the military have taken a serious battering as a result of the conduct of some of its leaders, I am frankly amazed that the Secretary of Defense would even entertain such an ill-conceived proposal.

The recent and highly publicized instances of adultery, sexual harassment, and rape within America's military have wounded the prestige of our armed services and have ruined individual lives, families, and careers. The uneven handling of several high profile cases—ranging from swift and harsh punishment meted out to enlisted personnel and junior officers to an apparent blind eye turned to the misconduct of certain high-ranking officers—has only exacerbated the problem and led to the perception of a double standard in the military.

I sympathize with the many problems facing our military leadership in today's volatile international environment. Resources are scarce, forces are stretched thin, and tensions are mounting in potential trouble spots around the world. But leadership requires the ability to set a good example and stand by one's principles, regardless of how difficult that may be. The solution to the moral and ethical turmoil threatening to engulf today's U.S. military forces is not to lower the standards to the level of the least common denominator. The solution is to restore and to apply the discipline and unique military code of conduct equally and across the board.

In this country, we have always looked up to the military for leadership and role models. What kind of a message does this proposal send to our young people, who are struggling to define their values in a society that increasingly seems to hold core values in contempt? How are parents supposed to explain this sea change in the military's moral code to their children? What is the Defense Department thinking? Why on earth is the Pentagon sending such mixed messages to the men and women in uniform? Even that nonsensical term ''political correctness'' does not require this.

If the Secretary of Defense is willing to entertain a proposal that would essentially treat adultery—conduct that inherently involves dishonor, lying, and cheating—with a wink and a nod, what comes next? Will it be okay to cheat on an exam at the military academies if the instructor is too tough? Will ''little white lies'' be acceptable to get out of unpleasant duties? Will the occasional dereliction of duty be overlooked as long as no one gets hurt? Will the Marines be asked to change their motto from ''Always Faithful'' to ''Usually Faithful'' or ''Sometimes Faithful''? If so asked, I have a feeling the Marines will say ''nuts.''

The core values of America's military services are not there for window dressing. Taken together, they form the basis of a sacred trust. It is a trust that must extend to placing one's life in the hands of one's comrades. It is a trust that goes up the chain of command and down the chain of command and across the chain of command. It is trust that is absolute—there can be no shades of gray on the battlefield. There can be no shades of gray at the helm of the ship in the storm. There can be no shades of gray in the cockpit.

I hope that the Secretary of Defense will rethink this misguided proposal to weaken the rules governing adultery and fraternization in the military. The effect can only be to erode the time-honored military principles that have served our Nation throughout its history, in peacetime and in war. Our nation's military leadership, including the Secretary of Defense, who once served here as a very able Senator and respected colleague, must draw a line in the sand when it comes to the moral conduct of the armed services. The services must not be seduced into exchanging their code of conduct for a code of convenience.

Again, I salute the Marines for their unwillingness to compromise their

standards, and I call on Secretary Cohen to reject this and any other proposal that would compromise the integrity of this nation's military forces.

Mr. President, I yield the floor, and I again thank my friend from Minnesota, Senator GRAMS, for his kindness and courtesy.

Mr. GRAMS. I thank the Senator.

Mr. President, I ask unanimous consent that I be allowed to speak for up to 45 minutes.

The PRESIDING OFFICER. Is there an objection? The Chair hears none, and it is so ordered.

Mr. GRAMS. Mr. President, I want to make three separate statements, one dealing with Social Security, looking at the background and the history of the program as we move toward possible debate on change and reforms. Also, a statement supporting Senator SHELBY on his amendment dealing with CRA and small banks. And also a brief statement on the Government Shutdown Prevention Act, which is aimed at trying to pass legislation that will prevent the Government from shutting down in the future even if Congress cannot reach an agreement on budget or appropriation matters.

SOCIAL SECURITY AND THE GENDER/RACE GAP

Mr. GRAMS. Mr. President, in my continuing series of statements on the troubled Social Security program, I have discussed the history of Social Security, the program's looming crisis, and the old-age insurance reform efforts undertaken by other nations.

Today, I want to discuss an aspect of Social Security that often gets distorted in the reform debates going on throughout this great nation.

It is the issue of how the current Social Security system puts women and minorities at a greater financial risk and disadvantage than other retirees face today.

We must address the questions of how these Americans will fare under any reform of the current system, so we can empower them with the ability to have a more secure retirement future than that which Social Security promises today.

First, it is essential to understand why these Americans were put at a disadvantage in a system supposedly established to help them. To do that, we must go back to the beginnings of the Social Security program.

When Social Security was first enacted in the 1930s, the discriminative elements were inherently built into the system. Professor Edward Berkowitz of George Washington University has done excellent research on this subject.

According to his studies, policy makers taking part in the first Social Security advisory council freely indulged in racial and sexual stereotypes. They made a widow's benefit equal to only three-quarters of the value of a single man's benefit.

Their rationale for the decision was, according to one member, that a ''widow could look out for herself better than the man could.''

Douglas Brown, the chairman of the advisory council, even suggested that a single woman could adjust to a lower budget ''on account of the fact that she is used to doing her own housework whereas the single man has to go to a restaurant.''

Another example of Social Security's inherently discriminative nature is that domestic workers were not covered by Social Security when the program was set up.

One early policy maker explained that it was difficult to collect contributions from the ''colored woman . . . who goes from house to house for a day's work here and a day's work there.''

Clearly, things were different then.

At that time, most women stayed home, and only 6 people out of 10 reached age 65.

Despite the fact that the Social Security program provided an opportunity to redistribute income from wealthier individuals to low-income retirees—an effort to help provide assistance to those less fortunate—the inequality of women and minorities was never adequately addressed.

In fact, the disparity has grown under the current Social Security system.

The profile of today's retiree is quite different than it was in the 1930s and continues to change.

More women today are working outside the home, less than half of America's working women receive pensions today, life expectancy is increasing, while minority populations continue to grow in number.

But our Social Security system has failed to make the needed adjustments. As a result, financial gender and racial gaps are growing larger for those retired or nearing retirement. Women and minorities are suffering under the current Social Security system.

For women and minorities, average income continues to remain low. This means there is less money available to personally save for one's own retirement.

Furthermore, payroll taxes have increased 36 times over the last 27 years, forcing families to squeeze more out of less take-home pay.

According to the Heritage Foundation, today's payroll taxes consume as much of the family budget as do costs for housing, and nearly three times more than annual health care.

So it is not surprising that growing numbers of women and minorities are becoming increasingly dependent upon their Social Security checks. If we are going to successfully raise their quality of life once they reach retirement age, we must begin to look outside the proverbial box today.

Mr. President, I would like to begin by focusing on women, since they are disproportionately dependent upon Social Security. There are a number of factors that create this reliance.

While we can rally around the idea that our Social Security system is supposedly ''gender neutral,'' issues such as income levels, years out of the workforce, and marital status all impact a woman's retirement security.

At the forefront of the issue is the fact that women tend to outlive men, just as they have been doing for the past 500 years. With today's retirees beginning to collect benefits at age 65, it is not unlikely for a woman to spend nearly one-fourth of her life on Social Security.

And because women statistically receive lower benefits than men, typically have fewer saving, and are less likely to have a pension, it means they are forced to live longer on less.

We are finding that a retirement security system that was termed a success in the past threatens future female retirees the most.

Over the past few decades, women have made great progress in the workplace.

Today, there are more women working at higher-paying jobs. But according to the General Accounting Office, the labor force participation rate for women aged 25 to 34 remains at 75 percent, and only four-fifths that of men.

Further complicating the issue is that when women do work, 25 percent work part-time. There are a variety of reasons for this, including the fact that women are more likely to take time off for family reasons.

However, it leads to fewer opportunities for benefit coverage—including pensions—and lower earnings, and ultimately, less reserve money to save for themselves and their future.

Today, the average female retiree earns approximately $621 per month, compared to her male counterpart at $810 per month.

The formula used to calculate benefits for women, as well as men, assumes the highest 35 years of earnings. Today, nearly 75 percent of women earn $25,000 or less. For those years an individual is out of work—for instance, taking time off to raise a family or care for an ailing loved one—the salary is counted as ''zero.''

In addition, any length of time less than 35 years of working count as ''zero'' earnings. As a result, the median number of years with ''zero'' earnings for workers turning 62 in 1993 was 15 years for women, compared to only 4 years for men.

This means nearly half the years being considered in the benefit formula for women are counted as ''zero'' earnings years and the average salary for earning years is $25,000 or less.

Currently, there are some advocating the benefits formula be raised to 38 years.

While the number of working women continues to grow, the Social Security Administration's own projections reveal that only 30 percent of female retirees in 2020 will have 38 years of earnings—compared to about 60 percent of their male counterparts.

This is extremely detrimental to unmarried women who either divorced before 10 years of marriage or never married, because their benefit calculations are exclusively dependent upon their own earnings calculations.

And currently, the poverty rate for elderly divorced, separated, or never-married women is the highest of any group—nearly 30 percent.

But marriage in and of itself doesn't always improve a woman's situation.

In fact, 64 percent of all elderly women living in poverty are widows. This is because when a spouse dies, the widow's benefits are reduced by up to one-half. Meanwhile, statistics show that to live alone, a widow requires at least 75 percent of what it costs as a couple.

Furthermore, if a widow has yet to reach age 65 when a spouse dies, and has no dependent children, she is not entitled to any survivor benefits. Thus, without private savings, the benefit reduction leaves most widows financially unprepared for retirement.

Let me share with you the real story of two women. Susan of Colorado made an annual income of $20,000, and she paid the 12.4 percent payroll tax into the Social Security system from each of her paychecks while raising kids, sending them to schools, and seeing them married.

But when Susan died at age 64, she left nothing from Social Security for her children.

Joan of New York, a 46-year-old homemaker, never worked outside the home after being married, and instead chose to raise her children.

Her husband was self-employed, and paid a 15.3 percent payroll tax into the Social Security and Medicare programs. When Joan's husband died of a heart attack at age 49, all she received from Social Security was $200 for his funeral.

Since she has no skills to help her find a job, no savings, and gets no help from Social Security despite the thousands and thousands of dollars her family poured into the system, Joan is now helpless and suffering from depression.

I then ask if the system is so harmful to women, why are there so many out there arguing against change? How can we sit back and hold women hostage to a program for nostalgia's sake?

I would argue we cannot, and it is our job to ensure that every woman has an opportunity to live out her golden years in financial security. And I agree we must dispel the ''myths'' that threaten efforts to improve women's retirement security.

One fact-based ''myth'' is that because women may feel less confident about their retirement security, we will be unable to change it for the better.

First and foremost, it is critical to ensure that current and future beneficiaries remain unaffected by any change to the Social Security program if they choose to stay with the traditional system. We made a covenant with our older Americans and have a responsibility to protect them from any uncertainty during the transition from a pay-as-you-go system to a future funded one.

But we also have a responsibility to future beneficiaries to clearly notify them that without dramatic change to the system, they will not receive adequate benefits from Social Security.

They are more likely to see reductions in alternative means of savings as a result of the economic impact of the system going bankrupt. Because women are living longer than men, they are most likely to experience the hardship longer.

As Members of Congress, we owe it to women to preserve and improve their retirement security.

The next fact-based ''myth'' is that because women are less likely to take financial risks, their earnings may be less than their male counterparts under a market-based system.

It is true, statistically, that women have historically invested more conservatively than men. Furthermore, women may have less invested in outside accounts than men.

But it is interesting to note that according to the National Association of Investors Corporation, all-women investment clubs earn higher returns than all-men clubs do. Who says women cannot make financial decisions?

Even under the most conservative investment strategies, such as super-safe U.S. Treasury Bonds, women fare better than they would under the current system.

According to a recent Cato Institute study, if women retiring in 1981 were provided the opportunity to invest their savings in personal retirement accounts with earnings sharing, the average single woman could expect to receive 57.9 percent more in retirement benefits and the average female divorcee could expect 67.2 percent more.

The average widow could expect 96.5 percent more, nearly double the benefits than under Social Security. The average wife could expect to receive 207.5 percent more than under the existing Social Security program.

While the National Center for Women and Retirement Research has found women may feel less confident about making financial decisions, there is no reason to believe women lack the skills to understand the challenges and long-term benefits of investments. Pension experts agree that education is a critical factor in helping individuals make better investment choices, and the GAO has found evidence that investor education can help to alleviate the problem.

So even though some advocates of the status quo argue men may fare ''better'' than women under a market-based system, I believe they are missing the point that both would fare better than they do under the current system. It appears as though some would prefer ''equality'' in misery than the potential for some ''inequality'' at a much higher standard of living for all. Furthermore, there is nothing to show that women retirees could not fare better than men, even though, statistically, they are not doing so now under the current system.

One of the most troubling fact-based myths is that the current system protects women from running out of benefits before they die more than a personal retirement account would. The premise is that since women live longer than men do, they will need benefits longer. Under the current system, retirees are promised benefits until death, even though on average, they exhaust their contributions within the first five years of retirement. In a system of personal retirement accounts, benefits would be based upon one's own contributions, the age at which one retires, and the performance of their account.

It is true that women, again, tend to outlive men. And yes, it is true that an independent study found women are more likely than men to spend a lump sum distribution from a defined contribution plan. However, that should not imply that women could not be trusted with a private savings account. In fact, that same study showed women are equally as likely as men to rollover lump sums from a defined benefit plan into an IRA, or to save and invest the money. We must also remember these studies are based upon the current situation, where these men and women anticipate uninterrupted benefits from Social Security.

In the future, however, if the current system remains unchanged, a maximum of 75 percent of the current benefit level will be available to retirees. In other words, future retirees could expect to lose 25 percent of retirement benefits. Once the IOU's that now make up the Social Security trust fund begin being cashed in, the economy will suffer, employment rates may suffer, taxes may need to be raised, and the ability for an individual to prepare for the reduction in Social Security benefits will be significantly reduced.

Mr. President, I would say to those arguing for the status quo that urging women to hold out for some future promise of benefits that are not likely to be there is folly. And in fact, holding out will likely leave women increasingly dependent upon their benefits at the same time those benefits are being reduced.

But as I mentioned earlier, women are not the only individuals being misled by some in the debate. Race continues to be an important factor in determining the retirement security for some Americans. Retirement studies similar to those that focus on women have looked at minority workers, and I would like to briefly touch on the Hispanic and African-American populations.

By all accounts, the Hispanic population is relatively youthful. However,

as the Social Security system approaches insolvency and the rate of return on these workers' investments declines, Hispanics will be forced to bear a disproportionate share of that growing financial burden. The Census Bureau estimates that by the year 2050, Hispanics will make up nearly 25 percent of the work force, compared with only 11 percent last year. This will come at the same time tax rates, if the system stays the same, will need to be increased to cover the bankrupt trust fund. Some have estimated that the tax rate increase would have to be nearly 40 percent by then to cover benefit expenses—40 percent first for Social Security expenses. Such a tax burden promises to severely hamper the ability of young Hispanics to save for themselves.

But what do all those numbers mean? The Heritage Foundation did a model of a Hispanic community. They assumed 50,000 people lived there—all families of four made up of dual- income 30-year olds with two kids. By forcing these families to throw their payroll taxes into the Social Security system, the analysts estimated the community, as a whole, lost $12.8 billion in 1997 dollars over what it could have earned had they invested in a conservative portfolio. This small minority community, in effect, lost nearly half—this is just this small community—lost nearly half what the federal government spends on food stamps or education for this entire Nation!

But if an Hispanic couple from that community were able to take the dollars they would be required to pay into the current Social Security system and instead invest them in a portfolio, the outcome would have been remarkably different. Under the current system, the couple could expect about $420,000 in exchange for a lifetime of contributions. But with a conservative portfolio comprised of 50 percent U.S. Treasury Bonds and 50 percent blue chip equities, that same couple could nearly double their benefit to $767,000 in today's dollars. Treasury Bonds alone would yield over $100,000 more in benefits. That means this family would have enough to convert their benefit to an annuity paying out exactly what Social Security promised and still have more than $200,000 left over for any expenses —long-term health care or even just passing along to their children—something impossible under today's Social Security system.

The findings within the African-American community are similarly stunning. Like single Hispanic males, single African-American males have a lower life expectancy and are especially disadvantaged by the current Social Security system. Although the system aims to transfer funds to low-income individuals, these minorities are particularly hard hit.

According to the Heritage Foundation, a low-income, African-American male born after 1959 can expect to receive less than 88 cents back on every dollar he contributes to the Social Security trust fund. This translates into a lifetime cash loss of some $13,377—a loss these individuals can hardly afford Not a gain on their investment, but an actual loss on their investment. If we allowed that same male to invest his Social Security taxes in T-bonds, he would receive a post-tax increase in his lifetime income of nearly $80,000.

African-American women are similarly disadvantaged by the current system. Enabling a 21-year-old single mother to invest her payroll taxes into low-risk/low-yield government bonds, rather than the Social Security system, would more than double her rate of return. That means this woman could expect to get back $93,000 more, after taxes, than she would under the current system. And with a little risk, the numbers could even more than double.

Mr. President, many solutions have been proposed to stave off the impending Social Security trust fund crisis: raising retirement ages, increasing payroll taxes, decreasing benefits—the list goes on. But we cannot forget that those choices will only exacerbate a problem that is already becoming progressively worse. Such proposals put at greatest risk those the system was aimed to help the most.

When our Founding Fathers created this great Nation, they declared each American had the right to life, liberty, and the pursuit of happiness. If we continue on our present track with the current Social Security system, we are truly undermining those principles. Sentencing women and minorities to a retirement life of poverty is unfair. The threat of raising payroll taxes by nearly 40 percent to fund a bankrupt retirement system threatens to steal away our children's liberty. And turning our backs on the reforms we have the power to undertake—reforms that will truly revive our ailing system—steals away every American's right to pursue happiness. Mr. President, rather than scaring women and minorities away from the options we have before us, let us give them the freedom that comes with personal retirement choices, the peace of mind that retirement security provides, and the ability to lead a better life in retirement than the one they are being promised today.

CREDIT UNION MEMBERSHIP ACCESS ACT

Mr. GRAMS. Mr. President, I want to talk a little bit, as I mentioned earlier, on an amendment offered by Senator SHELBY dealing with the CRA.

I take a few moments today to rise in support of the amendment offered by the Senator from Alabama and urge my colleagues to support it as well.

Senator SHELBY's leadership on this issue is well-established and he should be commended for his perseverance, even in the face of fierce opposition by some of his colleagues and the Clinton administration.

Mr. President, this amendment is a simple and appropriate step to removing an inappropriate and unnecessary burden from our Nation's small banks and thrifts. The amendment exempts small banks and thrifts, under $250 million in assets, from the grasp of the Community Reinvestment Act, or CRA.

I am sure that some of my colleagues may come to the floor and argue that the Federal banking regulators have taken steps to remove the burdens from banks, and thus, this amendment is unnecessary. Although I commend the regulators for easing the burden of CRA, this contention does justify the appropriateness of the underlying arguement that government-mandated credit allocation is inappropriate. As we have seen most recently in Asia, when the government mandates that the private markets allocate their resources in set ways—capital in this case—the results can be disasterous.

I think there are three arguments which must be considered regarding Senator SHELBY's amendment.

The first is, What was the justification for enactment of CRA in the first place? The Community Reinvestment Act was enacted in 1977 in response to rumors of redlining in the banking industry. The debate at that time shows that supporters felt there were three factors justifying enactment, and they are: first, that banks enjoy a semi-exclusive franchise—due in part to interstate banking restrictions and activity restrictions on competitors such as thrifts and credit unions; two, that the government limits competition within the banking sector by limiting interstate banking and limiting the acitivities of competitors such as credit unions and thrifts; and, third, that the Government restricts the cost of money to banks through interest rate caps on savings accounts and a prohibition on paying interest on demand deposits. If these three points, as the record shows, truly were the justification for imposing CRA on banks, the authors would certainly have to reconsider their action in light of the current environment facing banks.

Banks no longer enjoy the limited competition they did in 1977. The Reigel-Neal Interstate Banking and Branching Efficiency Act of 1994 opened the doors to interstate banking, thus providing competition not only among banks within a state but with banks across the country as well. Also, the bill we are considering today will throw open the doors of competition to another set of competitors—credit unions—which will be able to add any group of individuals they choose, limited only by its size. Also, these two examples I have just explained do not take into account all of the non-bank financial services which have evolved and expanded since 1977—including money market accounts, mutual funds, and deposit-like insurance products.

Banks also no longer enjoy protection against set costs which had been

imposed through interest rate controls. The 1980 Depository Institutions Deregulation and Monetary Control Act of 1980 appropriately removed these price controls which inhibited competition.

The second argument which must be considered when we discuss the Shelby amendment is the claim that the amendment will exempt 88% of the banks from coverage under the CRA. Although this percentage seems staggering—and may sway someone who feels that CRA is okay in some instances—a closer look reveals that opponents of the amendment are using sleight of hand to give the impression that this amendment will have a deeper impact than it truly will. Although it may be true that 88% of banks are exempted, in terms of the number that really counts—that is, assets—the impact that this exemption will have is overstated. That is because less than 12% of bank assets are exempted.

The approximately 8,100 banks exempted have $593 billion in assets, but that accounts for only 11.7% of bank assets in this country. These assets are only one-half-of-one percent, or $3 billion, more than the combined assets of the soon-to-be-completed Bank of America—NationsBank merger. In other words, one bank in the country will soon have close to the same number of assets as the 8,100 banks which would be exempted under this amendment. When you realize that the overall impact of this amendment on the CRA is so small, you must question why it is being contested with such vigor.

The third contention which must be contemplated in considering this amendment is whether it will have a negative impact on preventing discrimination. To listen to the critics of the amendment, one would believe that the amendment gives banks a ''get out of jail free'' card when it comes to discrimination.

However, you must understand that this amendment in no way restricts the enforcement of the Fair Housing Act, the Equal Credit Opportunity Act, or the Home Mortgage Disclosure Act. These acts, designed to prevent discrimination, will remain unfettered in detering inappropriate practices of financial institutions. The amendment in no way weakens laws designed to protect individuals; instead, it removes the inappropriate policy of dictating where banks must operate.

Mr. President, I realize that some in the credit union movement are concerned that adoption of the Shelby amendment may endanger swift enactment of this legislation. However, after contemplating the points raised, I do not understand how the President could consider vetoing a bill based on this appropriate and narrow relief and I do not understand how any of my colleagues can argue the doom and gloom scenarios they are painting about this amendment.

So, again, Senator SHELBY should be commended for his leadership and his amendment should be adopted, insisted on in conference, and signed into law by the President.

GOVERNMENT SHUTDOWN PREVENTION ACT

Mr. GRAMS. Mr. President, I rise today to express my deep disappointment and frustration about the Senate's inaction to consider and pass the Government Shutdown Act.

Mr. President, this week I sought to offer S. 547, the Government Shutdown Prevention Act, as an amendment to the Legislative Branch Appropriations. This amendment, originally sponsored by Senator MCCAIN, would create an automatic procedure for a CR at the end of each fiscal year. The essence of the amendment is that we cannot and will not allow a Government shutdown, we will not allow disruption of the services we rely on from the Government, and we will simplify and facilitate the process of passing a continuing resolution.

What issue is more relevant to the legislative branch than acting responsibly to keep the Government in business? This amendment would have ended the annual battle we have each year on what is included in a CR and at what level of spending. It would end the last-minute mischief of adding new pork and new spending into a CR because everybody wants to avoid a shutdown. So you are blackmailed into doing something you do not want to do.

Unfortunately, I was unable to offer this amendment due to germaneness concerns and lack of leadership support.

In May of 1997, during the debate on the Supplemental Appropriation bill—this was covering the flood disasters that occurred in Minnesota and the Dakotas of that year, and others around the country—Senators MCCAIN and HUTCHISON offered this amendment, but later withdrew it based on a commitment made by both Senate majority and minority leaders that the Government Shutdown Prevention Act would be allowed to be considered as a separate measure in the near future. The leaders specifically promised a full debate on the legislation with one relevant amendment for each leader.

Mr. President, I would remind my colleagues of the word of the Minority Leader at a news conference he held back on June 11, 1997. I am quoting here from a transcript of the news conference:

> Senator ROD GRAMS sent a letter to all leadership yesterday which offers a very simple, yet I think extraordinarily acceptable solution: strip out the legislation that is the source of the controversy.

So back again to why the President vetoed the emergency supplemental, it was because of this very part.

The minority leader went on to say:

> Have an up or down vote on the census, have an up or down vote on the CR, have an up or down vote on the disaster bill. I cannot think of anything more simple than that. I think it is the right thing to do. I have indicated to Senator LOTT this morning that I think it is the right thing to do.

In a news conference the following day, the Minority Leader repeated his support again:

> We would be willing to set a time certain for each of the pieces of legislation, very short time limits for debate ended. I think it is an excellent proposal, and I am hopeful that that is ultimately what we agree to.

Mr. President, that was indeed what we ultimately agreed to.

It has been over a year now since that debate ended. The Senate never had an opportunity to consider this as a separate measure, so I have chosen to again raise this as a non-controversial measure that will force the Congress to act responsibly to avoid a government shutdown, and also for those who made those promises to live up to their word.

During last year's debate, some of my colleagues argued that since a budget agreement was reached between the White House and Congress, there was no need for this amendment anymore. I argued at the time that the budget agreement made the amendment even more crucial for a responsible government. And here we are again, with just a few weeks left in this session to consider 10 appropriations bills and all 13 conference reports.

My major concerns were, and still are, that the many economic assumptions and spending priorities within the budget agreement make our budget and appropriation process uncertain. The current budget disagreements have again clearly proved my point.

Mr. President, as you know, during this year's budget debate, some members are calling for more spending for their favorite programs. Others, like myself, prefer larger tax cuts and larger spending reductions. As a result, the House and the Senate have approved a budget resolution with significantly different tax and spending priorities. Those differences have prevented us from completing the budget resolution conference report, which is long overdue in accordance with our budgetary rules. It is possible that Congress may not be able to produce a budget this year at all, or finish the regular appropriations legislation before the fiscal year ends on September 30 of 1998.

What would this mean, Mr. President? This means the American people will have once again been held hostage to a government shutdown simply because Congress and the White House, or the House and the Senate, do not agree on tax cuts and spending priorities, or seek to slow down the appropriations process by offering controversial or non-germane amendments.

In 1995, we witnessed the longest federal government shutdown in history, which caused financial damages and inconvenience to millions of Americans simply because of disagreements between the Congress and the President in our budget process.

That was a very costly shutdown. The shutdown disrupted the lives of

hundreds of thousands of Americans. Some retirees and veterans could not promptly receive their social services, such as Medicare benefits. Families could not obtain passports, or visit national parks and museums. Millions of dollars were lost to small business owners and local communities. Federal employees were furloughed with a fear of not getting paid, although they were—at again, a loss to the taxpayer. Even our troops stationed overseas were affected by the shutdown. The interruption caused immeasurable financial damage to the American people and to this country, bottom line.

The most serious damage done by the 27-day shutdown was that it shook the American people's confidence in their government and in their elected officials. Even today, we have not yet undone this damage. We need to restore the public's faith in its leaders by showing that we have learned from our mistakes. Passage of this good-government contingency plan will send a clear message to the American people that we will no longer allow them to be held hostage in budget disputes between Congress and the White House or among ourselves.

We all have different philosophies and policies on budget priorities, and of course we will not always agree. But there are essential functions and services of the federal government we must continue regardless of our differences in budget priorities.

More often, without a good-government contingency plan, the continuing resolution has become impossible as we argue over funding levels and whether pork project ''A'' or pork project ''B'' deserves our support. Debate on program funding is not based on merits but on political leverage. As a result, billions of the taxpayers' hard-earned dollars are wasted in this process.

The virtue of this amendment is that it would allow us to debate issues about our spending policy and the merits of budget priorities while we continue to keep essential government functions operating. The American people will no longer be held hostage to a government shutdown. So, as I said earlier, there are still plenty of uncertainties involved in our budget and appropriations process, particularly this year. If we continue on our current course and the government again shuts down as it did three years ago, it will be another devastating blow to the American people, from senior citizens to disaster victims.

We must ensure that a good-government contingency plan is in place to keep the government up and running in the event that a budget agreement is not reached.

Mr. President, this good-government contingency plan is sound policy, I believe it is wise policy, and it is responsible policy. With a dwindling number of legislative days left in this Congress, I strongly believe that it is vitally important to immediately consider and pass this overdue measure to end the annual shutdown battle we face every year. This should be non-controversial legislation we can all support. I therefore strongly urge the Senate leadership to bring this legislation up for a full debate and vote as earlier agreed.

Is there any time remaining?

The PRESIDING OFFICER. The Senator has 7 minutes and 19 seconds remaining.

Mr. GRAMS. Mr. President, I yield back my remaining time, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

The distinguished Senator from Tennessee is recognized.

PATIENTS' BILL OF RIGHTS

Mr. FRIST. Mr. President, I rise today to speak on the Patients' Bill of Rights, a bill that was introduced last week by my colleague from Oklahoma, Senator DON NICKLES, and members of the Senate Republican Task Force on Health Care Quality, our distinguished majority leader, TRENT LOTT, with a total of 47 cosponsors.

I am really quite pleased with this particular bill. I have had the opportunity to work on the task force because it is a product of months and months of very thoughtful discussion, vigorous debate among ourselves. I think, as most people know, on the task force were some of our most conservative members and some of our most moderate members within our caucus. It really is a consensus proposal to improve health care quality. As a practicing physician, I am absolutely convinced that health care is delivered best when that relationship between the doctor and the patient is given the very highest priority. My goal in this debate, the debate that we will have over the coming weeks, is to do everything possible to empower patients and doctors to be that focal point, to be that place where ultimately the quality of care is decided.

Much of the debate will center around who is practicing medicine today. Is it bureaucrats in Washington? Is it bureaucrats in health maintenance organizations? Is it bureaucrats in the U.S. Congress? Ultimately, I think that we can address this issue, if in coming together in a bipartisan way with a reasonable, timely voice, with a reasonable thought, come back to that central premise that the doctor and the patient or the nurse and the patient, at the level where that really very intimate interaction is carried out, where one's problems are professed and treatment plans and diagnoses are generated, if we keep coming back to that as being the central focus of the Patients' Bill of Rights in everything that we do over the next several weeks, we will be doing a great service to the public, to all Americans.

Now, our proposal that has been put forth is grounded on a Patients' Bill of Rights. It offers a number of protections for individuals, for patients, for potential patients, and that is No. 1, by guaranteeing full access to information as to what is in one's health plan.

If you ask your typical Tennessean or American, you say, what really does your plan cover and what does it not cover, most of us, including me, throw up our hands and say, ''I don't know.'' If you, going back to my own field, develop a cardiomyopathy and a sick heart, it deteriorates over time and you need a heart transplant, does your plan, I could ask any of my colleagues, cover heart transplants? And they will probably say, ''I don't know. I understand it is very expensive. I also understand it could save my life. But I don't know the answer to that question.''

We need to guarantee full access to everybody. Whether it is a health maintenance organization, a managed care plan, any type of plan, we need to guarantee that patient full access to that information. We do that in our bill.

Secondly, we do need to make sure that patients receive the necessary emergency care, and it really does boil down to the fact that if a so-called prudent lay person, meaning somebody with average intelligence, common sense, develops chest pain, they don't know whether it is indigestion or a massive heart attack. They go to the emergency room. They should be able to walk into that emergency room and be taken care of without fear that coverage will be denied for that particular service. We address that right up front. We allow patients to keep their doctor during a pregnancy or extended illness even if their doctor for some reason leaves a plan or is terminated from a plan, so-called continuity of care. We allow individual patients direct access to that pediatrician without having to go through a gatekeeper or to that obstetrician or gynecologist without having to go through a gatekeeper first.

The great fear I think that all of us in America have today, and I think it is the fear that, again, drives much of the debate, is that our health plan will not be there for us if we get sick. If my young 11-year-old son develops a heart murmur, a virus, will there be somebody there to help him? Will that health plan respond to those needs? Or will my HMO deny me seeing the doctor who I feel is the very best person to take care of my son, who I know and people have told me is a better doctor. Will I be denied the opportunity to see that doctor by my health plan?

Many people fear that they will be denied the benefits they have even paid for and that they have been promised. Others are absolutely convinced today that their health plan cares much more about cost, cares much more about profits, cares much more about the

bottom line than about quality. And that is because of the focus on cost and saving money.

We in this body talk about how we have to slow the cost of health care, we have to reduce health expenditures because of all of those pressures. HMOs have been allowed to go too far. They have not been held accountable. Our bill takes that focus and puts it right on quality, on quality. I say that because you can list 10 rights, and you can list 400 mandates, and you can say we have licked the problem. Unless you come back to focusing on quality, you have made yourself feel good. We have responded to the public sentiment of let's bash the HMOs, but you have done nothing for that next generation, nothing for the overall health care system unless you come back to those two principles: The doctor-patient, the primacy of that doctor-patient interaction, No. 1, and, No. 2, focus on quality.

Therefore, you will see in the bills that are before us—and there are basically two bills, one from each side of the aisle, although I hope that both sides will end up to some degree through debate coming to a bipartisan agreement, but the bills are very different, and I think that is where the debate is going to have to play out because every day you are exposed on this floor and through press conferences to ''Let's kill the HMOs, capture that sentiment, put these mandates on the people and we fix the system.''

What we have to do as a body is figure out really how to fix the system with the help of the American people, recognize that our health care system is changing and changing dynamically, and what we define as quality is changing dynamically. And thus whatever we do we cannot establish a system through well-intended mandates which rigidify this system and destroy the dynamism that is inherent in the public marketplace, in the private marketplace, in private industry, in Government-run programs today which recognize that quality is a new science, it is an evolving science, it is dynamic, it is energetic, everyday breakthroughs are made on how we determine quality. So let's be very careful and make sure that we, through well-intended mandates, don't come and box in this dynamism which is so important to the future of health care delivery.

Our bill focuses on quality. Now, any physician today—and I am a physician. I have worked with managed care before coming to the Senate—any physician will tell you that managed care—and we use the word ''HMOs'' and everybody needs to recognize that managed care is a broad spectrum of entities. But a physician will tell you, anybody who has worked with an HMO, HMOs have gone too far. Not all of them. HMOs too often control the whole issue of what service is covered and what is not, regardless of what that physician may feel is in the best interest of the patient. And that same physician will very quickly tell you that what coverage you are allowed to give that patient ultimately defines the care and the outcome of that patient.

Therefore, I don't blame my fellow physicians coming forward and saying, listen, I am being held accountable for decisions that I am not even allowed to make, whether it is coverage or admission to a hospital or the number of days in a hospital. I am not making that decision, yet I am held accountable.

Well, our bill hits this inequity head on. Basically, it says it is not fair. That is inequitable. You, physician, you should not be held accountable. The HMO should be held accountable.

We need to fix the system. The critical measure of this bill that we have put forward is to hold the health plans accountable for the coverage decisions they make and to take the whole essence and the power of denial of care out of the hands of the HMOs and place it in the hands of the way we fix the system—a strong appeals process internally and a strong external appeals process where decisions can be made by medical experts—yes, physicians—medical experts independent of the plan.

Our bill requires that health plans make coverage determinations rapidly, quickly, not weeks later or months later or years later. We put some time specifically, actually in the bill; we say it must be made sometime but definitely not later than 72 hours after the request. We want to protect patients, before harm occurs, by setting up a process that is not present in many—I don't know whether to say most or not—but it is simply not present in many of the HMOs today. But it is a process for patients and their families to get an immediate answer over what is covered and what is not covered and, if there is a disagreement, resolution right then and there, not a year later or 5 years later or 2 years later, after whatever potential for harm may occur.

Furthermore, we require health plans to provide quick internal grievance, as well as these independent, external, appeals processes in areas where there might be some question, like: Is a particular procedure or use of a device investigational or experimental? The whole point is, we need to hold the plans accountable. And we do it by fixing the system.

Our bill provides protections for patients who rely on health plans that States do not. This will be another issue, but our bill basically says that there are a group of people who are unprotected today. Yes, the purpose of our bill, and where we see the Federal responsibility as being, is to protect the unprotected, the people who, by law, are not being protected by an entity. That is the group that we focus on. We fix the system where it is broken, without this whole issue—which has really captured the attention of the press and really taken focus away from the quality issue, which is the really important issue—this issue about lining the pockets of trial lawyers in the process of the bills that are discussed today.

We do demand that all 125 million Americans have this strong internal appeals process, grievance process, as well as external appeals process. We want the questions answered up front, when it really matters, and not years later by a trial lawyer.

Our bill guarantees patients the right to access their own medical information. It gives them the right to make modifications and to amend their medical information if they find something that is incorrect. In addition, we require health plans to inform you of the plan's practices with regard to confidentiality of medical information, with regard to privacy of your medical record. We require health plans to establish safeguards to protect that confidentiality, to protect that privacy, to protect that security of your health information.

As you can tell, I just believe the heart of the problem that we have today with HMOs is that they focus too much on cost, on the bottom line, without anybody coming in and demanding that they look at quality—quality. Our bill, more than any other bill, focuses on this issue of quality.

Some believe that quality can be legislated today. It is a subtle issue, but it is a point that I have a real obligation to make because I have been so intimately involved. That is, the science of quality and understanding what quality is today in health care is a relatively young science. It is a science that is maybe 10 years old. I think you can crystallize that by asking yourself, What is quality today? How did I choose my doctor? Did I choose my doctor because I knew that he was a better doctor than the doctor across town? If you feel your doctor is pretty good, step back and ask yourself, Do I really know he is a good doctor? Or is he just a nice guy? Does he just answer the telephone when I call? What are the standards that we, as a society, have to compare one doctor to another doctor? We are entrusting our lives to them for a heart transplant or heart surgery. How do we judge them? The information is not there. The answer is: We don't have the answer.

Therefore, we as a body have to be very careful before we come in and mandate what quality is, because we don't know what quality is. We are learning about it, but it is an evolving science. It is something we are learning about on an ongoing basis. It is important because one approach mandates quality, the other says let's support and figure out what quality is. That is the Federal responsibility: Let's pull together the private entities, the public entities; let's take advantage of state-of-the-art information systems; let's coordinate this information and determine what quality is and then disseminate that information out so we

can educate people broadly so they can answer that very basic question, ''Do I have a good doctor or do I not have a good doctor?'' Or, ''Is that plan a good plan for me and that one a bad plan for me?''

Mandating data collection: Right now, there are plans being proposed on both sides in the House and Senate that just say let's collect more data, let's have all information from a health plan—demographics and age and gender and outcome and results and patient satisfaction surveys—let's just collect all that data and send it to the Secretary of Health and Human Services. It sounds pretty good, if we knew what it meant, if it didn't mean that a doctor is going to have to sit down and talk to a patient and then go take a piece of paper and fill out a 20-point questionnaire and then give it to a bureaucrat, whom he has had to go out and hire to sit in his office to compile it for a health care plan that has another whole system, to send it to the Secretary of Health and Human Services, who gets this data from millions and millions of doctor-patient interactions. And what are we going to do with it? Let's invest in the science of figuring out what we do with it before we mandate the collection.

Our legislation promotes quality improvement by supporting research, to give patients and physicians better and more useful information to judge quality. Our Patients' Bill of Rights establishes an agency. We call it the Agency for Health Care Quality Research, AHQR. I hate to use those initials, but by the time this debate is finished, I hope everybody in America knows what AHQR is. Its purpose is to foster overall improvement in health care quality through supporting pertinent health sciences research, then disseminating that information through public and private partnerships—pretty simple, pretty straightforward. I believe it is the fundamental problem we have today with managed care, with HMOs, with focusing on dollars, with focusing on the bottom line, because nobody is focusing on quality.

Some of my colleagues will come forward and say, ''You mean as a Republican you want to create a whole new Federal bureaucracy and agency?'' The answer is no. We don't do it very well, I think, in Washington. But when we go in one direction, I think it is important to build on the past, and we have done just that. The agency that we propose is built on the platform of a current agency which I feel is doing a very good job. But we take that agency, called the Agency for Health Care Policy and Research, we refocus the agency on quality, because quality is the issue today. It may have been ''cost'' 5 years ago, but it is ''quality'' today. Then we enhance that agency to become the hub and the driving force of all of the many quality efforts that are going on in Federal programs today.

There are many different agencies all across this country, Federal agencies, that do focus on health care. They all have—not all of them, but many of them have programs and a little subdivision devoted to quality. Our Agency for Health Care Quality Research will help coordinate all of those many very positive efforts. We will focus on not just HMO quality, where so much of the debate and anger is, but we will focus on quality on the managed care setting, the urban setting, the rural setting, the setting of the solo private practitioner. This agency will have, as its mission, improving quality, and the disseminating of that information to everybody in health care today.

Thus, if we agree that this fundamental issue on our debate is that HMOs have, to some extent—I don't want to sort of categorize them because I don't think that is fair—but if the debate is that HMOs have ignored quality because of an almost obsession with cost, then let's hit the problem; let's go after how we, as a nation, can improve quality and what is our Federal responsibility. If we are talking about a Patients' Bill of Rights, the ones that we have in our bill are very, very important. But I think the most basic right for a patient is that right to quality health care. That is what our bill, like no other bill, addresses.

This particular agency has a role that is not to mandate. It is not to mandate a national definition of ''quality,'' but, rather, it is to support the science that is necessary to provide information to patients so they will know whether or not they are receiving good quality of care, to provide information to physicians so they can compare what they are doing to the next physician and modify their behavior, so they will know what good quality is and modify their behavior so they can deliver better care to all of their patients, information to enable employers and individuals to become wise purchasers or wise shoppers of health care based not on cost, or not on cost alone, but on cost and quality.

The agency will stimulate public-private partnerships to advance and share what we learn about quality. Quality just means different things to different people. It is constantly being refined. As I said, it is just a few years old as a science; therefore, in collaboration with the private sector, the agency will conduct and will coordinate health science research that really will accelerate our understanding of what quality means to clinicians and to patients, how to measure that quality and how to use this information to improve your own health and your own quality of life.

This agency will have as a major purpose and objective the sharing of this information. We have medical advances that are made daily. We see them in the newspaper; we see them on the news each night when we go home. In truth, many of these discoveries do not make it out into the general practice of medicine for too long. We need to do a better job in narrowing the gap between what we know and what we do, and this agency will accomplish that.

We need to get the science that we know is good science quicker to the American people by sharing this information among public entities and private entities, and this effective dissemination will be a major purpose of the agency.

In addition, the agency will develop evidence rating systems to know what a good doctor is, what a good plan is, whether or not the treatment that has been recommended for your diabetes is an effective treatment.

This agency will play a vital role in facilitating innovative inpatient care in this whole area of new technologies and assessment of new technologies. As chairman of the Science, Technology, and Space Subcommittee of the Commerce Committee and the Public Health and Safety Subcommittee of the Labor Committee, we held hearings and people came before us again and again about new technologies and the confusing methodologies that our Federal Government has set up, that each agency has set up, hoops through which they need to travel before that new technology is disseminated or shared with the American people.

The agency that we are setting up will establish a consistent methodology with coordination across Federal agencies so that people will know what guidelines they must follow in a consistent way to have technologies evaluated and then appropriately disseminated.

In its mission to promote and facilitate quality and quality development, this particular agency will have a focus on improved information-based computer systems which are so necessary for quality scoring and which will facilitate informed decisionmaking by providers, by physicians, by nurses, and by patients. The agency will aggressively support the development of these state-of-the-art information systems for health care quality which then can be shared both by the public and the private sector. The setting is important. Again, as I mentioned previously, so much of the discussion today, as we talk about bills of rights, is focused just on health maintenance organizations.

I think it is important for our colleagues to realize that our bill goes beyond just health maintenance organizations and looks at quality in all different settings. Quality improvement applies to the care that is given in that solo private practitioner's office in the managed care setting or at the health maintenance organization. This agency will understand that part of its mission will be to specifically address quality in rural areas in underserved areas, using such technologies as telemedicine and other long-distance-type technologies.

Our bill addresses the fact that patients do want to know if they are receiving good care, but compared to what? Statistically accurate, sample-

based national surveys will efficiently provide reliable and affordable data without the other approach, which is excessively mandated, overly intrusive, potentially destructive mandatory reporting requirements, which as I have described previously, in the long run take away time from that doctor-patient interaction.

You simply do not need to have a doctor, after every patient interaction, fill out a questionnaire at every visit and then send that information to Washington. It can be a waste of physician time, taking time away from the patient, and will ultimately drive up what patients have to pay for the care they receive. Our approach is very different.

As I mentioned, they are sample-based national surveys. We expand the current Medical Expenditure Panel Survey to require that outcomes be measured and reported to Congress so that as a nation—as a nation—we can better determine the state of quality and the cost of quality in our Nation's health care.

The role of the Agency for Health Care Policy and Research is not to mandate national standards of clinical practice. Definitions and measures of quality, as I said, are an evolving science, a science that is critically important to our ability to make educated, informed decisions.

Another aspect of our bill that is important for our colleagues to understand is a part of the bill—because it is a very important part of the bill—is the strong focus on women's health issues. As a nation, it is time that we focus on diseases and health issues that are faced by women. In our bill we specifically emphasize women's health research and prevention activities at the National Institutes of Health and at the Centers for Disease Control and Prevention. The goal is to support the critical role that our public health agencies—the NIH and the CDC—play in providing a broad spectrum of activities to improve women's health. That includes research, screening, prevention, treatment, and education.

Among others, these provisions in women's health promote basic and clinical research for the aging process in women, for osteoporosis, for breast cancer, Paget's disease, for ovarian cancer. We expand our research efforts in the important area of cardiovascular disease. Many people—in fact, I am sure many of our colleagues—do not realize that the No. 1 killer, cause of death for U.S. women is cardiovascular disease. We need to expand our research efforts there. We do that in our bill.

Our bill reauthorizes the National Breast and Cervical Cancer Screening Program which provides crucial screening services for breast and cervical cancers to underserved women. Our bill supports data collection through the National Center for Health Statistics and National Program of Cancer Registries, which are the leading sources of national data on the health status of women. Support of these valuable programs will help ensure scientific progress in our fight against these diseases and will lessen the burden of these diseases on millions of women and their families.

Another component of our bill which is not in any bill currently before the U.S. Senate except for ours—which is not a part of the Patients' Bill of Rights in the House of Representatives—it is a part of the bill, again, which I feel demonstrates that this piece of legislation is forward thinking; it fulfills our responsibility, I believe, of looking ahead and seeing what obvious challenges there are, challenges that could potentially disrupt the delivery of health care in this country—that is our responsibility—and to respond, and to respond now, before they become potentially debilitating, have a debilitating effect on health care in this country.

This provision is one—and it is a right—it is one of the Bill of Rights, and it is a right that every woman and every man and every child should be free from the fear that an insurance plan or an HMO will discriminate against them because of a positive genetic test.

The human genome project, a 15-year, very successful project, initiated by our Federal Government, being carried out in a wonderfully unique public-private partnership, by the year 2005, we will have defined over 3 billion bits of genetic information called DNA which comprise the human genome which explains in large part our genetic makeup—3 billion bits of information defined over this very successful program.

We have learned tremendous scientific progress, but it has introduced the fact that once we link these genes to diseases and conditions—and we see it happening almost every day; there was an article in the Washington Post just yesterday about linking several genes with Alzheimer's disease and the onset or when Alzheimer's disease comes being linked to these genes.

Again, tremendous science, yet it strikes right at the heart of this fear that the information in some way will not be used to help you but will be used to hurt you, that access to that information and the result of whether or not you have that gene will be used by an HMO or an insurance company to deny you coverage, to increase your premium, to use against you that fear in not getting a test, a potentially beneficial test. If you had a test which, with 80 percent predictability, said you were going to have breast cancer, wouldn't you want to know the result of that test? I would, because it means I might get a mammogram once a year instead of once every 2 years, or I might do a breast exam once a week instead of once a month, because we know the earlier diagnosis of best cancer, earlier detection, means earlier treatment, and earlier treatment means cure instead of delay, which means, many times, it cannot be cured.

The promise of that test will be defeated unless we act, and we act today, to eliminate the fear of genetic discrimination based on genetic tests which are coming online at a rapid pace. Our ability to predict what diseases individuals may be at risk for in the future has caused grave concern that this powerful information—information that affects every one of us in the room; we all have this genetic information; we all carry it in our genes—the fear that that information might be used against you.

I am really troubled when the Tennessee Breast Cancer Coalition tells me that genetic counselors right now are facing women every day who are afraid to even have these genetic tests performed. Women are avoiding genetic testing due to concerns that they will lose their insurance coverage even though that genetic test might be saving them. We must prohibit discrimination in health insurance against healthy individuals and their families based on genetic information.

Think about it—3 billion of these little bits of information on a single human genome; we all carry genetic mutations that may place us at risk in the future for some disease, even if we are healthy today. Therefore, each of us is at potential risk for discrimination.

If I receive a genetic test that shows I am at risk for cancer, diabetes, or heart disease, should this predictive information be used against me or my family? The answer is no. That is a right. We address that right in our bill. I think it an important point because it shows our bill is forward looking, looking to the future, not a set of rigid mandates based on what we think we know about quality today, but we look to the future.

I want to commend the Senator from Maine, Senator SNOWE, whose original bill provided the framework and really the sound principles upon which this legislation is based. She has supported our task force effort and worked with us in a step-by-step way to craft this legislation. I also would like to mention Senator JEFFORDS, who had the foresight to include these provisions, since we are talking about basic rights.

Our bill very specifically prohibits health insurers from requiring collection of the results of these predictive genetic tests. It prohibits them from using that information, if they do have it, to deny coverage. And it prohibits insurers from using that information, if they do have it, to adjust rates or to increase rates.

Preventing genetic discrimination does have enormous implications that I will continue to come back to, and that is improving quality. It improves the quality of care to an individual patient. But also, if one is afraid to have the results of a genetic test released to somebody outside or participate in a large protocol, investigational protocol, that means that research overall

into what these tests mean and how they might be beneficial will be slowed down, thus affecting the quality of health care for all Americans.

Lastly, our bill enhances access and choice of health insurance coverage in a number of ways which we will debate on the floor, areas that increase access to and affordability of health care of several areas, that include provisions which I am very excited about, and that is to allow the self-employed individuals, for the first time, to fully conduct their health care expenses. It only makes sense. We have really been punishing self-employed individuals, not giving them the same tax treatment that somebody has if they are working for a large company. It doesn't make sense. What we want to do is level that playing field and allow these self-employed individuals to fully deduct their health care expenses, just like people who work for large companies. It addresses access, because it means that these self-employed individuals are more likely to go out and enter the insurance market.

Our bill provides greater flexibility to employees who use the so-called flexible spending accounts to pay for health care. Our bill gives individuals the opportunity to have control over the health care decisions and costs through medical savings accounts. Medical savings accounts allow a patient to access the physician of their choice and to choose the medical treatment that they want if they choose that option.

As you can tell, our bill contains a lot. The reason that I wanted this afternoon to outline our bill is to make sure that our colleagues spend the next several days looking very carefully at the differences between the two bills that are before us, because the approach is very, very different. Both bills are well intended. I will say that I am very hopeful that we can pass a bill, a strong Bill of Rights. But that Bill of Rights needs to include a right to quality health care for all Americans. Our approach is very, very different. The intentions, I believe, of both bills are the same.

I am hopeful that we can engage in this debate without too much in the way of rhetoric. There is a lot of rhetoric that has been thrown on the floor here and in press conferences, but I hope we can come back and say this is an important issue. It is not one, really, to play politics with. It is not one to defer to another Congress or to filibuster or to make a part of the next elections. It is the sort of issues that we, as trustees to the American people, have an obligation to address and to address in this Congress.

Our Patients' Bill of Rights offers all Americans quality improvement based on the foundation of strong science. Our Patients' Bill of Rights offers all Americans patient protection, to access the care they need from the doctor they choose. Our Patient Bill of Rights offers all Americans trust in that doctor-patient relationship, that central point through which I believe quality needs to be defined and health care delivered. We reinstate that trust. Our Patient's Bill of Rights offers all Americans access to more affordable health insurance coverage. Our bill does represent a forward-looking approach to provide for continuous improvement in health care quality, and it meets our goal of assuring that the doctor and the patient define quality—not HMOs, not bureaucrats, not trial attorneys, and not the U.S. Congress.

Mr. GORTON addressed the Chair.

The PRESIDING OFFICER. The Senator from Washington is recognized.

VETO OF COVERDELL LEGISLATION AND RELEASE OF HOUSE EDUCATION AND THE WORKFORCE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS REPORT

Mr. GORTON. Mr. President, our self-proclaimed ''Education President'' has just seen fit to veto the most significant bipartisan education legislation passed by the 105th Congress—the Education Savings and School Excellence Act. As many Americans know, this legsilation's main feature is to allow families to establish education savings accounts in which parents can invest $2,000 a year and allow that money to grow tax free. Parents can use the money to pay for school expenses including tutoring, computers, school fees and private school tuition.

Why has the President seen fit to veto this legislation? Well, he has received a great deal of pressure from those who believe that we should not increase the control parents have over the education of their children.

In addition to providing tax-free education savings accounts for families, this legislation includes provisions that would: authorize a literacy program to improve the reading skills of America's youth; allow Federal funding for education reform projects that provide same gender schools and classrooms; allow States to make awards to public schools that demonstrate a high level of academic achievement; and allow states to test teachers and provide merit pay programs.

With the recent news that 60 percent of prospective teachers in Massachuesetts taking a basic certification test were unable to pass, it is unfortunate that the President's veto will not allow States like Massachusetts to help current and prospective teachers reach their full potential, as well as reward those who perform in a superior manner. I signed a letter to the President along with 42 other senators asking that he sign the education savings account legislation and pointing out this very feature. Unfortunately, our plea fell on deaf ears.

Mr. President, I have worked diligently to fashion, over the past year a return to our parents, teachers, principals, superintendents and school board members control over the education of their children. The Federal Government has too much influence and misuses too many resources that would be better spent in classrooms across America.

As a member of the Senate Budget Committee Education Task Force, I found that no one in the Federal Government even knows exactly how many education programs are overseen by the Federal Government. Although the Department of Education annually publishes a ''Digest of Education Statistics,'' the most recent version of which is over 500 pages in length, there is no mention of how many education programs are administered by Federal agencies.

I have, however, heard testimony from the General Accounting Office about the duplication of Federal education programs. In January of this year Dr. Carlotta Joyner of the GAO appeared before the Senate Budget Committee Education Task Force and presented us with a graphic that highlights the web of Federal education programs in only three areas of education: at-risk and delinquent youth, early childhood programs, and teacher training programs. Dr. Joyner explained to us that 15 Federal departments and agencies administer 127 at-risk and delinquent youth programs, 11 Federal departments and agencies administer more than 90 early childhood programs, and 9 Federal departments and agencies administer 86 teacher training programs.

It is no wonder that more and more, States and local school districts are suffocated by a tidal wave of papers, forms and programs, each of which no doubt began with good intentions. The net result of this tidal wave, however, is precisely what makes it difficult to set priorities in each of the states and school districts across the country to determine that which will best serve their students.

As I have stated previously, the only reason I can discern that the President would veto this legislation is that he believes that schools will be improved through more control from Washington, D.C. Unlike the President, however, I believe our best hope for improving the education of our children is to put the American people in charge of their local schools.

I also believe it is appropriate at this time to give my colleagues in the Senate some good news on the education front. Last Friday, the House Education and Workforce Subcommittee on Oversight and Investigations adopted a report entitled ''Education at a Crossroads: What Works and What's Wasted in Education Today'' by a vote of 5–2. This report is a result of two-and-a-half years of work by that subcommittee and the dedication of it's chairman, Congressman HOEKSTRA. The report is more than 70 pages long and I will not touch on all the issues it discusses, but I do want to point out some of the conclusions the subcommittee reached.

The report's conclusion states in part:

. . . the central theme of what we learned is that the federal government cannot consistently and effectively replicate success stories throughout the nation in the form of federal programs. Instead, federal education dollars should support effective State and local initiatives, ensuring that neither impedes local innovation and control, nor diverts dollars from the classroom through burdensome regulations and overhead.

The report goes on to give specific steps for Congress to take to improve education in America. The report advocates increasing the ability of States and local communities to waive federal education regulations, reducing the tax burden on families, passing tax-free education savings account legislation, improving federal support for charter schools, and otherwise encouraging more parental choice in education.

I have long been an advocate of many of the suggestions outlined in this report. I hope that my colleagues in the Senate will take the time to review the report Congressman HOEKSTRA's subcommittee has prepared and consider where they stand on these issues. It is long past time for both parties in Congress to stop simply giving lip service to the idea of local control of education, and to put our money where our mouths are.

Finally, I want to remind my colleagues that although I have introduced and passed twice in the last year an amendment that would allow States and local school districts increased control over the education of their children. Because of the insistence of Democrats in the Senate, the President, and even some Members of my own party this legislation has not yet survived a conference committee. Although I have not yet been successful in passing this legislation into law to give States and local communities the relief they deserve and need to improve education in America, I will again in the near future propose legislation that moves us toward this goal. Whether through block grants or some other means, I am committed to the belief that real education reform will not take place through ''. . . guidance from above . . .'', but from parents and educators in communities across this land as they are empowered to direct the education of their children.

Mr. President, I note also present on the floor is Senator FRIST, the chairman of the Senate Budget Committee task force on education, whose work is of equal importance to that of Congressman HOEKSTRA's and whose report I also commend to the Members of this body. He is our great expert on health care, but he is also a major leader in education reform in the U.S. Senate, and we all owe him a great debt of gratitude.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Thursday, July 23, 1998, the federal debt stood at $5,537,084,024,142.92 (Five trillion, five hundred thirty-seven billion, eighty-four million, twenty-four thousand, one hundred forty-two dollars and ninety-two cents).

One year ago, July 23, 1997, the federal debt stood at $5,367,623,000,000 (Five trillion, three hundred sixty-seven billion, six hundred twenty-three million).

Five years ago, July 23, 1993, the federal debt stood at $4,342,543,000,000 (Four trillion, three hundred forty-two billion, five hundred forty-three million).

Twenty-five years ago, July 23, 1973, the federal debt stood at $455,892,000,000 (Four hundred fifty-five billion, eight hundred ninety-two million) which reflects a debt increase of more than $5 trillion—$5,081,192,024,142.92 (Five trillion, eighty-one billion, one hundred ninety-two million, twenty-four thousand, one hundred forty-two dollars and ninety-two cents) during the past 25 years.

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–6165. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule regarding measures to expedite resolution of certain common carrier formal complaint proceedings (Docket 98–154) received on July 22, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6166. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Pauls Valley, Ratliff City, and Sulphur, Oklahoma, Abilene, Bowie, Highland Village, Mt. Pleasant and Overton, Texas)'' (Docket 97–84) received on July 22, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6167. A communication from the Administrator of the Energy Information Administration, Department of Energy, transmitting, pursuant to law, the Administration's annual report for 1997; to the Committee on Energy and Natural Resources.

EC–6168. A communication from the Chairman of the Appraisal Subcommittee, Federal Financial Institutions Examination Council, transmitting, pursuant to law, the Subcommittee's annual report; to the Committee on Banking, Housing, and Urban Affairs.

EC–6169. A communication from the Secretary of Defense, transmitting, notice of military retirements; to the Committee on Armed Services.

EC–6170. A communication from the Under Secretary of Defense for Acquisition and Technology, transmitting, pursuant to law, certification that full-up live-fire test and evaluation of the Department of the Navy's CH–60 Fleet Combat Support Helicopter would be unreasonably expensive and impractical; to the Committee on Armed Services.

EC–6171. A communication from the Administrator of the Agricultural Marketing Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Limes and Avocados Grown in Florida; Relaxation of Container Dimension, Weight, and Marking Requirements'' (Docket FV98–911–2) received on July 22, 1998; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6172. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Importation of Tomatoes from France, Morocco and Western Sahara, Chile, and Spain'' (Docket 97–016–2) received on July 22, 1998; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6173. A communication from the Administrator of the Rural Housing Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Guaranteed Rural Rental Housing Program'' (RIN0575–AC14) received on July 22, 1998; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6174. A communication from the Secretary of Agriculture, transmitting, a draft of proposed legislation entitled ''The State Meat and Poultry Inspection Assistance Act''; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6175. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–383 adopted by the Council on June 2, 1998; to the Committee on Governmental Affairs.

EC–6176. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–384 adopted by the Council on June 2, 1998; to the Committee on Governmental Affairs.

EC–6177. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–385 adopted by the Council on June 2, 1998; to the Committee on Governmental Affairs.

EC–6178. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–386 adopted by the Council on June 2, 1998; to the Committee on Governmental Affairs.

EC–6179. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–393 adopted by the Council on June 2, 1998; to the Committee on Governmental Affairs.

EC–6180. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–398 adopted by the Council on June 2, 1998; to the Committee on Governmental Affairs.

EC–6181. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–402 adopted by the Council on June 16, 1998; to the Committee on Governmental Affairs.

EC–6182. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–404 adopted by the Council on June 16, 1998; to the Committee on Governmental Affairs.

EC–6183. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–405 adopted by the Council on June 16, 1998; to the Committee on Governmental Affairs.

EC–6184. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, copies of D.C. Act 12–407 adopted by the Council on June 16, 1998; to the Committee on Governmental Affairs.

EC–6185. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule regarding the discharge of pollutants from organic pesticide manufacture (FRL6126–6) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6186. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; Michigan: Withdrawal of Direct Final Rule'' (FRL6128–6) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6187. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plan; Indiana'' (FRL6129–7) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6188. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of State Plans for Designated Facilities and Pollutants: South Carolina'' (FRL6129–9) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6189. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule regarding approval of Minnesota landfill gas emissions control plans (FRL6128–8) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6190. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Extension of Operating Permits Program; Interim Approval Expiration Dates'' (FRL6128–9) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6191. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Protection of Stratospheric Ozone: Reconsideration of Petition Criteria and Incorporation of Montreal Protocol Decisions'' (FRL6129–2) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6192. A communication from the Director of the Office of Congressional Affairs, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''Respiratory Protection and Controls to Restrict Internal Exposures'' (RIN3150–AF81) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6193. A communication from the Director of the Office of Congressional Affairs, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''Licenses for Industrial Radiography and Radiation Safety Requirements for Industrial Radiographic Operations; Clarifying Amendments and Corrections'' (RIN3150–AE07) received on July 22, 1998; to the Committee on Environment and Public Works.

EC–6194. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule that identifies certain rulings that are no longer considered determinative (Rev. Ru. 98–37) received on July 23, 1998; to the Committee on Finance.

EC–6195. A communication from the Director of the Office of Surface Mining Reclamation and Enforcement, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Surface Coal Mining and Reclamation Operations Under the Federal Land Program; State-Federal Cooperative Agreements; Montana'' received on July 23, 1998; to the Committee on Energy and Natural Resources.

EC–6196. A communication from the Administrator of the Agricultural Marketing Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Fresh Bartlett Pears Grown in Oregon and Washington; Decreased Assessment Rate'' (Docket FV98–931–1 IFR) received on July 23, 1998; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6197. A communication from the Acting Assistant General Counsel for Regulations, Department of Education, transmitting, pursuant to law, the report of a rule regarding funding priorities for the National Institute on Disability and Rehabilitation Research received on July 23, 1998; to the Committee on Labor and Human Resources.

EC–6198. A communication from the Director of the Office of Regulatory Management and Information, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Priorities List for Uncontrolled Hazardous Waste Sites'' (FRL6130–9) received on July 23, 1998; to the Committee on Environment and Public Works.

EC–6199. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Canton, Normal, and Heyworth, Illinois)'' (Docket 96–225) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6200. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Gurdon, Arkansas)'' (Docket 98–40) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6201. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Johnstown and Altamount, New York)'' (Docket 98–31) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6202. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Walla Walla and Pullman, Washington, and Hermiston, Oregon)'' (Docket 97–246) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6203. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Horseshoe Beach and Otter Creek, Florida)'' (Docket 97–239) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6204. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Salmon, Idaho)'' (Docket 98–51) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6205. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of the Commission's Rules Concerning Maritime Communications'' (Docket 92–257) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6206. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Federal-State Board on Universal Service'' (Docket 96–45) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6207. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Shenandoah, Virginia)'' (Docket 98–30) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6208. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Point Arena, California)'' (Docket 97–236) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

EC–6209. A communication from the Associate Managing Director for Performance Evaluation and Records Management, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Table of Allotments, FM Broadcast Stations (Fowler, Indiana)'' (Docket 98–38) received on July 23, 1998; to the Committee on Commerce, Science, and Transportation.

REPORT OF COMMITTEE

The following report of committee was submitted:

By Mr. CHAFEE, from the Committee on Environment and Public Works, with amendments:

S. 1883. A bill to direct the Secretary of the Interior to convey the Marion National Fish Hatchery and the Claude Harris National Aquacultural Research Center to the State of Alabama, and for other purposes (Rept. No. 105–263).

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. BIDEN:

S. 2351. A bill to direct the Secretary of the interior to make corrections to a map relating to the Coastal Barrier Resources System; to the Committee on Environment and Public Works.

By Mr. LEAHY (for himself, Mr. ASHCROFT, and Mr. BURNS):

S. 2352. A bill to protect the privacy rights of patients; to the Committee on Finance.

By Mr. DURBIN (for himself, Mr. KENNEDY, Mr. LAUTENBERG, Mr. MOYNIHAN, Mr. CLELAND, Mr. GRAMS, Mr. SARBANES, Mr. LEVIN, and Mr. DEWINE):

S. 2353. A bill to redesignate the legal public holiday of ''Washington's Birthday'' as ''Presidents' Day'' in honor of George Washington, Abraham Lincoln, and Franklin Roosevelt and in recognition of the importence of the institution of the Presidency and the contributions that Presidents have made to the development of our Nation and the principles of freedom and democracy; to the Committee on the Judiciary.

By Mr. BOND (for himself, Mr. HOLLINGS, Mr. FAIRCLOTH, Mr. COCHRAN, and Mr. BENNETT):

S. 2354. A bill to amend title XVIII of the Social Security Act to impose a moratorium on the implementation of the per beneficiary limits under the interim payment system for home health agencies, and to modify the standards for calculating the per visit cost limits and the rates for prospective payment systems under the medicare home health benefit to achieve fair reimbursement payment rates, and for other purposes; to the Committee on Finance.

By Mr. BINGAMAN:

S. 2355. A bill to prevent truancy and daytime juvenile crime; to the Committee on Labor and Human Resources.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BOND (for himself, Mr. HOLLINGS, Mr. FAIRCLOTH, Mr. COCHRAN, and Mr. BENNETT):

S. 2354. A bill to amend title XVIII of the Social Security Act to impose a moratorium on the implementation of the per beneficiary limits under the interim payment system for home health agencies, and to modify the standards for calculating the per visit cost limits and the rates for prospective payment systems under the medicare home health benefit to achieve fair reimbursement payment rates, and for other purposes; to the Committee on Finance.

MEDICAL HOME HEALTH BENEFICIARY PROTECTION ACT OF 1998

Mr. BOND. Mr. President, I rise today to introduce the ''Medicare Home Health Beneficiary Protection Act of 1998'' on behalf of myself, Mr. HOLLINGS, Mr. FAIRCLOTH, and Mr. COCHRAN.

I have long believed that home care is the key to fulfilling the desire of virtually all seniors and those with disabilities to remain independent and within the comfort of their own homes. Home care is also often the only source of care for many disabled individuals and frail elderly, especially those living in underserved rural and urban areas of our country.

Today, however, home health care is facing a crisis.

In an effort to reduce Medicare home health expenditures and fraud and abuse, the Balanced Budget Act of 1997 replaces cost-based reimbursement for home health services with a Prospective Payment System (PPS), effective October 1, 1999. In the meantime, Congress, at the recommendation of the Health Care Financing Administration (HCFA), imposed an Interim Payment System (IPS), or new per beneficiary caps on home health agencies.

There is no question that transitioning home health into a PPS is needed to ensure that all home health providers are cost-effective in the deliverance of services. But is also quite clear that the current IPS, coupled with HCFA's interpretation of the surety bond statute, is threatening access to these invaluable services throughout our nation. Quite simply, the IPS is fatally flawed and works tremendous injustice and hardship.

In my home State of Missouri, reputable home health agencies provide high quality care to over 124,000 seniors and disabled are facing a crisis. I support making the deliverance of services more efficient and rooting out bad actors in the Medicare home health program, but I am deeply concerned about a punitive IPS which is driving scrupulous, quality providers out of business. In Missouri alone, over 35 home health agencies have shut their doors since enactment of the BBA of 1997. Nationwide, over 1000 home health providers have closed or stopped accepting Medicare patients.

In St. Louis, the two largest, free-standing home health providers closed their doors this year—leaving hundreds of elderly and disabled patients searching for a new provider. The Visiting Nurse Association of St. Louis which served the St. Louis area for 87 years eliminated all of their Medicare home health services as of May, forcing over 600 patients to find a new source of care.

It is imperative that Congress act now to impose a moratorium on the IPS. My bill not only accomplishes this equitable goal, but it also puts pressure on HCFA to move expeditiously towards the establishment of PPS for home care.

I have written a letter to Secretary Shalala outlining the concerns and outlining the serious situation and I have asked she move expeditiously on this.

A study conducted by The George Washington University Medical Center, Center for Health Policy Research, entitled ''Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality'', confirms why Congress must take expedited action in removing the IPS.

Summarizing, the study concluded that:

The home care population represents an increasingly sicker population requiring more acute management of chronic illness and higher intensity acute care;

The BBA's reductions in Medicare home health coverage and financing can be expected to affect the sickest and highest cost patients and punish the very agencies that specialize in the provision of care to this population;

The most severe effects of the interim payment system fall on the sickest patients living in states with the lowest utilization patterns;

The BBA's interim payment system will shift costs to other payers (notably Medicaid) while rewarding inefficient agencies who care for relatively healthier patients; and

The interim payment system will make it more difficult to design and implement the permanent prospective payment system scheduled to become effective in FY 2000.

To those, I might add, Mr. President, when you take a look at cost when you force people out of home health care if they are Medicare-eligible beneficiaries, you are going to wind up putting them in institutions where the cost will be significantly greater and the benefits to the individuals served and to the communities will be far less.

This is false economy and it is causing a real crisis in communities throughout our country. So not only are beneficiaries and providers of home health alerting us to the devastation of this system, but outside experts are also telling us why we must revisit this issue.

Reducing Medicare's growth rate is a worthy and much needed goal; however, doing it in such a way that threatens access to critical home health services is downright unconscionable. Truly reforming Medicare means more than simply ratcheting down payments to providers and services to beneficiaries. While this approach is the short-term solution, it has serious consequences for many vulnerable patients and honest providers.

Mr. President, I want to conclude my remarks by recognizing the efforts of my distinguished colleague from Iowa and Chairman of the Senate Committee on Aging, Senator CHUCK GRASSLEY, who first highlighted the devastating impact of the IPS and HCFA's surety bond rule on Medicare beneficiaries and home health providers. I thank him for his dedication and leadership and look forward to working with him to rectify this problem.

I ask unanimous consent that letters from the National Easter Seal Society and the National Council of Senior Citizens as well as my letter to Secretary Shalala dated July 24, be printed in the RECORD.

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

NATIONAL EASTER SEAL SOCIETY,
OFFICE OF PUBLIC AFFAIRS,
Washington, DC, July 23, 1998.

Hon. CHRISTOPHER BOND,
U.S. Senate,
Washington, DC.

DEAR SENATOR BOND: Easter Seals is pleased to support your legislation to place a moratorium on the Medicare interim payment system (IPS) for home health agencies

and the automatic payment reductions slated for 1999. These Balanced Budget Act (BBA) measures threaten access to essential home health services for Medicare beneficiaries, particularly those with significant disabilities and chronic conditions. They represent flawed approaches to reducing Medicare spending that will have a devastating impact on beneficiaries and families, and force high-quality providers, including Easter Seals, from the Medicare program.

Easter Seals is dedicated to assisting people with disabilities to live with equality, dignity, and independence. Each year, Easter Seals serves more than one million persons through a nationwide network of 106 affiliated organizations that offer a wide range of home and community-based services, including medical and vocational rehabilitation, early intervention and special education services, assistive technology, housing, and camping and recreation services. Easter Seals provides quality care, including home health care, to thousands of Medicare beneficiaries annually. A significant percentage of these beneficiaries have catastrophic, chronic, and/or medically complex conditions. It is these individuals that will suffer most under BBA.

Easter Seals' supports a transition to prospective payment in home health that is responsible, cost-effective, and consistent with high quality care. Payment methodologies should reflect the varying, legitimate service needs of medicare beneficiaries.

Easter Seals greatly appreciates your efforts to halt implementation of IPS by the Health Care Financing Administration until such time that an appropriate prospective payment system can be adopted. Easter Seals also opposes the sweeping reduction of payment for home health services, that may take effect in 1999, as a flawed strategy that will cause undue harm to beneficiaries and service providers. These BBA provisions undermine appropriate, quality home and community services for Medicare beneficiaries and drive away efficient and caring providers, such as Easter Seals, that serve them. Thank you very much for your leadership with this important legislative initiative.

Sincerely,

RANDALL L. RUTTA,
Vice President,
Government Relations.

NATIONAL COUNCIL OF SENIOR CITIZENS,
Silver Spring, MD, July 23, 1998.

Hon. CHRISTOPHER BOND,
Senate Russell Office Building,
Washington, DC.

DEAR SENATOR BOND: The National Council of Senior Citizens applauds your leadership and commitment to addressing the very serious problems that the new Medicare interim payment system (IPS) poses for disabled and elderly individuals in need of home care.

As you so well know, home care patients are among America's most vulnerable citizens. They tend to be people who are sick, frail, lower income, and who depend upon this care for their very existence and dignity.

The interim payment system has threatened to take away this vital lifeline. Our Board has taken a position that IPS must be reconsidered on an urgent basis. We urge you to introduce legislation to impose an immediate and retroactive moratorium on IPS. Only in this way can Congress bring about a speedy solution to this pressing problem.

Thank you again for your vision and leadership. America's Medicare beneficiaries are looking to you and the Congress for a remedy to this devastating system.

Sincerely,

STEVE PROTULIS,
Executive Director.

U.S. SENATE,
COMMITTEE ON SMALL BUSINESS,
Washington, DC, July 24, 1998.

Hon. DONNA E. SHALALA,
Secretary, Department of Health and Human Services, Washington, DC.

DEAR MADAM SECRETARY: It has become clear that the Health Care Financing Administration's (HCFA) implementation of the home health Interim Payment System (IPS) and the surety bond requirements is having a devastating impact on thousands of conscientious and cost-effective home health agencies and the Medicare home health beneficiaries, especially the most medically complex patients.

As you know, the Senate Committee on Small Business held a hearing on July 15 to give home health providers, HCFA, and others the opportunity to examine these issues and explore possible solutions. Nine witnesses, including representatives of small freestanding home health agencies, testified about the crippling effect HCFA's rules are having on reputable small agencies and their ability to provide high-quality care to their patients.

I remain extremely disappointed that HCFA turned down the Committee's invitation to attend this important hearing. Unfortunately, HCFA's decision not to testify was interpreted as indifference to the impact its actions are having on small home health providers and patients. This decision was characterized by members of our Committee as ''reckless, arrogant, and disgraceful.''

It is imperative that the Department of HHS and HCFA work with Congress to enact an immediate moratorium on the IPS, until, home health moves into a prospective payment system, to stop the unjustified closure of scrupulous home health agencies and further loss of beneficiary access to home care services. The IPS is fatally flawed and does not comport with what Congress intended. Rather than reduce the rate of growth of the Medicare home health benefit, as we were led to believe would be the result, the IPS is causing a precipitous decline from last year's reimbursement, leading to serious dislocation all over the country.

Hundreds of home care providers are literally on the brink of closure. Many have already closed, leaving the sickest patients searching for new home health care providers. I am aware of at least one state where the IPS-related closure of a home health agency has led to the loss of all home health services for many rural patients.

Imposing a moratorium on the IPS would give Congress an opportunity to work with the Department of HHS and HCFA, Medicare consumers, and the home health industry to develop a solution to this critical situation, which must be solved by the end of the 105th Congress. This crisis requires your immediate attention.

As you are aware, our July 15 hearing also focused on HCFA's regulations to implement the surety bond requirements in the Balanced Budget Act of 1997. The recent suspension of the deadline for compliance with these regulations narrowly averted a further crisis in home health care. It was the intent of Congress that the home health surety bond requirement act as a guarantee against fraud by home health agencies. HCFA took this reasonable tool intended to curb home health fraud and, as implemented, turned it into an unworkable, punitive vehicle for the collection of routine overpayment. HCFA's distortion of Congressional intent has now forced the agency to suspend its flawed bond regulations. Pending further rulemakng, HCFA should withdraw its surety regulations and immediately release all existing bonds from potential liability for recovery of overpayments.

I urge HCFA to work with Congress, home health providers, and the surety bond industry in developing new surety bond regulations in full compliance with the Administrative Procedures Act and the Regulatory Flexibility Act as amended in 1996. There must not be a repetition of the chaotic situation which caused Congress to intervene in the surety bond crisis in the first place.

Your prompt reply is appreciated.

Sincerely,

CHRISTOPHER S. BOND,
Chairman.

By Mr. BINGAMAN:

S. 2355. A bill to prevent truancy and daytime juvenile crime; to the Committee on Labor and Human Resources.

TRUANCY PREVENTION AND JUVENILE CRIME REDUCTION ACT OF 1998

Mr. BINGAMAN. Mr. President, I rise today to introduce the Truancy Prevention and Juvenile Crime Reduction Act of 1998. In doing so, I would like to discuss the importance of this measure and how I believe the issue of truancy, as it relates to juvenile crime, has long been neglected.

More people are realizing that truancy often is the first sign of trouble in the life of a young person. It is the first indication that a young person may be on a sad track to a life of crime, drugs, and other serious problems.

Of course, in most every case, it is an early indication that a young person has no interest in school and inevitably will drop out. This is especially sad because many truants and eventual dropouts are two and a half times more likely than high school graduates to be on welfare and twice as likely to be unemployed or to be paid at the lower end of the wage scale.

Truancy is the top-ranking characteristic of criminals—more common than such factors as coming from a single-parent family and being abused as a child. High rates of truancy directly are linked to high daytime crime rates, including violence, burglary and vandalism. As much as 44 percent of violent juvenile crime takes place during school hours, and as much as 75 percent of children ages 13 to 16 who are arrested and prosecuted for crimes are truants. It is startling to know that some cities report as many as 70 percent of daily student absences are unexcused, and the total number of absences in a single city can reach 4,000.

Moreover, society pays a very heavy social and economic price due to truancy. Only 34 percent of inmates have completed high school education, and we all are well aware of the staggering costs associated with incarcerating an individual. Sadly, as many as 17 percent of youth under the age of 18 that enter adult prisons have not completed eighth grade, 75 percent have not completed 10th grade.

Put in graphic economic terms, it is estimated that truants and high school drop outs cost the nation $240 billion in lost earnings and foregoing taxes over their lifetimes, and the cost of associated crime control is staggering and perhaps immeasurable.

In most cases the parents may not be aware their child is truant, and we

have to do a better job of notifying them when a child is not in school. Most studies indicate that when parents, schools, law enforcement and community leaders all work together to prevent truancy, to intervene at its early stages, and to create meaningful accountability, we can increase school attendance and reduce daytime crime rates.

Because truancy is usually an indicator of later delinquency and criminal behavior, we have one of the best opportunities to identify the kids that are on track to later problems and to intervene before the problems get too serious. The unfortunate truth, however, is that is addressing juvenile crime, we have not focused enough attention on this specific issue, and although prevention programs can work, there is a lack of targeted federal funding for effective truancy prevention.

The Departments of Justice and Education both have recognized truancy prevention as a key reducing juvenile crime. The Departments jointly have issued a series of reports called ''Youth out of the Education Mainstream,'' that shine a positive spotlight on various proven comprehensive, collaborative truancy models from around the country.

Once such program is the Daytime Curfew Program in Roswell, New Mexico, and the Truancy Intervention Project in Fulton County, Georgia, administered by Judge Glenda Hatchett. Another successful program included in this Act is the Grade Court, which is Farmington, New Mexico, administered by Judge Paul Onuska. All of these programs integrate parental involvements with schools, law enforcement, judiciary, and other community stakeholders in a collaborative effort to reduce truancy and juvenile crime.

This Act authorizes $25 million per year targeted at building upon integral partnerships between local government, schools, law enforcement, and the courts. Without a doubt, $25 million is a very small price to pay when you consider the dividends we expect when young people stay in school and out of trouble.

In general, this Act provides incentives for partnerships between schools and local government, including local law enforcement to build parental involvement in situations where they may be useful and parental responsibility when necessary. The Act also provides incentives for these partnerships to develop meaningful penalties for young people and even their parents when truancy has become a chronic problem, and to allow schools the means to develop in-school alternatives to suspension and expulsion for chronic truants. This Act also will give schools the resources to acquire the technological tools to notify parents automatically in the event of an unexcused absence.

The Act is endorsed by the Youth Law Center, the Children's Defense Fund, and the National Network for Youth, which has more than 500 community youth-serving organizations and personnel nationwide all committed to helping keep our young people on track and keeping our communities peaceful. I thank these organizations for their assistance and know this Act will be enthusiastically received by many more important organizations. I urge my Senate colleagues to support the bill for passage this year.

Mr. President, I ask unanimous consent that the bill be printed in the RECORD.

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

S. 2355

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 ''Truancy Prevention and Juvenile Crime Reduction Act of 1998''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Truancy is the first sign of trouble—the first indicator that a young person is giving up and losing his or her way.

(2) Many students who become truant eventually drop out of school, and high school drop outs are two and a half times more likely to be on welfare than high school graduates; twice as likely to be unemployed, or if employed, earn lower salaries.

(3) Truancy is the top-ranking characteristic of criminals—more common than such factors as coming from single-parent families and being abused as children.

(4) High rates of truancy are linked to high daytime burglary rates and high vandalism.

(5) As much as 44 percent of violent juvenile crime takes place during school hours.

(6) As many as 75 percent of children ages 13–16 who are arrested and prosecuted for crimes are truants.

(7) Some cities report as many as 70 percent of daily student absences are unexcused, and the total number of absences in a single city can reach 4,000 per day.

(8) Society pays a significant social and economic cost due to truancy: only 34 percent of inmates have completed high school education; 17 percent of youth under age 18 entering adult prisons have not completed grade school (8th grade or less), 25 percent completed 10th grade, and 2 percent completed high school.

(9) Truants and later high school drop outs cost the Nation $240 billion in lost earnings and foregone taxes over their lifetimes, and the cost of crime control is staggering.

(10) In many instances, parents are unaware a child is truant.

(11) Effective truancy prevention, early intervention, and accountability programs can improve school attendance and reduce daytime crime rates.

(12) There is a lack of targeted funding for effective truancy prevention programs in current law.

SEC. 3. GRANTS.

(a) DEFINITIONS.—In this section:

(1) ELIGIBLE PARTNERSHIP.—The term ''eligible partnership'' means a partnership between 1 or more qualified units of local government and 1 or more local educational agencies.

(2) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' has the meaning given the term in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801).

(3) QUALIFIED UNIT OF LOCAL GOVERNMENT.—The term ''qualified unit of local government'' means a unit of local government that has in effect, as of the date on which the eligible partnership submits an application for a grant under this section, a statute or regulation that meets the requirements of paragraphs (12), (13), (14), and (15) of section 223(a) of the Juvenile Justice and Delinquency and Prevention Act of 1974 (42 U.S.C. 5633(a)).

(4) UNIT OF LOCAL GOVERNMENT.—The term ''unit of local government'' means any city, county, township, town, borough, parish, village, or other general purpose political subdivision of a State, or any Indian tribe.

(b) GRANT AUTHORITY.—The Attorney General, in consultation with the Secretary of Education, shall make grants in accordance with this section on a competitive basis to eligible partnerships to reduce truancy and the incidence of daytime juvenile crime.

(c) MAXIMUM AMOUNT; ALLOCATION; RENEWAL.—

(1) MAXIMUM AMOUNT.—The total amount awarded to an eligible partnership under this section in any fiscal year shall not exceed $100,000.

(2) ALLOCATION.—Not less than 25 percent of each grant awarded to an eligible partnership under this section shall be allocated for use by the local educational agency or agencies participating in the partnership.

(3) RENEWAL.—A grant awarded under this section for a fiscal year may be renewed for an additional period of not more than 2 fiscal years.

(d) USE OF FUNDS.—

(1) IN GENERAL.—Grant amounts made available under this section may be used by an eligible partnership to comprehensively address truancy through the use of—

(A) parental involvement in prevention activities, including meaningful incentives for parental responsibility;

(B) sanctions, including community service and drivers' license suspension for students who are habitually truant;

(C) parental accountability, including fines, teacher-aid duty, community service;

(D) in-school truancy prevention programs, including alternative education and in-school suspension;

(E) involvement of the local law enforcement, social services, judicial, business, and religious communities, and nonprofit organizations;

(F) technology, including automated telephone notice to parents and computerized attendance system; or

(G) elimination of 40-day count and other unintended incentives to allow students to be truant after a certain time of school year.

(2) MODEL PROGRAMS.—In carrying out this section, the Attorney General may give priority to funding programs that attempt to replicate 1 or more of the following model programs:

(A) The Truancy Intervention Project of the Fulton County, Georgia, Juvenile Court.

(B) The TABS (Truancy Abatement and Burglary Suppression) program of Milwaukee, Wisconsin.

(C) The Roswell Daytime Curfew Program of Roswell, New Mexico.

(D) The Stop, Cite and Return Program of Rohnert Park, California.

(E) The Stay in School Program of New Haven, Connecticut.

(F) The Atlantic County Project Helping Hand of Atlantic County, New Jersey.

(G) The THRIVE (Truancy Habits Reduced Increasing Valuable Education) initiative of Oklahoma City, Oklahoma.

(H) The Norfolk, Virginia project using computer software and data collection.

(I) The Community Service Early Intervention Program of Marion, Ohio.

(J) The Truancy Reduction Program of Bakersfield, California.

(K) The Grade Court program of Farmington, New Mexico.

(L) Any other model program that the Attorney General determines to be appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $25,000,000 for each of fiscal years 1999, 2000, and 2001.

ADDITIONAL COSPONSORS

S. 1529

At the request of Mr. KENNEDY, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 1529, a bill to enhance Federal enforcement of hate crimes, and for other purposes.

S. 1647

At the request of Mr. BAUCUS, the name of the Senator from Nevada (Mr. BRYAN) was added as a cosponsor of S. 1647, a bill to reauthorize and make reforms to programs authorized by the Public Works and Economic Development Act of 1965.

S. 1759

At the request of Mr. HATCH, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 1759, a bill to grant a Federal charter to the American GI Forum of the United States.

S. 1868

At the request of Mr. NICKLES, the name of the Senator from Georgia (Mr. COVERDELL) was added as a cosponsor of S. 1868, a bill to express United States foreign policy with respect to, and to strengthen United States advocacy on behalf of, individuals persecuted for their faith worldwide; to authorize United States actions in response to religious persecution worldwide; to establish an Ambassador at Large on International Religious Freedom within the Department of State, a Commission on International Religious Persecution, and a Special Adviser on International Religious Freedom within the National Security Council; and for other purposes.

S. 1924

At the request of Mr. MACK, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1924, a bill to restore the standards used for determining whether technical workers are not employees as in effect before the Tax Reform Act of 1986.

S. 2180

At the request of Mr. FAIRCLOTH, his name was added as a cosponsor of S. 2180, a bill to amend the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 to clarify liability under that Act for certain recycling transactions.

S. 2348

At the request of Mr. BURNS, the name of the Senator from New York (Mr. D'AMATO) was added as a cosponsor of S. 2348, a bill to amend the Communications Act of 1934 to reduce telephone rates, provide advanced telecommunications services to schools, libraries, and certain helath care facilities, and for other purposes.

SENATE CONCURRENT RESOLUTION 109

At the request of Mr. COVERDELL, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of Senate Concurrent Resolution 109, a concurrent resolution expressing the sense of the Congress that executive departments and agencies must maintain the division of governmental responsibilities between the national government and the States that was intended by the framers of the Constitution, and must ensure that the principles of federalism established by the framers guide the executive departments and agencies in the formulation and implementation of policies.

SENATE RESOLUTION 199

At the request of Mr. TORRICELLI, the name of the Senator from Arkansas (Mr. BUMPERS) was added as a cosponsor of Senate Resolution 199, a resolution designating the last week of April of each calendar year as ''National Youth Fitness Week.''

AMENDMENT NO. 3013

At the request of Mr. CAMPBELL, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of amendment No. 3013 intended to be proposed to S. 1112, a bill to require the Secretary of the Treasury to mint coins in commemoration of Native American history and culture.

AMENDMENTS SUBMITTED

CREDIT UNION MEMBERSHIP ACCESS ACT

GRAMM (AND ENZI) AMENDMENT NO. 3336

Mr. GRAMM (for himself and Mr. ENZI) proposed an amendment to the bill (H.R. 1151) to amend the Federal Credit Union Act to clarify existing law and ratify the longstanding policy of the National Credit Union Administration Board with regard to field of membership of Federal credit unions; as follows:

Strike section 204 of the bill and renumber the sections accordingly, and beginning on page 45, line 24, strike all through page 46, line 4, and redesignate subparagraphs (E) and (F) on page 46 as subparagraphs (D) and (E), respectively.

NOTICES OF HEARINGS

COMMITTEE ON LABOR AND HUMAN RESOURCES

Mr. JEFFORDS. Mr. President, I would like to announce for information of the Senate and the public that a hearing of the Senate Committee on Labor and Human Resources will be held on Tuesday, July 28, 1998, 10 a.m., in SD–430 of the Senate Dirksen Building. The subject of the hearing is Substance Abuse: The Science of Addiction and Options for Treatment. For further information, please call the committee, 202/224–5375.

COMMITTEE ON LABOR AND HUMAN RESOURCES

Mr. JEFFORDS. Mr. President, I would like to announce for information of the Senate and the public that an executive session of the Senate Committee on Labor and Human Resources will be held on Wednesday, July 29, 1998, 9:30 a.m., in SD–430 of the Senate Dirksen Building. The committee will consider S. 1380, Charter Schools Expansion Act and S. 2213, the Education Flexibility Amendments of 1998. For further information please call the committee, 202/224–5375.

ADDITIONAL STATEMENTS

THE PASSING OF BUCK MICKEL

• Mr. HOLLINGS. Mr. President, as the Senate conducts its business today, South Carolina mourns the passing of one of its greatest citizens. Buck Mickel, a man who stands as a giant in the history of the Carolina Upstate, passed away Thursday morning, July 23. One of the greatest pleasures of my life has been my long friendship with Buck. I count it a privilege to have known him and to have learned from his example.

Every moment of Buck's 72 years was spent in dynamic enterprise and productive activity. He was a tireless dynamo, a man whose vigor and energy was rivaled only by his bold ideas, humanitarian impulses, and sincere humility. No simple description of Buck does justice to the scope of his activities or the importance of his full life to the lives of everyone who lives in the Upstate.

Buck was a savvy businessman. When he took the reins of Daniel Construction Company in the early 1960s, he steered it from its position as a successful, regional business to a thriving, global company. By the time he retired from active management of the company in 1987, he had expanded Daniel Construction's business, taken it public in 1969, and merged it with Fluor Corporation in 1977 to create today's construction and engineering giant, Fluor Daniel Corporation. In the meantime, he created thousands of jobs for South Carolinians and other Americans and helped lead the way in the creation of overseas operations for U.S. companies.

In fact, after Buck ''retired'' (any use of this word in connection with Buck Mickel must be taken with more than a grain of salt) in 1987, he continued to travel the world to help groom young Fluor managers for eventual leadership within the company.

Leadership was the theme of Buck Mickel's extraordinary life. His sense of duty and responsibility, with the recognition that he was a natural-born leader if ever there was one, informed every aspect of Buck's life.

Buck's prodigious achievements as a businessman and his famed savvy qualify him as a great success on their own.

Les McCraw, who succeeded Buck as head of Fluor, summed up Buck's position in his field. ''To say that he was a giant in the construction industry is a gross understatement,'' Mr. McCraw said. ''He clearly was one of the all-time leaders in that industry and had been for 40 years.''

But Buck's friends know his greatest passion was not commerce. He was consumed by a desire to enrich and expand the economic and cultural life of South Carolina, and he devoted every waking minute to those twin tasks. Robert Royall, South Carolina's Secretary of Commerce, said Buck ''loved South Carolina as much as anyone I have ever known and contributed more to developing the state than anyone in my lifetime. . . . He was constantly thinking about ways to help the state.''

Buck stayed in regular contact with almost everyone in public life in South Carolina. I spoke to him just last week, and as always, he was spinning ideas about how to help the state. In fact, Mr. President, the universal reaction among public figures in South Carolina since Buck's death has been disbelief. It's just hard to believe that a man so vital, so full of ideas and concern for others, could pass from among us. It may take awhile for us to realize the full import of his death, but when we do, I believe Buck's death will hit us as hard as any in our state's history.

Highest on the list of Buck's achievements is the revitalization of downtown Greenville, SC, and the tremendous development of the region's economy. As the Greenville News wrote, Buck ''put his imprint on virtually every civic project in Greenville for almost half a century.'' Buck was instrumental to Greenville's building its Peace Center for the Performing Arts, which has won national acclaim as a venue for the live arts; restoring numerous dilapidated buildings in Greenville proper; luring important businesses back to the downtown area; and raising funds for a new sports arena. These developments have transformed Greenville in a way impossible to imagine if you haven't lived there, Mr. President.

Of course, Buck's beneficence and energy were by no means limited to Greenville. He helped attract Michelin, BMW, and other international businesses to the state. Buck supported secondary education—his support helped make the Governor's School for the Arts possible—and higher education. He and his wife, Minor, were active with Furman, Clemson, and Wofford Universities, as well as with the University of South Carolina. Buck rose from humble origins and relied on a scholarship to Georgia Tech University, so he knew the importance not only of education but of financial support for those in need of aid. He and his wife gave generously of their time and money to South Carolina colleges and endowed many scholarships.

Buck Mickel's life has touched almost every life in my state. Because Buck was so humble and modest, most of those he helped do not even realize the debt they owe him. With Buck Mickel's passing, South Carolina has lost one of its greatest civic and business leaders. Quite honestly, Mr. President, I don't know how we will replace him.●

HONORING TRACIE MITCHELL

● Mr. SMITH of Oregon. Mr. President, in 1995, when I was privileged to serve as President of the Oregon State Senate, I was invited by State Representative Margaret Carter to tour Portland Community College, which was located in her district, in the heart of Oregon's largest city. As I represented a rural Eastern Oregon district, I looked upon this tour as a valuable learning opportunity. And what I learned was that PCC was offering a lifeline for many economically disadvantaged students who were seeking to build a better future for themselves and their family.

I was so impressed with the work of PCC, that when I was elected to the United States Senate, I approached PCC with the idea of each year giving one of their students the opportunity to serve as an intern in my Washington, D.C. office.

The student selected to serve as the first PCC intern was Tracie Mitchell, whose final day in my office is today. I just want to take a minute to salute Tracie, not only for her outstanding work in my office, but also for the outstanding accomplishments at home and in her career. Through the programs at PCC, Tracie, a mother of two wonderful children—Ruben and Shea, earned a degree in Microelectronics, and has gained employment at Tektronix, one of Oregon's outstanding high tech companies.

I know that Tracie is anxious to return to her children, her job, and her classes at PCC, and I thank her for her service to my office and to all Oregonians. If she has learned as much from her internship as my office as learned from her, then I know this summer has been a very rewarding experience.●

ORDERS FOR MONDAY, JULY 27, 1998

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 12 noon on Monday, July 27, and I further ask that when the Senate reconvenes on Monday, immediately following the prayer, the routine requests through the morning hour be granted and the Senate begin a period of morning business until 1 p.m., with Senators permitted to speak therein for up to 5 minutes each.

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

Mr. FRIST. Mr. President, I further ask unanimous consent that following morning business the Senate resume consideration of H.R. 1151, the credit union bill.

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

PROGRAM

Mr. FRIST. Mr. President, for the information of all Senators, when the Senate reconvenes Monday, there will be a period for morning business until 1 p.m. Following morning business, the Senate will resume consideration of the credit union bill. Several amendments are expected to be offered and debated. It is expected that Senator HAGEL will be on the floor ready to offer his amendment regarding credit union loans at 1 p.m. on Monday. It is also hoped that the debate could conclude by 2 p.m. on the Hagel amendment, and Senator MACK will then be recognized at approximately 2:40 p.m. for a 20-minute statement. Senator SHELBY is expected to offer his amendment regarding the CRA at 3:30 p.m., and we hope to conclude that debate by 4:30 when Senator GRAMM's amendment recurs under a previous consent. Therefore, additional votes, other than the previously ordered 5:30 p.m. vote, can be expected.

ADJOURNMENT UNTIL MONDAY, JULY 27, 1998

Mr. FRIST. 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.

There being no objection, the Senate, at 3:30 p.m., adjourned until Monday, July 27, 1998, at 12 noon.

EXTENSIONS OF REMARKS

TRIBUTE TO THE LATE ADMIRAL ALAN SHEPARD

HON. F. JAMES SENSENBRENNER, JR.

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. SENSENBRENNER. Mr. Speaker, we are saddened to learn of the passing of one of America's great pioneers, Rear Admiral Alan Shepard. Admiral Shepard leaves an enduring legacy of heroism, perseverance, and dedication to the exploration of space ad service to his country.

Admiral Shepard served as a Navy fighter pilot and test pilot before being selected as one of the first group of astronauts in 1959. As the commander of Freedom 7, Admiral Shepard became the first American to venture into space.

Following his historic flight, Admiral Shepard was told he would never fly into space again. But he would not be deterred. Ten years later, he commanded Apollo 14 and was the fifth American—the fifth person—to walk on the Moon.

Those who have worked with Admiral Shepard in both the formulation of space policy and oversight of America's space program came to appreciate his wise counsel and fine wit as he educated us on the complex issues involved. I am confident that his contributions to America's space program will not be forgotten by his countrymen.

Admiral Shepard also served his country outside of the cockpit. Following his retirement from NASA and the U.S. Navy in 1974, he brought his determination and leadership to down-to-Earth goals, becoming a successful businessman and raising money for college scholarships so young Americans could grow up to become scientists and engineers. He was on the Board of Directors for both the Houston School for Deaf Children and the National Space Institute.

This afternoon, Admiral Shepard's spacecraft, ''Freedom 7'' will arrive at the National Air and Space Museum where it will be on display in remembrance of not only his historic first flight into space, but of the lasting contributions of this great American to his country.

And now, Admiral Shepard has joined his fellow crewman of Apollo 14—the late Stuart Roosa—and we wish him fair winds and following seas, and offer our condolences to his wife Louise, and his daughters Laura, Alice and Julie.

A TRIBUTE TO ALYCE LIVINGSTON

HON. GLENN POSHARD

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. POSHARD. Mr. Speaker, I rise today to pay tribute to my constituent and dear friend, Mrs. Alyce J. Livingston of Decatur, Illinois who has recently passed. She was a devoted citizen and my condolences and best wishes go to her family and all who will miss her.

Alyce was born on July 19, 1934 in Paducah, Kentucky. She was a dedicated student, and her scholastic excellence throughout her years at Lincoln High and West Kentucky Vocational School led her to my district during the 1950's, where she attended Millikin University.

Alyce recognized the importance of providing quality child care service to Decatur's next generation. As founder and director of the Tiny Tots Nursery, she inspired and shaped our young children. In addition, Alyce was also a lab technician for the A.E. Stanley Manufacturing Company, where she provided nearly thirty years of service.

As a faithful community leader, Alyce spent her time helping the city of Decatur and increasing momentum in the Civil Rights struggle. She was a long time member of the National Association for the Advancement of Colored People (NAACP), where she served as an advisor and member of the Joe Slaw Civil Rights Awards Committee. Her strong beliefs in equality fostered her persistent efforts to build unity in Decatur. Furthermore, Alyce was a Decatur Township Trustee who committed five years to the city and was a member of the St. Peter's African Methodist Episcopal Church. She is survived by her husband of 40 years, Mr. David C. Livingston, President of the Illinois NAACP, and her two sons, Malcolm and David.

Mr. Speaker, citizens such as Alyce Livingston exemplify the undying devotion critical to community involvement. I will miss her dedication, her persistence, and most of all, her friendship. Mr. Speaker, please join me in recognizing Mrs. Alyce J. Livingston whose dedication to her career, community, and her personal convictions had a profound impact on those who knew her, including myself. It has been an honor to have represented her in the United States Congress.

CONGRATULATING WILLIAM SCHIERBROCK

HON. GREG GANSKE

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. GANSKE. Mr. Speaker, I rise to speak of William Schierbrock of Council Bluffs, Iowa, who was honored on July 12, 1998 for his attainment of Eagle Scout.

Mr. Speaker, I ask you and my other distinguished colleagues to join me in congratulating William Schierbrock for his commendable achievement. His parents Thomas and Jeanette Schierbrock can be proud of their son because it takes a great deal of tenacity and devotion to achieve such an illustrious ranking. This young man has a promising future ahead of him.

IN HONOR OF THE 50TH ANNIVERSARY OF THE STATE OF ISRAEL

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. KUCINICH. Mr. Speaker, I rise today in honor of the 50th Anniversary of the State of Israel. Over the course of its history, this democracy has built a thriving economic and political system and a unique culture, in spite of internal and external challenges and hardships. Today, Israel shares a common goal of advancing the cause of humanity, seeking a stable and genuine peace in the Middle East, and generously shares its collective gifts with the rest of the world.

Israel and the United States share a common background based on pioneering and a united people's determination for political independence. Both countries were built on democratic principles which have withstood the test of time, serving as beacons of freedom, hope and opportunity.

Although situated across an entire ocean, thousands of miles apart, Israel and the United States have many similarities. An open exchange of ideas has cultivated the special relationship between the two countries. Over its fifty years in existence, Israel has become a State that has achieved considerable advancements. In honor of the 50th Anniversary of the State of Israel's establishment, many organizations in the Cleveland area, such as the Jewish Community Federation of Cleveland, will host commemorative celebrations.

My fellow colleagues, please join me in recognizing this exciting and momentous occasion.

HONORING KAVANAGH'S FURNITURE FOR THEIR 125 YEARS OF BUSINESS

HON. RICHARD E. NEAL

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. NEAL of Massachusetts. Mr. Speaker, I am privileged today to have the opportunity to acknowledge and honor Kavanagh Furniture of Springfield, MA, for its 125th year of business.

In 1873, Mr. Dennis Nelen opened his establishment as a ''wholesaler and retailer in elegant furniture, hair and husk mattresses'' and before 1900 he partnered with Mr. William Kavanagh. Today, Kavanagh's is the largest furniture store in Western Massachusetts and has three sister stores with a fourth on the way. It is Springfield's oldest family owned business still in existence and one of the oldest operating furniture stores in the entire United States.

In an era where retailers often sacrifice quality service for quantity sold, Kavanagh's

has remained a testament to the beauty of the family business. in their establishment, quality service is a trait passed down through the generations. Mr. Jack Nelen, who became Kavanagh's president in 1965 and is the grandson of the original founder, began making deliveries for the store when he was just a teenager. The success of a family business can be measured, in part, by the duration of its existence. Kavanagh Furniture has survived and flourished through two world wars, the Great Depression, and several other fluctuations in the economy. They were also able to last during the recession of the early 90s even though furniture was considered a luxury by many. Perhaps more impressive has been Kavanagh's ability to survive the local ''big chain'' competition, while located in an area not supported by mega-mall traffic. In this regard, the Nelen family business can be considered a huge success and a strong example for other family businesses.

Only 1 out of 30,000 retail stores makes it to be 100 years old, and Kavanagh's has now reached its 125th year in the business. Not only has Kavanagh's created lasting personal success for its owners and employees, it has been an enormous asset to the community and neighborhood as well. Its list of civil activities and commitments includes being a catalyst for and taking part in fund raisers for The Children's Miracle Network, Shriner's Hospital, the Red Cross, and the United Way. Kavanagh's once even held a free picinc for over 2,500 city kids.

The Kavanagh Furniture store is an anchor for the community. It has taken care of its customers and has been rewarded with 125 years of business. I wish the Nelen family and all of the folks at Kavanagh's success in continuing a great tradition of excellent service to their customers and the community at large as they embark on the 21st century and another 125 years.

STRUCTURED SETTLEMENT PROTECTION ACT

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. SHAW. Mr. Speaker, today I rise along with my colleague Mr. STARK and a broad bipartisan group of our colleagues from the Ways and Means Committee to introduce the Structured Settlement Protection Act.

The Act addresses serious public policy concerns that are raised by transactions in which so-called factoring companies purchase recoveries under structured settlements from injured victims.

Recently there has been dramatic growth in these transactions in which injured victims are induced by factoring companies of sell off future structured settlement payments intended to cover ongoing living and medical needs in exchange for a sharply-discounted lump sum that then may be dissipated, placing the injured victim in the very predicament the structured settlement was intended to avoid.

As long-time supporters of structured settlements and the congressional policy underlying such settlements, we have grave concerns that these factoring transactions directly undermine the policy of the structured settlement tax rules. The Treasury Department shares these concerns.

Because the purchase of structured settlement payments by factoring companies so directly thwarts the congressional policy underlying the structured settlement tax rules and raises such serious concerns for structured settlements and injured victims, it is appropriate to deal with these concerns in the tax context.

Accordingly, we are proposing legislation to impose a substantial excise tax on the factoring company that purchases the structured settlement payments from the injured victim. The excise tax would be subject to an exception for genuine court-approved hardship cases to protect the limited instances of true hardship.

The following is a detailed discussion of the Bill's provisions.

BACKGROUND

In acting to address the concerns over factoring companies that purchase structured settlement payments from injured victims, the Treasury Department noted that: ''Congress enacted favorable tax rules intended to encourage the use of structured settlements—and conditioned such tax treatment on the injured person's inability to accelerate, defer, increase or decrease the periodic payments—because recipients of structured settlements are less likely than recipients of lump sum awards to consume their awards too quickly and require public assistance.'' (U.S. Department of the Treasury, General Explanations of the Administration's Revenue Proposals (Feb. 1998), p. 122).

Treasury then observed that by enticing injured victims to sell off their future structured settlement payments in exchange for a heavily discounted lump sum that may then be dissipated: ''*These 'factoring transactions' directly undermine the Congressional objective to create an incentive for injured persons to receive periodic payments as settlements of personal injury claims.*'' (Id. at p. 122 [emphasis added].)

The Joint Tax Committee's analysis of the issue echoes these concerns: ''Transfer of the payment stream under a structured settlement arrangement arguably subverts the purpose of the Code to promote structured settlements for injured persons. (Joint Committee on Taxation, Description of Revenue Provisions Contained in the President's Fiscal Year 1999 Budget Proposal (JCS–4–98), (February 24, 1998), p. 223).

The Treasury Department in the Administration's FY 1999 Budget has proposed a 20-percent excise tax on factoring companies that purchase structured settlement payments from injured victims. Under the Administration's proposal, ''any person purchasing (or otherwise acquiring for consideration) a structured settlement payment stream would be subject to a 20 percent excise tax on the purchase price, unless such purchase is pursuant to a court order finding that the extraordinary and unanticipated needs of he original recipient render such a transaction desirable.'' (Treasury General Explanation, at p. 122.) The proposal would apply to transfers of structured settlement payments made after date of enactment.

DESCRIPTION OF THE ACT

1. Stringent Excise Tax on Persons Who Acquire Structured Settlement Payments in Factoring Transactions.

In its analysis of the Administration's proposal, the Joint Tax Committee notes the potential concern that in some cases the imposition of a 20-percent excise tax may result in the factoring company passing the tax along by reducing even further the already-heavily discounted lump sum paid to the injured victim for his or her structured settlement payments. The Joint Committee notes that ''[o]ne possible response to the concern relating to excessively discounted payments might be to raise the excise tax to a level that is certain to stop the transfers (perhaps 100 percent). . . .'' (Joint Committee on Taxation, Description of Revenue Provisions Contained in the President's Fiscal Year 1999 Budget Proposal (JCS–4–98) (February 4, 1998), p. 223).

Factoring company purchases of structured settlement payments so directly subvert the Congressional policy underlying structured settlements and raise such serious concerns for structured settlements and the injured victims that it is appropriate to impose on the factoring company a more stringent excise tax rate applied against the amount of the discount reflected in the factoring transaction (subject to a limited exception described below for genuine court-approved hardships).

Accordingly, the Act would impose on the factoring company that acquires structured settlement payments directly or indirectly from the injured victim an excise tax equal to 50 percent of the difference between (i) the total amount of the structured settlement payments purchased by the factoring company, and (ii) the heavily-discounted lump sum paid by the factoring company to the injured victim.

Similar to the stiff excise taxes imposed on prohibited transactions in the private foundation and pension contexts—which can range as high as 100 to 200 percent—this stringent excise tax is necessary to address the very serious public policy concerns raised by structured settlement factoring transactions.

Unlike the Administration's proposed tax imposed on the purchase price paid by the factoring company, the excise tax imposed on the factoring company under the Act would use a more stringent tax rate of 50 percent and would apply to the excess of the total amount of the structured settlement payments purchased by the factoring company over the heavily-discounted lump sum paid to the injured victim.

The excise tax under the Act would apply to the factoring of structured settlements in tort cases and in workers' compensation.

A structured settlement factoring transaction subject to the excise tax is broadly defined under the Act as a transfer of structured settlement payment rights (including portions of payments) made for consideration by means of sale, assignment, pledge, or other form of alienation or encumbrance for consideration.

2. Exception from Excise Tax for Genuine, Court-Approved Hardship

The stringent excise tax would be coupled with a limited exception for genuine, court-approved financial hardship situations. Drawing upon the hardship standard enunciated in the Treasury proposal, the excise tax would apply to factoring companies in all structured settlement factoring transactions except those in which the transfer of structured settlement payment rights (1) is otherwise permissible under applicable Federal and State law and (2) is undertaken pursuant to the order of a court (or where applicable, an administrative authority) finding that ''the extraordinary, unanticipated, and imminent needs of the structured settlement recipient or his or her spouse or dependents render such a transfer appropriate.''

The exception is intended to apply to the limited number of cases in which a genuinely ''extraordinary, unanticipated, and imminent hardship'' has actually arisen and been demonstrated to the satisfaction of a court

(e.g., serious medical emergency for a family member). In addition, as a threshold matter, the transfer of structured settlement payment rights must be permissible under applicable law, including State law. The Act is not intended by way of the hardship exception to the excise tax or otherwise to override any Federal or State law prohibition or restriction on the transfer of the payment rights or to authorize factoring of payment rights that are not transferable under Federal or State law. For example, the States in general prohibit the factoring of workers' compensation benefits. In addition, the State laws often prohibit or directly restrict transfers of recoveries in various types of personal injury cases, such as wrongful death and medical malpractice.

The relevant court for purposes of the hardship exception would be the original court which had jurisdiction over the underlying action or proceeding that was resolved by means of the structured settlement. In the event that no action had been brought prior to the settlement, the relevant court would be that which would have had jurisdiction over the claim that is the subject of the structured settlement or which would have jurisdiction by reason of the residence of the structured settlement recipient. In those limited instances in which an administrative authority adjudicates, resolves, or otherwise has primary jurisdiction over the claim (e.g., the Vaccine Injury Compensation Trust Fund), the hardship matter would be the province of that applicable administrative authority.

3. Need to Protect Tax Treatment of Original Structured Settlement

In the limited instances of extraordinary and unanticipated hardship determined by court order to warrant relief under the hardship exception, adverse tax consequences should not be visited upon the other parties to the original structured settlement. in addition, despite the anti-assignment provisions included in the structured settlement agreements and the applicability of a stringent excise tax on the factoring company, there may be a limited number of non-hardship factoring transactions that still go forward. If the structured settlement tax rules under I.R.C. §§72, 130 and 461(h) had been satisfied at the time of the structured settlement, the original tax treatment of the other parties to the settlement—i.e., the settling defendant (and its liability insurer) and the Code section 130 assignee—should not be jeopardized by a third party transaction that occurs years later and likely unbeknownst to these other parties to the original settlement.

Accordingly, the Act would clarify that if the structured settlement tax rules under I.R.C. §§72, 130, and 461(h) had been satisfied at the time of the structured settlement, the section 130 exclusion of the assignee, and section 461(h) deduction of the settling defendant, and the Code section 72 status of the annuity being used to fund the periodic payments would remain undisturbed.

That is, the assignee's exclusion of income under Code section 130 arising from satisfaction of all of the section 130 qualified assignment rules at the time the structured settlement was entered into years earlier would not be challenged. Similarly, the settling defendant's deduction under Code section 461(h) of the amount paid to the assignee to assume the liability would not be challenged. Finally, the status under Code section 72 of the annuity being used to fund the periodic payments would remain undisturbed.

The Act provides the Secretary of the Treasury with regulatory authority to clarify the treatment of a structured settlement recipient who engages in a factoring transaction. This regulatory authority is provided to enable Treasury to address issues raised regarding the treatment of future periodic payments received by the structured settlement recipient where only a portion of the payments have been factored away, the treatment of the lump sum received in a factoring transaction qualifying for the hardship exception, and the treatment of the lump sum received in the non-hardship situation. It is intended that where the requirements of section 130 are satisfied at the time the structured settlement is entered into, the existence of the hardship exception to the excise tax under the Act shall not be construed as giving rise to any concern over constructive receipt of income of the injured victim at the time of the structured settlement.

4. Tax Information Reporting Obligations With Respect to a Structured Settlement Factoring Transaction

The Act would clarify the tax reporting obligations of the person making the structured settlement payments in the event that a structured settlement factoring transaction occurs. The Act adopts a new section of the Code that is intended to govern the payor's tax reporting obligations in the event of a factoring transaction.

In the case of a court-approved transfer of structured settlement payments of which the person making the payments has actual notice and knowledge, the fact of the transfer and the identity of the acquirer clearly will be known. Accordingly, it is appropriate for the person making the structured settlement payments to make such return and to furnish such tax information statement to the new recipient of the payments as would be applicable under the annuity information reporting procedures of Code section 6041 (*e.g.*, Form 1099–R), because the payor will have the information necessary to make such return and to furnish such statement.

Despite the anti-assignment restrictions applicable to structured settlements and the applicability of a stringent excise tax, there may be a limited number of non-hardship factoring transactions that still go forward. In these instances, if the person making the structured settlement payments has actual notice and knowledge that a structured settlement factoring transaction has taken place, the payor would be obligated to make such return and to furnish such written statement to the payment recipient at such time, and in such manner and form, as the Secretary of the Treasury shall by regulations provide. In these instances the payor may have incomplete information regarding the factoring transaction, and hence a tailored reporting procedure under Treasury regulations is necessary.

The person making the structured settlement payments would not be subject to any tax reporting obligation if that person lacked such actual notice and knowledge of the factoring transaction.

Under the Act, the term ''acquirer of the structured settlement payment rights'' would be broadly defined to include an individual, trust, estate, partnership, company, or corporation.

The provision of section 3405 regarding withholding would not apply to the person making the structured settlement payments in the event that a structured settlement factoring transaction occurs.

5. Effective Date

The provisions of the Act would be effective with respect to structured settlement factoring transactions occurring after the date of enactment of the Act.

NATIONAL WEATHER SERVICE—OVER 200 YEARS OF FORECASTING, WARNING AND PROTECTING THE AMERICAN PEOPLE

HON. TIM ROEMER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. ROEMER. Mr. Speaker, I rise to bring to my colleagues' attention the outstanding work of the National Weather Service. Especially during this red-hot summer, we should acknowledge the tremendous work of the National Weather Service to observe, predict, forecast and warn the American people of weather events.

The National Weather Service, as part of the National Oceanic and Atmospheric Administration [NOAA] of the Department of Commerce, utilizes a wide variety of tools, from low-tech to state of the art technology to accurately predict and forecast what will happen in our skies today, tomorrow, and beyond.

It was suggested earlier today that the National Weather Service doesn't have sufficient records of past weather conditions to be able to put this summer's heat wave in proper historical perspective. I would like to remind my colleagues that the NOAA has the world's largest active archive of weather data. Not only can they tell you what the weather was in the 1950's, they can tell you what the temperature and conditions were during the early days of the republic.

How do we now that? The NOAA's National Climatic Data Center has Benjamin Franklin's handwritten observations of the heat and humidity of a Philadelphia summer over 200 years ago.

Not only does the NOAA have an incredible store of historical data, they are receiving 55 gigabytes of new weather information each day—the equivalent of 18 million pages a day.

Armed with this wealth of historical data, and constantly added to and refined with the incorporation of new satellite and computer information, the National Weather Service creates computer models. These models reflect the heritage of past weather systems, to accurately forecast tomorrow's weather. So when the National Weather Service says its going to be hot tomorrow in South Bend, or Dallas or St. Louis, you can count on it.

I commend the NOAA and the NWS on their outstanding work on behalf of the American people.

AMERICA FACES THREAT FROM A BALLISTIC MISSILE ATTACK

HON. NEWT GINGRICH

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. GINGRICH. Mr. Speaker, as former Secretary of Defense Donald Rumsfeld pointed out earlier this week, America faces a very real and serious threat from a ballistic missile attack. The bipartisan Rumsfeld commission unanimously concluded that the threat is much greater and the warning time available to defend against that threat is much shorter than the Clinton administration has admitted. Finally, the commission expressed concern that

the ability of our intelligence community to assess these threats is severely deteriorating. I believe that it is now more important than ever to renew our commitment to working to deploy a national missile defense system. I want to bring the following enlightened editorials by William Safire, Frank Gaffney, Jr., and Thomas Moore to the attention of my colleagues which echo the serious concerns expressed by Mr. Rumsfeld and his colleagues on the Commission.

[From the Washington Times; July 21, 1998]

ALARM BELL ON VULNERABILITY TO MISSILES

THE UNITED STATES MUST PROMPTLY BEGIN DEPLOYING DEFENSES AGAINST BALLISTIC MISSILE ATTACK

(By Frank Gaffney, Jr.)

The release last week of a long-awaited ''second opinion'' on the missile threat to the United States more than lived up to high expectations.

The blue-ribbon, bipartisan panel—chartered by Congress and ably led by former Defense Secretary Donald Rumsfeld—unanimously warned that ''the U.S. might well have little or no warning before operational deployment'' of ballistic missiles capable of delivering, for example, Iranian, Iraqi or North Korean weapons of mass destruction against American cities.

This finding stands in stark contrast to the pollyannish, and highly politicized, judgment rendered by the Clinton administration's 1995 National Intelligence Estimate (NIE) on the emerging danger posed by ballistic missiles. Incredibly, that NIE found there would be no threat from long-range ballistic missiles for at least 15 years.

Of course, in order to reach this preposterously sanguine conclusion, the Intelligence Community had to make three heroic assumptions:

(1) Neither Russia nor China—which have such long-range missiles in place today—would pose a danger.

(2) Neither of these nations would help any other state accelerate the acquisition of ballistic missile technology.

(3) And only the continental United States would be considered as targets, since Alaska and Hawaii would be within range of medium-range missiles from Korea.

The Rumsfeld Commission made short work of these assumptions. It noted that Russia and China are both undergoing unpredictable transitions and are actively spreading ballistic missile and other dangerous technologies. (The commission also confirms a recent finding of Sen. Thad Cochran's Governmental Affairs Subcommittee that the United States is itself an important, albeit unintentional, contributor to the hemorrhage of proliferation-sensitive equipment and know-how.)

Perhaps most importantly, Mr. Rumsfeld and his cohorts—including Dr. Berry Blechman, Dr. Richard Garwin and Gen. Lee Butler, individuals expected by the Democrats who appointed them to dissent from any sharp critique of the administration's NIE and, thereby, to neutralize the impact of the commission's findings—addressed themselves to the missile threat to all of the United States. They confirmed that Alaska and Hawaii are at risk in the near-term. The Rumsfeld commissioners went on, however, to point out that missiles now in the inventories of virtually every bad actor on the planet could be readily launched from tramp steamers or other vessels at the vast majority of the American population living within 100 miles of the nation's coastlines.

As columnist William Safire pointed out in the New York Times yesterday, this reality means the United States could be subjected to blackmail, with potentially profound diplomatic and strategic implications. He lays out three frighteningly plausible scenarios in which the use of North Korean, Iraqi or Chinese missiles are threatened to compel American accommodation.

Moreover, Mr. Safire makes explicit a conclusion the Rumsfeld Commission could only imply, given that its mandate was limited to addressing the missile threat, not what should be done in response to it: The United States must promptly begin deploying defenses against ballistic missile attack. Mr. Safire endorses an approach that will produce far more effective anti-missile protection, far faster and far more inexpensively than any other option—by adapting the Navy's AEGIS fleet air defense system to give it robust missile-killing capabilities.

The AEGIS option has been receiving increasing support in recent weeks. A classified study prepared by the Pentagon's Ballistic Missile Defense Organization that has just been released to Congress reportedly confirms the conclusions of an analysis prepared by another blue-ribbon commission sponsored a few years ago by the Heritage Foundation: Sea-based missile defenses are technically feasible and could contribute significantly to protecting the United States—all the United States—as well as America's forces and allies overseas against ballistic missile attack.

The inherent appeal from strategic, technical and fiscal points of view also prompted Jim Nicholson, the chairman of the Republican National Committee, to make prompt deployment of the AEGIS system the centerpiece of a dramatic pronouncement: In these pages on June 21, he invited ''President Clinton, Vice President Al Gore and other Democrats to join [the GOP] and make safeguarding America [against ballistic missile attack] a bipartisan project. If they will not, the Republican Party is prepared to have this become a political issue.''

The problem, as Mr. Safire has pointed out, is that a sea-based missile defense (and indeed, any other that would provide territorial protection of the United States) is inconsistent with the 1972 Anti-Ballistic Missile (ABM) Treaty. Worse yet, the nation would even be denied the ability to adapt the AEGIS system to make effective defenses against short-range missiles if new treaty arrangements negotiated by the Clinton administration and signed in New York last September are ratified.

The good news is that the Senate seems unlikely to go along with these agreements. This is particularly true in light of a new legal memorandum prepared for Heritage and providing analytical backup for the common-sense proposition that the ABM Treaty ceased to exist after the other party, the Soviet Union, ceased to exist. It is hard to believe any responsible Senator would want to adopt new treaty impediments to missile defenses in the grim strategic environment described by the Rumsfeld Commission.

The bad news is that the Clinton administration is proceeding with implementation of the September agreements even though they have yet to be submitted to the Senate for its advice and consent, to say nothing of their having been approved. In a May 1 memorandum, Defense Secretary William Cohen directed that ''formal planning and preparation activities'' to ensure compliance with these accords be undertaken using fiscal 1998 funds. As a practical matter, this means steps that would be non-compliant—for example, developing more capable Navy missile interceptors for the AEGIS system—will be strangled in the crib.

Taken all together, these developments make one thing perfectly clear: The United States will be defended against missile attack. The only question is: Will its defenses be put into place before they are needed, or after? The answer depends on leadership. With the warning given by the Rumsfeld report and the feasible, affordable defense offered by the AEGIS option, there is no excuse for not providing such leadership on a bipartisan basis. Failing that, the Republicans must not shrink from doing so as a ''political issue.''

[From the New York Times, July 20, 1998]

TEAM B VS. C.I.A.—RUMSFELD REPORT: IGNORE AT PERIL

(By William Safire)

WASHINGTON.—Imagine you are the next U.S. President and this crisis arises:

The starving army of North Korea launches an attack on South Korea, imperiling our 30,000 troops. You threaten massive air assault; Pyongyang counterthreatens to put a nuclear missile into Hawaii. You say that would cause you to obliterate North Korea; its undeterred leaders dare you to make the trade. Decide.

Or this crisis: Saddam Hussein invades Saudi Arabia. You warn of Desert Storm II; he says he has a weapon of mass destruction on a ship near the U.S. and is ready to sacrifice Baghdad if you are ready to lose New York. Decide.

Or this: China, not now a rogue state, goes into an internal convulsion and an irrational warlord attacks Taiwan. You threaten to intervene; within 10 minutes, ICBM's are targeted on all major U.S. cities. Decide.

Before you do, remember this: in 1998, the C.I.A. told your predecessor that it was highly unlikely that any rogue state ''except possibly North Korea'' would have a nuclear weapon capable of hitting any of the ''contiguous 48 states'' within 10 to 12 years. (That's some exception; apparently our strategic assessors are untroubled at the prospect of losing Pearl Harbor again.)

You have no missile defense in place. The C.I.A. assured your predecessor you would have five years' warning about other nations' weapons development before you would have to deploy a missile defense.

But the C.I.A. record of prediction is poor. President Bush was assured that Saddam would have no nuclear capability for the next 10 years; when we went in after he invaded Kuwait, however, we discovered Iraq to be less than a year away. And India, despite our expensive satellite surveillance, surprised us with its recent explosion.

Six months ago, Congress decided to get a second opinion about our vulnerability. Donald Rumsfeld, a former Defense Secretary, was named to lead a bipartisan Commission to Assess the Ballistic Threat to the United States. Its nine members are former high Government officials, military officers and scientists of unassailable credibility. Cleared for every national secret, these men with command experience had the advantage denied to compartmented C.I.A. analysts.

The unclassified summary of this ''Team B's'' 300-page report was released last week and is a shocker. The direct threat to our population, it concluded, ''is broader, more mature and evolving more rapidly than has been reported in estimates and reports by the intelligence community.''

Not only are Iran and other terrorist states capable of producing a nuclear-tipped missile within five years of ordering it up; they are capable of skipping the testing and fine-tuning we have depended on as our cushion to get defenses up. That means, the commission concluded, the warning time the U.S. will have to develop and deploy a missile defense is near zero.

Let's set aside our preoccupation with executive privileges and hospital lawsuits long

enough to consider the consequences of Team B's judgment. The United States no longer has the luxury of several years to put up a missile defense, as we complacently believe. If we do not decide now to deploy a rudimentary shield, we run the risk of Iran or North Korea or Libya building or buying the weapon that will enable it to get the drop on us.

Rumsfeld's commission was charged only with assessing the new threat and not about what we should do to meet the danger.

Nine serious men concluded unanimously that our intelligence agencies, on which we spend $27 billion a year, are egregiously misleading us. Smiling wanly, the Director of Central Intelligence, George Tenet, responded that ''we need to keep challenging our assumptions.''

Wrong; we need to defend ourselves from the likely prospect of surprise nuclear blackmail. A first step is Aegis, a naval theater defense (named after the goatskin shield of Zeus). But that requires this President to redefine a 1972 treaty with the Soviets that he thinks requires us to remain forever naked to all our potential enemies.

The crisis is not likely to occur as Clinton's sands run out. His successor will be the one to pay—in the coin of diplomatic paralysis caused by unconscionable unpreparedness—for this President's failure to heed Team B's timely warning in 1998

[From the Washington Times, July 20, 1998]

EVERY ROGUE HIS MISSILE

The Commission to assess the Ballistic Missile Threat to the United States delivered its findings to Congress last week, and it would take more than nerves of steel not to find the Commission's report spine-chilling. According to the nine-member bipartisan Commission, the United States could be vulnerable to ballistic missile attack from any number of countries within the next five years. Needless to say, it is not the best boys on the block who look to build ballistic missiles; think North Korea, think Iran, and many other aspiring regional players. Swell, just swell.

But almost as chilling as the findings themselves is the fact that they are completely at odds with the National Intelligence Estimate (NIE) produced by the CIA just 3 years ago, a document that blithely predicted that this threat would surely not be a problem until 15 years down the road. (Or at least, not for the 48 contiguous states, leaving Alaska and Hawaii to fend for themselves.) Not only was the CIA estimate too optimistic to be believed, it was also blatantly political in the sense of providing arguments for the Clinton administration's opposition to a national ballistic missile defense.

At the time, an incredulous Republican Congress mandated a new study to be done, a ''Team B'' approach if you will, an alternative analysis. In January, the Commission, under the leadership of former Secretary of Defense Donald Rumsfeld, sat down with the mandate and the access over a six-month period to look at all the CIA's information and studies. Their conclusions were unanimous, and ought to convince any doubters that the urgent need is there to counter the growing threat from abroad before it is too late.

The language of the 30-page unclassified executive summary (the classified report delivered to the intelligence committees of Congress is five times as long) deserves to be quoted to underline the gravity of the situation:

''Concerted efforts by a number of overtly or potentially hostile nations to acquire ballistic missiles with biological or nuclear payloads pose a growing threat to the United States, its deployed forces and its friends and allies. These newer, developing threats in North Korea, Iran and Iraq are in addition to those already posed by Russia and China, nations with which we are not now in conflict but which remain in uncertain transitions. The newer ballistic missile-equipped nations' capabilities will not match those of U.S. systems for accuracy or reliability. However, they would be able to inflict major destruction on the U.S. within about five years of a decision to acquire such a capability (10 years in the case of Iraq). *During several of those years, the U.S. might not be aware that such a decision had been made.*'' (Emphasis added.)

So, will the Rumsfeld Commission change minds in the White House? It should, but don't hold your breath. The Clinton administration is wedded not to real defense but to an unrealistic policy of arms control by international treaties, which often not only are not enforceable, but may exacerbate the problem. Every time a U.S. ambassador delivers a demarche to Russian or Chinese officials over some piece of proliferation business, we signal how American intelligence works—after which information tends to dry up.

Even more problematic is the fact that the administration is forging ahead with the revision of the Anti-Ballistic Missile (ABM) treaty, seeking implementation of this dubious document before the Senate has approved it, as noted by Thomas Moore of the Heritage Foundation on the opposite page. In fact, most of the administration's resistance to missile defense rests on the notion that this would violate the ABM treaty and offend the Russians, one of the four successor nations that inherited ballistic missiles from the Soviet Union, with which the original treaty was concluded in 1972. Touching as such solicitude for Russian sensitivities may be, it hardly takes into account the fact that Russia is one of the primary sources of proliferation when it comes to missile technology—and precisely one of the problems.

Enough is enough. We have in the Rumsfeld Commission report evidence aplenty that we are facing a serious national security threat. To continue to leave Americans vulnerable is unconscionable.

[From the Washington Times, July 20, 1998]

THE BEST DEFENSE IS A MISSILE DEFENSE

(By Thomas Moore)

On July 15 a Congressional commission headed by former Defense Secretary Donald Rumsfeld and composed of some of America's best strategic analysts released its report on the ballistic missile threat to the United States. Contrary to what the Clinton administration would have us believe, the bipartisan Rumsfeld Commission found that a hostile power could deploy long-range missiles capable of striking the United States with little or no warning. The proliferation of missile components or entire systems might equip a rogue regime with strategic missiles before the intelligence community could alert us in time to respond.

Of course, the best response to the development of such weapons is ballistic missile defense, but the Clinton administration has steadfastly opposed it. In 1995, to deflect criticism of its anti-missile defense posture, the administration tasked the intelligence community to answer skewed questions about the missile threat. These questions were clearly designed to produce an assessment favorable to the president's policies. The result was a National Intelligence Estimate (NIE) assessing the missile threat to the U.S. homeland as 15 years in the future—and incidentally, omitting Hawaii and Alaska from consideration. Garbage in, garbage out, as they say. It was this deeply flawed NIE that forced Congress to create the Rumsfeld Commission.

It should come as no surprise that the White House politicized U.S. intelligence in order to justify its neglect in defending the nation. In fact, President Clinton politicizes everything he touches. In the words of William Kristol, he and his minions subordinate all the purposes and instrumentalities of government to their selfish purposes. This is the real significance of the parade of scandals emanating from the White House. Perhaps the American people are willing to tolerate sexual misconduct in high office as long as the Dow Jones index continues to soar. But they cannot afford to tolerate official misconduct that jeopardizes their safety and survival.

Why does the Clinton administration continue to leave Americans defenseless against the world's deadliest weapons? The failure to counter missiles armed with hyperlethal weapons is incomprehensible, since we now have the technology to do the job, and at an affordable cost. But deliberate vulnerability is the administration's preferred policy. It is without precedent in human history—that a great military and economic power, faced with a dire and growing threat, and possessing the means to protect itself, intentionally chooses to remain vulnerable.

The primary obstacle to missile defense is the 1972 Anti-Ballistic Missile (ABM) treaty with the now defunct Soviet Union. This Cold War relic prohibited each treaty partner from deploying a nationwide missile defense and placed other limits on testing and development, crippling the U.S. missile defense program from the very beginning. The fall of the USSR should have eliminated the ABM Treaty as an obstacle to missile defense. Yet arms control and foreign policy elites, clinging to their old dogmas like pagan priests, have kept the U.S. ensnared in the ABM treaty even though our treaty partner and the Cold War conditions that gave rise to it are long gone.

The Heritage Foundation recently commissioned a study by the Washington law firm of Hunton & Williams which concludes that the ABM treaty legally terminated with the end of the USSR and the resulting absence of a bona fide treaty partner. This conclusion is based on the relevant Constitutional law and international law, and has been vetted by the nation's top legal scholars.

However, the Clinton administration is no wedded to the ABM treaty that it is attempting to solve the problem of no legally valid successor by creating a new ABM treaty. An agreement signed last year in New York would convert the now defunct ABM treaty into a new, multi-lateral agreement with Russia, Ukraine, Belarus and Kazahstan. The administration's new ABM agreement would impose new restrictions on the most promising theater missile defenses as well.

Article II, Section 2 of the U.S. Constitution and other laws require that this new ABM treaty come before the Senate for its advice and consent. But the Clinton administration is quietly implementing it without the Senate's approval. This is official misconduct writ large. If allowed to get away with this breach of the Constitution and statute law, the White House would lock us into vulnerability to ballistic missiles for the foreseeable future. As in the suborning of U.S. intelligence, the White House shows a fundamental contempt for the legal and moral norms which have protected our liberty and security for 200 years and made our system of self-government the envy of the world.

Those who care about America's security and the rule of law must work to make sure

the administration does not succeed in implementing the sweeping new restrictions of the New York accords as a mere executive agreement. Defense Secretary William Cohen has already issued guidance to the Pentagon for compliance with the New York ''demarcation'' agreements on theater missile defenses, systems which were not even covered in the original ABM Treaty. The body which implements the ABM Treaty, the Standing Consultative Commission (SCC), will meet again in Geneva in September. Unless blocked by Congress, that meeting will approve a periodic five-year renewal of the 1972 ABM Treaty and take further steps to harden the New York ABM agreement into a fait accompli. Compounding the offense, the American delegation of the SCC is led by a man who has never received Senate confirmation.

Congress must insist that the White House stop the illegal implementation of the New York ABM agreement and submit it for the Senate's advice and consent in a timely fashion, using all the tools at its disposal if necessary. For example, Congress should amend the relevant appropriations bill to prohibit any funds for ABM treaty-related activities of the SCC until the Senate has had the chance to approve the new ABM package. The Senate can take legislative ''hostages,'' denying confirmation to administration appointees until the White House keeps its promise to submit the new agreements.

The unprecedented refusal of a U.S. president to perform the most important functions of his office—provide for the common defense and uphold the law—confronts the American people with a stark moral and political dilemma. If we are to have no say through our representatives in Congress over policies that put our lives in jeopardy, can we claim any longer to be self-governing citizens of a constitutional republic? The Rumsfeld Commission has sounded a clear warning about the threat of ballistic missiles. But this warning tell us something else—we can no longer cling to the illusion that the character of our leaders doesn't count. If our leaders won't fulfill their most important moral and political responsibilities, then we the people must held them accountable. The ancient Greeks believed that a man's character is his fate. The same may be said of nations.

POLITICAL VOTE AND A POLITICAL DEBATE ON A WOMAN'S RIGHT TO CHOOSE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. STARK. Mr. Speaker, I rise today to oppose the vote to override the President's veto of legislation passed by this Congress to criminalize a specific abortion procedure used in catastrophic pregnancies. Make no mistake about it, this is a political vote and a political debate—a debate fraught with inflammatory rhetoric and distorted facts.

The fact is, there is no medical procedure called a ''partial birth abortion''—that's a name made up by opponents of choice to distort the issue. What we're talking about is a procedure used in late term catastrophic pregnancies, when the fetus has a horrible abnormality, or the pregnancy seriously threatens the mother's life or health.

The vote to override the President's veto of this bill is a blatant attempt to shelter the hypocrisy of the abortion debate—that the strongest opponents of the right to choose also oppose programs promoting comprehensive sex education and birth control, which actually reduce unintended pregnancies. Instead, anti-choice Members of Congress would make access to family planning options more difficult, more dangerous, more expensive, and more humiliating. A vote to override the President's veto would threaten doctors with fines and imprisonment, and prevents not one teen pregnancy.

Doctors, not politicians, must decide what medical treatments are the best for these patients. Doctors use this procedure when they believe it is the safest way to end a pregnancy and leave the woman with the best chance to have a healthy baby in the future. Congress should not second-guess their medical judgment.

I ask my colleagues in the majority, who often express their disdain at the federal government's involvement in their personal lives, to oppose the veto override. It doesn't get more personal than this.

SECURITIES LITIGATION UNIFORM STANDARDS ACT OF 1998

SPEECH OF

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Ms. HARMAN. Mr. Speaker, as an original cosponsor of H.R. 1689, this day has been a long time coming.

I first want to commend the chairmen and ranking members of the relevant committees, as well as my friend and colleague, ANNA ESHOO, for their leadership.

Mr. Speaker, in 1995, Congress enacted, over the President's veto, the Securities Litigation Reform Act. This act limits the opportunities to bring abusive and frivolous class action suits—suits which divert precious financial resources from leading-edge high technology companies. The act continues protections for investors against genuine fraud, as it should, but protects forward-looking statements made by companies issuing nationally-traded securities from strike suits.

With ''strike'' suits in Federal courts less likely to succeed, a new venue has been increasingly used—State courts. Such suits potentially have the same chilling effect as those previously brought in Federal court—until today.

The measure before us, the Securities Litigation Uniform Standards Act, sets forth clear and uniform standards for bringing securities class actions under State law and would generally proscribe bringing a private class action suit involving 50 or more parties except in Federal court.

Mr. Speaker, enactment of this measure should complete an important reform initiated in 1995. Securities litigation needed reform. The future of our Nation's competitive advantage in the world lies in our ability to develop products and services that are on the leading edge of technology and research. The business ventures which undertake such activities are among the fastest growing sectors of our economy. Indeed, in many places in our country, including California's 36th District, they are the pride of our economy.

But if these business ventures are saddled by the costs and distractions of unwarranted lawsuits, filed when stock prices fluctuate for reasons often beyond the control of business management, the consequences are to chill economic growth. Despite the absence of wrongdoing by managers, corporations are essentially forced to pay large sums to avoid even larger expenses associated with their legal defense. The ultimate loser, of course, is the individual long-term investor whose share value was diminished as a result of these suits.

Mr. Speaker, let me assure my colleagues that the reform measure before us continues to protect investors. It recognizes the important role the private litigation system has played in maintaining the integrity of our capital markets. Yet, at the same time, the bill recognizes that forum shopping cannot be a new pathway for enterprising parties to gain new profits. The rights of the aggrieved investor to seek justice and restitution is maintained, while the opportunity to manipulate procedures to the detriment of the company and legitimate investors is hopefully ended.

The Securities Litigation Uniform Standards Act is supported by the Securities and Exchange Commission and the administration and I urge its support.

THE GROWING U.S. TRADE DEFICIT WITH CHINA AND JAPAN

HON. WILLIAM O. LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. LIPINSKI. Mr. Speaker, I rise today to speak about our rapidly growing trade deficit with China and Japan and to strongly urge the Administration to take stronger measures to lower foreign trade barriers to American goods and services.

China and Japan are this nation's largest deficit trading partners. In 1997, our respective trade deficits with China and Japan were $53 billion and $58.6 billion. That's a combined deficit of over $110 billion. Needless to say, but nevertheless an important issue to emphasize, the massive trade deficits with Japan and China costs us billions of dollars of exports and tens of thousands—even hundreds of thousands of jobs.

The Administration bears a large part of the blame by deferring to our deficit trading partners during negotiations instead of being more aggressive in promoting fair trade agreements that advance the interests of American workers. It's not as if the Administration does not have the tools to force foreign nations to open up their markets. They do. Section 301 of the Trade Act of 1974 comes to mind. It just seems to me that they lack the will and initiative. Do they even care about the great American middle class, or are they just pandering for political posturing?

I strongly believe with all of my heart that the Administration can do more to open up foreign markets, especially with our largest deficit trading partners: China and Japan. Section 301 is a powerful tool in our arsenal. Congress gave it to the executive branch, but this Administration has been extremely reluctant to

use it. Since this Administration came into office in 1992, not once has a Section 301 investigation been initiated against China despite the overwhelming evidence of massive trade barriers to American products.

Back in 1991, the Bush Administration initiated a Section 301 case against China. We pushed, and China blinked. Since then, however, China has consistently failed to follow through with their obligations outlined in the agreement. It's time to pull out Section 301 again, because American jobs and American working families are at stake here. It's time to stop talking about the problem and time to start doing something about the problem.

PERSONAL EXPLANATION

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. CONYERS. Mr. Speaker, yesterday evening I was at the White House and missed three Roll Call votes.

On rollcall vote No. 330, I was unavoidably detained. Had I been present, I would have voted ''no,'' and I ask unanimous consent that this statement be placed in the appropriate portion of the RECORD.

On rollcall vote No. 333, I was unavoidably detained. Had I been present, I would have voted ''present,'' and I ask unanimous consent that this statement be placed in the appropriate portion of the RECORD.

On rollcall vote No. 334, I was unavoidable detained. Had I been present, I would have voted ''aye.''

TRIBUTE TO MINISTER O'LANDA DRAPER

HON. HAROLD E. FORD, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Friday, July 23, 1998

Mr. FORD. Mr. Speaker. I rise today to honor the memory of international—acclaimed gospel music recording artist Minister O'landa Draper, whose recent death at the age of thirty-four has marked a tragic loss for the city of Memphis, Tennessee, the music industry, and humankind.

The growth and evolution of this twentieth century psalmist has its roots in the richest tradition of Memphis music. O'landa Draper's phenomenal musical talents were recognized by his mother, Marie Draper, and others early in his childhood. In order to prepare for what he knew to be his calling in life, O'landa studies at Overton Performing Arts High under the director of his mentor, Ms. Lula Hedgemon. It was here that he first directed and led a choir, a skill which he continued to develop at the University of Memphis, directing the University's Gospel Choir. At the age of twenty-two with these experiences, O'landa set out on his own and formed a twelve member gospel choir known as ''O'landa Draper and the Associates.''

From that point, O'landa Draper's reputation as an innovative arranger, composer, and musician catapulted him into the heights of the gospel music industry. Most notably, his demonstrative, energetic method of choir direction became a signature style which changed the face of the musical genre of contemporary Gospel.

''O'landa Draper and the Associates'' played a significant role in the development of a creative revival of the gospel music industry. The heightened exposure and renewed appeal of gospel music attracted a new generation of fans. Minister Draper was a five-time Grammy nominee and a Dove, Vision, and Stellar award winner. A member of he Board of Governors for the National Academy of Recording Arts and Sciences, Minister Draper performed for Presidents Carter, Bush, and Clinton, and for the 1994 Grammy Awards show. Some of the most esteemed members of the gospel and secular music industries recorded and performed with Minister Draper because of his dynamism, excellence and creativity. With only six albums to their credit, ''O'landa Draper and the Associates'' has already set an international standard for gospel music choirs.

O'landa's is a message of love, that defined the invigorating life of this ordained Church of God in Christ minister. His efforts to reach out to the distressed communities of this nation were evidenced by his support for AIDS victims and teenage mothers. His humanitarianism shown brightly with his established scholarship fund and financial support of homeless shelters. His love of God illuminated the lives of many as he shared the beautiful precepts of faith and hope through the wondrous gift of song.

His voice has now joined the heavenly choir to sing before the throne of our God forever, in that place where trouble shall cease and joy shall have no end.

For his life and magnanimous contributions to the community, Mr. Speaker, I would ask you and my colleagues in the U.S. House of Representatives to join with me in honoring the memory of this champion of God's crusade Minister O'landa Draper.

INTRODUCTION OF THE ENDANGERED SPECIES CONSOLIDATION ACT

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. YOUNG of Alaska. Mr. Speaker, today I am introducing the Endangered Species Consolidation Act which is a very simple, good government bill. This bill will reduce the number of federal agencies with direct responsibility for implementing and enforcing the Endangered Species Act.

The Endangered Species Act was originally enacted in 1973 to provide a federal program to insure that our plant and wildlife resources were protected from extinction. The Endangered Species Act or ESA as it is more commonly called, divides responsibility for its implementation and enforcement between two different federal agencies in two separate federal Departments. The Fish and Wildlife Service within the Department of the Interior is the primary federal agency with responsibility for enforcing the law. The 1997 budget for direct endangered species enforcement within the Fish and Wildlife Service is approximately $80 million. The Fish and Wildlife Service is responsible for listing and developing rules to protect all land based endangered or threatened species and all fresh water fish.

The National Marine Fisheries Service (NMFS), a division of the National Oceanic and Atmospheric Administration (NOAA) within the Department of Commerce has responsibility to implement and enforce the Endangered Species Act when it involves fish in the oceans or which migrate to the oceans, as well as marine mammals and sea turtles. Their annual buget is approximately $20 million.

The Fish and Wildlife Service has approximately 800 employees assigned to protect endangered species, while the National Marine Fisheries Service has approximately 270 employees assigned to protect endangered species.

With the listing of various species of salmon which can migrate hundreds of miles inland to spawn, the jurisdictional reach of the National Marine Fisheries Service now overlaps that of the Fish and Wildlife Service. Many companies and individuals are being required to obtain permits for land based activities from both the Fish and Wildlife Service and the National Marine Fisheries Service for the same activities because of the presence of species that are under the regulation of both agencies. In addition, federal agencies that impact endangered species must conduct consultations with both the Fish and Wildlife Service and the National Marine Fisheries Service in many cases. For example, a timber company in Washington with land adjacent to a stream where salmon migrate and with spotted owl habitat will have to obtain a permit from both agencies to conduct its business.

Having two agencies with overlapping responsibility is a waste of taxpayer funding and takes away resources that can be spent directly on species recovery.

This bill would simply transfer authority for enforcement of the Endangered Species Act to the Fish and Wildlife Service. The National Marine Fisheries Service would continue to regulate all other fishing activities and fisheries management, as well as continuing to protect all marine mammals.

Under the ESA, all federal agencies are required to use their resources and authorities to protect endangered species. Whenever the actions of any federal agencies are likely to impact an endangered speices, that federal agency is required to enter into a consultation with the federal agency that has primary responsibility for endangered species—The Fish and Wildlife Service, except when the species is one under the jurisdiction of the National Marine Fisheries Service. In that case, the agency must consult with NMFS. This duplication of effort and overlapping of responsibility has become very burdensome, expensive, and time consuming, not just for private citizens but for federal agencies as well.

It is time for us to consolidate the ESA functions of these two agencies into one primary agency. This means that when the NMFS will conduct an activity that affects an endangered species, such as issuing fishing permits, it will also be required to consult with the Fish and Wildlife Service, to insure that its activities do not harm those species.

This bill will save time and money for everyone involved in protecting endangered species and most of all will give the taxpayers the most and best conservation for our taxpayer dollars.

H. CON. RESOLUTION ON UGANDA

HON. HOWARD L. BERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. BERMAN. Mr. Speaker, today, I join my colleague Mr. Payne in submitting this resolution condemning the forced abduction of children by the rebel Lord's Resistance Army (LRA) in Northern Uganda. The LRA, a bizarre Christian group supported by the fundamentalist Islamic government in Sudan, has kidnapped some 10,000 Ugandan children and forced them to fight as insurgents. Some of these children are as young as eight years old.

Captive children raid and loot villages and serve in the front lines against the Ugandan army. They are also forced to help kill other abducted children who try to escape. Young teenage girls suffer the additional horror of serving as ''wives'' to ranking rebel soldiers. If they resist, they are beaten, sometimes severely. Girls may be given to several men in the course of a year.

I am heartened that the children's plight is getting more international attention. In March, the U.N. Commission on Human Rights condemned ''in the strongest terms'' the abduction of children in Northern Uganda, and the First Lady addressed the issue in a speech while visiting the country. Much more needs to be done, however.

This resolution condemns the abduction of children by the LRA in northern Uganda and calls for the immediate release of all LRA child captives. It urges the recently-appointed U.N. Special Representative on Children and Armed Conflict to aggressively address the situation, and encourages the U.N. Committee on the Rights of the Child to investigate. The resolution also calls on the Al-Bashir Government in Sudan to stop supporting the LRA and asks President Clinton to provide more support to U.N. agencies and non-governmental organizations working to rehabilitate and reintegrate former child soldiers into society.

I am proud to be an original cosponsor of this important legislation and I urge all my colleagues to support it. Let us help end the nightmare for children in Northern Uganda.

PERSONAL EXPLANATION

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mrs. MALONEY of New York. Mr. Speaker, on Monday, July 20, I was unavoidably detained and missed rollcall votes 297–306. Had I been present, I would have voted ''yes'' on rollcall votes 297, 298, 299, 300 and 301, ''no'' on rollcall vote 302, ''yes'' on rollcall votes 303, 304, and 305, and ''no'' on rollcall vote 306. Please place this in the appropriate place in the RECORD.

MR. STARR: WAIVE REPORTERS' PRIVILEGE OF SILENCE AND ALLOW THEM TO TELL WHAT THEY KNOW

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. CONYERS. Mr. Speaker, Independent Counsel Kenneth Starr is now the subject of multiple investigations of whether he and his staff illegally leaked confidential information to the media. Those investigations include a contempt hearing to be held by Chief Judge Norma Holloway Johnson of the federal court in Washington, and inquiries by the Office of Professional Responsibility of the Justice Department, and the D.C. Bar Counsel. In addition, the Independent Counsel is supposed to be investigating himself.

Mr. Starr has already admitted that he and his chief deputy, Mr. Jackie Bennett, routinely talk to the media on an off-the-record basis regarding their investigation of the President. The Independent Counsel claims, however, that his discussions were legal because the rule of grand jury secrecy does not reach information until it is presented to a grand jury. That argument, in my view, is incorrect.

An important question in these leak investigations will be exactly what was said during meetings between the prosecutors and reporters. In order to have a full and complete record of what went on during those sessions, the Independent Counsel should publicly release the reporters from their vows of silence. After all, is it fair for the Independent Counsel to share confidential information with reporters, and then force them to cover-up possible misdeeds?

I fully respect a reporter's First Amendment right not to reveal a source. But the Independent Counsel can relieve the reporters from having to make a difficult decision to stand mute. Given the significance of issues involving the investigation of the President, Mr. Starr should allow the court and public to know what his media contacts have to say on this subject.

On more than one occasion, the Independent Counsel has called on the President to urge others to waive privileges and testify. The first was when he wrote to the White House Counsel, Mr. Ruff, asking that the President tell Susan McDougal to waive her Fifth Amendment rights and testify before the White water grand jury. Mr. Starr did that even though Ms. McDougal had her own lawyer to advise her, and publicly said that she would not listen to what the President said. In addition, the spokesman for the Independent Counsel, Mr. Bakaly, criticized the President for refusing to urge Ms. McDougal to give up her rights.

A second instance involved the Secret Service. In April of this year, after the Secret Service argued that its agents could not be compelled to testify about the President, Mr. Starr requested that the President waive any Secret Service privilege and order the agents to appear before the grand jury. Mr. Starr made that request even though the privilege was asserted by the Secret Service and not the President, and the Secret Service's director, Mr. Merletti, considered the matter to be one of great national significance.

The President was right when he refused the Independent Counsel's ill-considered requests. But I cannot see any public interest in Mr. Starr's refusal to waive the privilege that requires his media contacts to remain silent in the face of these leak investigations. The Independent Counsel has made clear that he views the invocation of privileges as a roadblock to the truth. How, in good conscience, can he take a different position simply because he has now become the focus of the investigation?

STATEMENT FROM SOME VERMONT HIGH SCHOOL STUDENTS

HON. BERNARD SANDERS

OF VERMONT

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. SANDERS. Mr. Speaker, I would like to have printed in the RECORD this statement by a high school student from my home state of Vermont, who was speaking at my recent town meeting on issues facing young people today. I insert this statement in the CONGRESSIONAL RECORD as I believe that the views of this young person will benefit my colleagues:

STATEMENT BY ERIK KENYON, MEGAN WILLEY, KELLY COOK AND JUSTIN STURGES REGARDING GAY-STRAIGHT ALLIANCE

ERIK KENYON: Thank you.

United Nations here from the Bellows Free Academy Gay-Straight Alliance. You have already heard about gay-straight alliances, so we are just going to tell you a bit today about the way our school works.

Like most places in Vermont, St. Albans—over that way—is fairly isolated. For the first two years of high school, I just didn't date anyone. It was something I had no real urge to do. I never thought, well, maybe I'm gay, because the word never came up at all, until I went off to the Vermont Youth Orchestra—which is really cool—I have to get a plug in here; we have a concert tomorrow by the way—which is where I met my first gay person, and that United Nations. ''That makes sense. Why didn't I think of that?'' This is how isolated St. Albans really is. And St. Albans is actually a big progressive for the State of Vermont, if that tells you anything.

And so, at the beginning of the year, some students got together, and we wanted to start something, and the gay-straight alliance is what we decided on, and here is Justin to tell you about that.

JUSTIN STURGES: When we began, it was a new thing, you know, no one had even thought about GSAs, and so we were met with a certain degree of resistance. There is a story that goes along with this. When we first went into our headmaster's office, there were three of us, Erik, myself and another guy, who couldn't be here. He asked us, Well, how many of you people are there? And that, right there, set the mood. He has gotten better, and I think that we are the reason, to an extent. It was this sense of newness, this sense of an unchartered area that no one had been to yet, and we broke that.

And we have been met with certain degree of resistance from several people, from people in the school, from outside influences, from adults, from the teachers.

Here is Kelly. Kelly is going to talk about an experience of her's.

KELLY COOK: Hi.

Yeah. I joined GSA about three weeks ago, I think. One time, I was walking up to a coffee house which we put on quite often. And a

lot of people don't accept different people, like they call me a freak at my school. I'm like: Okay, whatever. I am just walking out with a whole bunch of people and suddenly these people come by with a truck and throw stones at me. That is the kind of stuff you have to get rid of.

And a lot of people just don't accept gay, bi, or different people at all, and I will hand it over to Erik.

ERIK KENYON: But we have been making success this year, and when we were starting out, there were some people all for us and supportive, and some people that were really against us. But most of the people were just sort of indifferent, and we won over most of them. And we have been working on the rest of them.

And a lot of the time this sort of change—well, the bills and all the policies help a great deal, but a lot of the times, it is that little things. Like an experience I had just last week, just in the cafeteria, and just bringing my tray up and dumping my garbage and all that, and behind me I could hear a chant of, ''Queer, queer, queer,'' getting louder and louder. It started as a stage whisper, which is hard with microphones. But it was just—it is kind of commonplace.

So I just did my thing, put all my stuff away, and then walked over to the table where it was coming from—it was quite obvious—and just stood there and stared at them. And they were just like: Hi. What? They got really uncomfortable, you know.

So I didn't say a thing, just walked away out in the hall, did something or other. And I was really surprised, the boy at the table that was doing it, came that and apologized to me. He said, you know: ''I'm sorry, I didn't mean it,'' and all that. And I was like: Okay, thanks. And he said, ''No, really, I'm sorry. I was just trying to show off. It was stupid.'' And he shook my hand. That was just, like: Oh, wow. That was change, and this is how a lot of these changes happen.

And a lot of other things have come up through the course of the day, about things that people would like to get put into place. And we can speak for some of those, like the harassment policy, which doesn't get exercised enough. It doesn't get exercised, because it is really difficult to exercise, but through our group, we had have had, I think three people so far who have gone through the process and done the paperwork to file the complaint, and the harassment has stopped.

We also put on a number of coffee houses, just to read poetry and stuff. It is a nice, relaxed atmosphere. It was odd at the first one, we had 100 people, out of a student body of 1,000, so you get that kind of one in ten, ten percent, and that was kind of neat.

We also have a Web page, put together for the GSA in the state, to try to help us network. It is a start, but we could use a lot more.

And, Justin?

JUSTIN STURGES: What we see needs to happen—we are obviously here for a purpose—we see, for the advancement of such things as we have been doing, we find it necessary for teachers to be trained. That is the one thing that has been left out. You know, we have done what we can for the student population, and will continue to try to educate them, to get them to be more open to our organization and anyone who is different from what they may see.

We find it necessary for the teachers to be trained, because they are the source, to an extent, because they are there in the classroom with all the students, because they come into contact with every student in that school. And, sometimes, they let things slip that, perhaps, they shouldn't.

Outright Vermont, right here in Burlington, does do a program, and we have talked to them about it, but there were restrictions in our school because of the amount of assemblies we have had and the amount of inservice time that we have had, and we couldn't get anything off the ground. But support for that is the one thing we are rallying for currently, the one thing we see that needs to happen.

Congressman SANDERS: Thank you very much

STATEMENT BY CHRISTIE NOLD REGARDING CHILD LABOR

CHRISTIE NOLD: My name is Christie Nold. I am an eighth grade student at Shelburne Community School.

For the past several weeks, I have been researching the topic of child labor in the U.S. and throughout the world. This is a brief summary of my findings.

The problem: Around the world, there are 250 million underaged children in the work force. There are nearly 300,000 underaged workers in the United States. Working conditions include: Wages as low as $1.50 per day; sexual abuse; physical punishment; exposure to dangerous chemicals; and children chained to their machines.

Companies that utilize child labor include: GAP, Nike, J.C. Penny, Esprit, Disney and many others. For example, workers are paid 6 cents to produce a 101 Dalmations outfit that is sold in the U.S. for $20.

Progress in the fight against child labor: As awareness of this problem that has grown, there has been progress in the fight to end child labor. My research has uncovered that our own congressman, Congressman Sanders, has been the leading spokesman in the U.S. Congress against child labor, and specifically against Nike. His efforts are producing results. As recently as Tuesday May 12, Phillip Knight, the CEO of Nike, announced the following changes in his companies practices: They will raise the minimum age of its workers to 16 at its clothing factor, and 18 at its shoe factories; they will adopt U.S. standards or fresh air inside their factories; they will ask individual foundations and rights groups to monitor Nike plants worldwide; they will begin having on-site education programs at their factories.

Congratulations, Congressman Sanders. Your efforts are paying off.

There is still much work to be done, as the ultimate goal is to bring jobs back to the U.S. and pay American workers a living wage. The Foul Ball Campaign is another area where progress has been made. For years, the vast majority of soccer balls were made and stitched in Pakistan using child labor. FIFA, the governing body of soccer, has determined that it will not put its stamps on soccer balls made by child labor.

The Rugmark campaign has also made progress. Hand-made oriental rugs are commonly made by children who are chained to their machines and guarded by men with guns. The Rugmark label was created in 1997 to indicate rugs that were made without child labor. Now, when you purchase an Oriental rug, you can look for this label.

In conclusion, child labor continues to be one of the worst social and economical problems in the world today. The goal of our generation is to help eliminate this problem by: Becoming aware of companies that utilize child labor and take our business elsewhere; let the leaders of these companies know that we have a lot of consumer power, and will not purchase their products; support those who are leading the fight against child labor.

Thank you.

Congressman SANDERS: That was an excellently written and presented paper. That was really good.

STATEMENT BY AMANDA BEAN, REBECCA WEST, NOEL BAKER, JESSICA DAILEY, SARAH MCDONOUGH, NIKKI ERNO, LOUISE MARTINEK, STACEY ZAK, JODY JERNIGAN AND CELINA COGLAN REGARDING TEEN PREGNANCY/WELFARE REFORM

JESSICA DAILEY. Jessica.

I would like to speak about teens and the resources that we seem to be lacking. We found that there are very few resources for teens either who are pregnant, or who aren't but need help. There is the Lund Family Center, which is pretty much the only one of its kind in the area. And we need more help. There is really nowhere for us to go.

There is also a problem with people who aren't pregnant. They have no really good teen pregnancy prevention programs out there for people at high risk, and we feel there needs to be put more of an emphasis on prevention and giving education for that.

Congressman SANDERS. Other thoughts? We would like to hear from as many folks as possible. Please don't be shy. Who else? Just pass the mike along.

JESSICA DAILEY. Nikki wanted me to say something for her.

Congressman SANDERS. Sure.

JESSICA DAILEY. Also, the program called Spectrum for people who have had children who are in SRS custody who are over the age of 16. However, there are no programs like that for people under 16, and a lot of people are falling through the cracks. There needs to be programs out there for people who are under 16 who are in SRS custody towed.

AMANDA BEAN. I know I am in SRS custody, and I have a daughter. I am not 16, and therefore I can't go into the Spectrum program because of that fact, and I have been living at the Lund Family Center for a very long time. And there are no programs for me except Lund, which, to me, feels like I am staying there a long time, when other girls could be coming into my spot, which could be helping them, when I have already been helped, but, yet, I am not old enough to go into that program that they have.

NOEL BAKER. I think that the schools really need to support our decision. In my case, school told me to get my GED or my adult diploma, and I am not old enough to do that. And I really wanted to get my education and everything, and Lund is the only resource out there that I could go to get my schooling and to parent my son. I really do think that the support of school would really help us right now.

JODY JERNIGAN. My name is Jody, and I'm 14. And I just wanted to say, make the point really clear that there is not much out there for teens, and pregnant teens. Lund has been really helpful, but we need more out there. We need things for teens to do so they are not getting pregnant, and also things for teens to do that are pregnant or that do have children, because there is nothing out there.

LOUISE MARTINEK. I just wanted to say that I think day cares need to be given more money. Day care workers are like making nothing and our day care has no money to do anything.

JESSICA DAILEY. About day care, I am unable to have my child in the day care center at Lund because there aren't enough spots open. It was unreal trying to find a day care that would take subsidy. And even when they did, I am still having to pay extra, and it is very, very difficult. And a lot of the day cares that will accept full subsidy, workers are being paid so low that you are not really getting quality with your child care.

I think that something needs to be done about that, because, I mean, it is pretty bad when you walk into a day care and you have a bunch of kids, hardly any day care workers, and they are not paying attention to

them. I have run into them a couple of times.

Congressman SANDERS. Other comments?

AMANDA BEAN. I was wondering about longer hours of day care, like not longer days, but being open longer. Most day cares are 5:00 or 6:00, and what about people who work until 9:00 or 10:00 at night and have to pay someone extra, and weekend day cares. I work on the weekends, and I have to pay somebody unreal amounts of money to babysit my kid, and there goes most of my money.

Congressman SANDERS. The issue that we are talking about obviously is a very personal and difficult issue. I very much applaud you all for coming up, and I thank you for doing that.

HONORING SGT. JOHN PETERSON

HON. MARGE ROUKEMA

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mrs. ROUKEMA. Mr. Speaker, I rise to call attention of my Colleagues to a tragedy in my Congressional District earlier this month. Sgt. John Peterson, a loyal and dedicated Alpine, New Jersey, police officer was critically injured on the job. His case has brought an outpouring of sympathy from our community.

Sgt. Peterson was directing traffic around a Bell Atlantic cable-stringing crew on Hillside Avenue in Alpine about 1:30 p.m. July 2 when he was struck by a car. The car turned from Church Street onto Hillside, then increased in speed while ignoring Sgt. Peterson's orders to stop. The sergeant finally attempted to jump out of the way but was struck by the car and suffered broken bones in his nose, pelvis, chest and shoulders, among other injuries. He was flown by helicopter to Hackensack University Medical Center, where he was listed in critical but stable condition at last report. A 71-year-old Cresskill woman has been changed with failing to comply with the directions of a police officer.

Sgt. Peterson has patrolled the streets of Alpine for more than 25 years, becoming well-known among the residents of the affluent Bergen County borough. He, his wife, Marie, two adolescent children and one grandchild live in nearby Emerson. The couple also have two adult children. When word of the accident and severe injuries spread, the community was shocked. As a result, Alpine residents Ed and Sally Desser have begun a fund-raising campaign to help Sgt. Peterson and his family pay for medical expenses. A fundraising barbecue will be held at the Desser's home this weekend.

Mr. Speaker, we all know that police officers are among the most valued members of our communities. They work nights, weekends and holidays to protect us, our families and our property. Their work is hard and their pay modest. And every day they know they may be called on to put their lives on the line. Officers' spouses and children pray each day that they will return home from work safely—not a worry most of us have to face. In a small and relatively crime-free community such as Alpine, those worries seldom turn into real-life tragedy. But this terrible accident reminds us of the dangers a police officer faces every moment of every day—whether chasing drug dealers through a crime-ridden corner of a major city or directing traffic in a peaceful suburb.

I ask all the Members of the House to join me in offering their gratitude to the hard work and dedication of officers like Sgt. Peterson across our nation. Let us strive to keep Sgt. Peterson and his family in our thoughts and prayers.

PERSONAL EXPLANATION

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. BECERRA. Mr. Speaker, on July 15, I was unavoidably detained during roll call vote number 282, on final passage of H.R. 3267, a bill concerning the Salton Sea. Had I been present for the vote, I would have voted ''no''.

EXPRESSING CONDOLENCES TO THE STATE AND PEOPLE OF FLORIDA FOR LOSSES SUFFERED AS A RESULT OF WILD LAND FIRES

SPEECH OF

HON. CARRIE P. MEEK

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Monday, July 20, 1998

Mrs. MEEK of Florida. Mr. Speaker, I rise in strong support of House Concurrent Resolution 298. The people in the northeast and central regions of the state of Florida have experienced great hardship because of the destruction of nearly 500,000 acres of land and over $276,000,000 dollars in aggregate damages.

I would like to express my heartfelt sympathy to the people who have personally incurred loss, or who had family and friends who sustained losses due to the brush fires that damaged or destroyed nearly four hundred homes and businesses in Florida.

We must also recognize the firefighters, from forty-seven states across this nation who unselfishly worked around the clock in extreme heat to combat these fires.

At the same time, this incident underscores the need to prepare ourselves in advance for future catastrophes. I am hopeful that we can learn from our experiences in this matter and apply our knowledge to prevention.

With the victims and families of this disaster in mind, I strongly urge my colleagues in the U.S. House of Representatives to vote for House Concurrent Resolution 298.

TRIBUTE TO CAROLE PONCHETTI

HON. GEORGE P. RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. RADANOVICH. Mr. Speaker, I rise today to pay tribute to Fresno Businesswoman Carole Ponchetti, President and Chief Executive Officer of J.E. Ethridge Construction Inc., for her efforts and success in the business arena. Carole Ponchetti's climb and dedication to her current position in a traditionally male-dominated field has made her very deserving of this recognition.

Mrs. Ponchetti has clearly demonstrated a drive for success. She attended California State University, Fresno, earning her license as a Class B General Building Contractor. In 1971, Mrs. Ponchetti began her career with Ethridge, working as a secretary in a one-employee office. Steadily climbing the corporate ladder in the mid 1980's, Mrs. Ponchetti was a key figure in the renovations of the Fresno Bee and the Fresno Metropolitan Museum.

Mrs. Ponchetti has served the community in more ways than one. She is currently on the Chamber of Commerce Board of Directors, a board member of the San Joaquin Business Investment Group (a minority interest), and a member of the Fresno Business Council.

Mr. Speaker, it is with great honor that I pay tribute to Carole Ponchetti for her effort with J.E. Ethridge Construction Inc. Her commitment and unfailing dedication serve not only as a model for current heads of business, but also for women who wish to enter and succeed in the business field. I ask my colleagues to join me in wishing Carol Ponchetti many more years of success.

RECOGNIZING LARRY D. HAAB

HON. GLENN POSHARD

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. POSHARD. Mr. Speaker, I rise today to pay tribute to my constituent, Mr. Larry D. Haab, who will be retiring from the Illinova Corporation, a power company in my congressional district. He has honorably served as Chairman, President and Chief Executive Officer, and will resign from the latter post this summer after more than 25 years of service. I wish him all the best during his retirement.

Larry attended Millikin University in my district and earned his bachelor of science degree in 1959. He recognized that commitment to his career and Illinova was essential in the business world. Larry established his career in the early 1970's when he was appointed manager of data processing at Illinova. His superior service to the company resulted in his promotion to vice president two years later, and reelection in the subsequent years until he achieved the presidency in 1989. By 1991, Larry had achieved the offices of Chairman and Chief Executive Officer. Larry recognized the potential of Illinova, and he wanted to expand it into larger and new markets. During his career, he helped in the growth of the corporation from a local utility to a nationwide business to an international operation.

In addition, Larry devotes his energy to serving on dozens of boards and councils with dynamic leadership and integrity. He understands the importance of being involved and committed to the Decatur community. From the Illinois Energy Association and the Millikin University Alumni Board to the Decatur County Economic Development Foundation, Larry has maintained active involvement with business and community issues. He is married to Ann Haab, and has two daughters and a son.

Mr. Speaker, please help me in recognizing Mr. Larry D. Haab for his dedication and commitment to Illinova and his community. As a member of the House Small Business Committee, it is a pleasure to witness businessmen

such as Larry Haab succeed. I wish him the best during his retirement. He has been very successful with Illinova, and it has been a pleasure to represent him in the United States Congress.

EDUCATION FUNDING

HON. BOB SCHAFFER

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. BOB SCHAFFER of Colorado. Mr. Speaker, just yesterday, I met with principals from schools in the 4th Congressional District of Colorado and I would ask my colleagues to consider the issues raised by these education professionals. Congress, they told me, has mounted bureaucratic obstacles which prevent them from putting federal education dollars to use for their students. The paperwork and bureaucratic red-tape associated with federal money are hurdles which prevent dollars from reaching the classroom.

Principal Betsy Dumph from the town of Hudson, Colorado, stated that small schools like hers simply do not have the money to hire professional grant writers to negotiate the extensive federal grant applications and are therefore at a competitive disadvantage to large districts when seeking federal grants. Another principal described how bureaucratic rules often keep her school ineligible for federal grants. The entire group expressed frustration with federal rules concerning special education which restrict them from removing dangerous students.

These principals aren't the only ones who feel this way. Teachers and parents in northern Colorado told the Committee on Education and the Workforce they share the same sentiments. Over 79% of respondents to an education survey in my district support sending the majority of all federal education funds directly to the classroom. Nearly 85% would support efforts to eliminate onerous federal mandates affecting education.

The objective of these Oversight hearings was to produce the Education at a Crossroads report to Congress. Based on witness testimony, the Subcommittee has made four recommendations—send dollars to the classroom not the education bureaucracy, strengthen local control, emphasize basic academics, and promote parental involvement. These suggestions came after two years of investigations and the testimony of 225 witnesses in 15 states including Colorado. The report was adopted by the Subcommittee on the 17th of July.

Before developing these recommendations, the Subcommittee made several observations: There are 760 federal education programs. An average of 48.6 million hours are spent doing paperwork. As little as 65 cents of every federal tax dollar makes it to the classroom. There are over 18,000 federal employees and full-time equivalents administering federal education programs.

There are disturbing national trends that Congress should address. For example, almost half of America's fourth-graders do not read at even a basic level. Half of all students from urban school districts fail to graduate on time, if at all. The average 1996 NAEP scores among 17-year-olds are lower than they were in 1984. American senior high students only outperformed two out of 21 nations in mathematics according to the Third International Mathematics and Science Study. Public higher education institutions spend one billion dollars on remedial education.

The answer to this situation is simple: Listen to educators, parents, and administrators and take their advice. For once, the government needs to support what works and take the suggestions of professionals who are making the grade and making a difference.

Mr. Speaker, the principals I met with, the letters, responses and phone calls I have received have pointed to the same thing. The findings in the Education at a Crossroads report come as no surprise because they simply state what people have been saying for some time—get rid of the red tape and put dollars in the classroom; trust teachers, local administrators and parents to make decisions about policy and budgeting rather than Washington bureaucrats in the Department of Education. It is time we listen.

JULIAN BREECE: ONE OF D.C.'S BRIGHT STARS

HON. ELEANOR HOLMES NORTON

OF THE DISTRICT OF COLUMBIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Ms. NORTON. Mr. Speaker, I rise today to recognize one of the bright stars of the District of Columbia, Julian O. Breece, Though only seventeen years old, Julian has compiled an exemplary academic record, extensive production and anchoring experience in local and national television, served as a Youth Ambassador to Israel, and participated in the Junior Statesmen summer school program. Now, I am proud to recognize his latest achievement: a $10,000 scholarship in the Arts and Humanities category of the Discover Card Youth Program. Julian joins a select group of only nine award recipients from around the nation, achievers who stand out personally and academically.

Julian Breece, like so many other D.C. students, is a gifted and talented young man. His 4.0 grade point average at Benjamin Banneker Academic Senior High School simply wasn't enough; Julian had to do more. He has worked with the D.C. Public Schools cable station, DC28, for two years, honing his skills as an anchor, writer and producer. Julian is a regular panelist on Black Entertainment Television's Teen Summit show, which airs nationally each week. I am proud that Julian uses his exceptional oratorical and communications skills to serve his community.

Julian's community service endeavors, awards and activities are simply too numerous to list here. From theater troupes to helping the homeless, from foreign affairs programs to science fairs, Julian Breece has made an important contribution to the life the District of Columbia. I have no doubt that he will continue to contribute to this city and this nation as he grows and matures, striving to promote cultural understanding and community awareness. My warmest congratulations to Julian on his latest award, and my regards to his parents, who have raised such a fine son!

ADDITION TO DEBATE ON HOUSE RESOLUTION 392

HON. BENJAMIN A. GILMAN

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. GILMAN. Mr. Speaker, I would like to include the letter of July 16 from Chairman BILL ARCHER and my reply of July 17 as part of the record of the proceedings on House Resolution 392, relating to the role of Japan in solving the economic crisis in Asia, that took place on the House floor on Monday, July 20:

COMMITTEE ON INTERNATIONAL RELATIONS,
Washington, DC, July 17, 1998.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means, House of Representatives.

DEAR BILL: Thank you for your letter about the consideration of H. Res. 392, relating to the role of Japan in solving the economic crisis in Asia.

I very much appreciate your willingness, in view of the urgency of this matter, to forego marking up the resolution in the Committee on Ways and Means.

After consultation with Chairman Bereuter and the minority, I am certainly prepared to bring H. Res. 392 to the floor as ordered reported by the Committee on International Relations on suspension without additional amendment. I also accept the other understandings set out in your letter.

I will be working with the Majority Leader to arrange for early consideration of the Resolution on the suspension calendar.

With best wishes,

Sincerely,

BENJAMIN A. GILMAN,
Chairman.

COMMITTEE ON WAYS AND MEANS,
Washington, DC, July 16, 1998.

Hon. BENJAMIN A. GILMAN,
Chairman, Committee on International Relations, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: I am writing in reference to H. Res. 392, relating to Japan, which was reported to the House by the Committee on International Relations, as amended, on June 25, 1998. The resolution was sequentially referred to the Committee on Ways and Means until July 17, 1998, to address provisions within the Committee's jurisdiction.

On July 15, 1998, the Subcommittee on Trade of the Committee on Ways and Means held a hearing to review U.S.-Japan trade policy. This very productive hearing allowed the Subcommittee to address the necessity for Japanese implementation of broad structural reforms, including deregulation of its economy, reform of its banking system, improved transparency, and the opening of its distribution system to eliminate exclusionary business practices.

Accordingly, in order to expedite consideration of this important legislation, I do not believe that a markup by the Committee on Ways and Means will be necessary on H. Res. 392. However, this is being done only with your assurance that you will bring the resolution, as reported by the Committee on International Relations, to the House for a vote under suspension of the rules, with no additional amendment. In addition, this action by the Committee on Ways and Means with respect to H. Res. 392 is being done with the understanding that it does not in any way prejudice the Committee's jurisdictional prerogative on this measure or any other

similar legislation, and it should not be considered as precedent for consideration of matters of jurisdictional interest to the Committee in the future.

I would appreciate your response to this letter, confirming this understanding with respect to H. Res. 392, and would ask that a copy of our exchange of letters on this matter be included in the record during floor consideration. Thank you for your cooperation and assistance on this matter.

With best personal regards,

BILL ARCHER,
Chairman.

TRIBUTE TO E.B. ''SWEDE'' ANTONELL, JOHN E. BOUDREAU, ROBERT F. BOWMAN, ROBERT L. STANFIELD AND HARVEY WILLIAMS FOR THEIR SERVICE TO THE CENTRAL SAN JOAQUIN VALLEY AGRICULTURAL COMMUNITY

HON. GEORGE P. RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. RADANOVICH. Mr. Speaker, I rise today to pay tribute to E.B. ''Swede'' Antonell, John E. Boudreau, Robert F. Bowman, Robert L. Stanfield and Harvey Williams for their service to the central San Joaquin Valley agricultural community. Each of these gentlemen has distinguished himself as a valued member of the agriculture-water industry.

Mr. E.B. ''Swede'' Antonell was born in Michigan and started his career as a chemist for U.S. Industrial Alcohol after studying chemistry at Stanford University. His service on the Southern San Joaquin Municipal Utility District Board of Directors dates back to the earliest days of water service from the Friant-Kern Canal.

Mr. Antonell came to Kern County in 1938 as a farmer and produce packer. He farmed citrus, potatoes, corn and cantaloupe. He saw that farmers in the Delano and McFarland areas were faced with the pumping of ground water to sustain their agriculture production and were depleting the subterranean water supply. Mr. Antonell decided to actively support the Friant water project, which would enable modern irrigation and use surface water to produce higher yielding crops. Mr. Antonell has been a longtime advocate for agriculture and water in the valley.

Long identified with water industry leadership in Kern County, Mr. Antonell represented the district as a Friant Water Users Authority director since the Authority's formation in October 1985. Beginning in January 1955, Mr. Antonell served as the director of the Delano-McFarland District of the Central Valley Project—Friant Division. Mr. Antonell also served as director of the Western Growers' Association, the California Potato Growers Association, the United Fresh Fruit and Vegetable Association, the Association of California Water Agencies Insurance Commission, and Governor Ronald Reagan's Citizens' Commission for Agriculture. On June 2, his 96th birthday, Mr. Antonell resigned and retired from the Southern San Joaquin Municipal Utility Board of Directors.

John E. Boudreau joined the Terra Bella Irrigation District in 1968. He has managed all administrative, engineering, operational and maintenance duties for the system which delivers water to agricultural and municipal users in this Tulare County community. Recently Mr. Boudreau has overseen a project of over $5 million that includes a municipal and industrial water treatment plant, a million gallon storage tank, pumping facilities and four miles of water lines.

Mr. Boudreau has managed the Friant Power Authority since its inception in 1979 and plans to continue in that role after his retirement from the irrigation district. He also manages the San Joaquin River Water Power Authority and has served on the Tulare County Grand Jury and as Chairman of the Tulare County Flood Control Commission. In Terra Bella, he has served as the past director of the Terra Bella Chamber of Commerce and the American Cancer Society. With the Association of California Water Agencies, he is the past chairman of the Thermal Electric Water Supply Committee and Manager-Engineers Section, as well as a former Executive Board member.

Mr. Boudreau earned his bachelor's degree in mechanical engineering at the University of Santa Clara. He served in the United States Army Reserve for eight years and achieved the rank of captain.

Robert F. Bowman completed six successful years as Chairman of the Board of the Friant Water Users Authority in January. His introduction to farming came 62 years ago when his parents moved to Kern County from Southern California and bought 40 acres near Buttonwillow. Mr. Bowman has farming interests in the Corcoran, Angiola and Tipton areas. His crops have included cotton, alfalfa, wheat, safflower and sugar beets.

Mr. Bowman has served on the Friant Water Users Authority board since 1988 and was vice chairman for two years. His other board service includes the Upper San Joaquin Water and Power Authority, Mid-Valley Water Authority, Central Valley Project Authority, Association of California Water Agencies, Central Valley Project Water Association and California Farm Water Coalition. He also chairs the Friant Water Users Political Action Committee. Mr. Bowman has distinguished himself as a fighter for Friant water and San Joaquin Valley water rights.

Robert Bowman is past chairman of the California Ag Council, which is made up of the state's major agricultural cooperatives. He has also served as director for both the Western Cotton Growers' Association and CalCot. Mr. Bowman is a 1950 graduate of Cal Poly—San Luis Obispo and served in World War II as an U.S. Army infantry lieutenant.

Robert L. Stanfield is retiring from a 35-year career with the Madera Irrigation District where he has been the district manager for the past 23 years. Mr. Stanfield's family has nearly 130 years of history in the Madera area.

After earning a degree in civil engineering from Chico State College, Robert Stanfield began his career working part time for the Madera Irrigation District (M.I.D.). He was then recruited to become an engineer for the district. After rising through the ranks he became M.I.D.'s general manager/chief engineer in 1975. He has also served as the manager of the Chowchilla-Madera Power Authority for M.I.D. and the Chowchilla Water District. A Madera Canal hydroelectric power plant was named in honor of Robert Stanfield in 1986. He has been involved with the Friant Power Authority since its inception and the Upper San Joaquin River Water and Power Authority.

Mr. Stanfield is a Madera County Chamber of Commerce director and San Joaquin River Conservancy board member. He has chaired the Association of California Water Agencies and the Madera City Planning Commission. He also serves on the California Chamber of Commerce Water Resources Committee and the Friant Water Users Authority Advisory Committee.

Harvey Williams served for 26 years in a variety of positions with the U.S. Bureau of Reclamation and has managed the Shafter-Wasco Irrigation District for the last decade. Mr. Williams is from the state of Washington and earned a degree in agricultural engineering from Washington State College. He served two years in the U.S. Army Corps of Engineers in combat engineering.

In 1961, Harvey Williams joined the U.S. Bureau of Reclamation on its Columbia Basin Project in the Operation and Maintenance section of the newly built irrigation systems which brought farming to that region. In 1971, Mr. Williams transferred to Fresno as the Bureau's operations chief in the Friant Division of the Central Valley Project. He was appointed to the district manager's position in the Shafter-Wasco Irrigation District in Kern County on March 1, 1987. During his tenure with Shafter-Wasco, the district developed a major pumping plant and pipeline system that links the several regional water projects. This efficient system has increased and enhanced the overall water supply management and delivery to its customers. As a result, more than 40,000 acre feet of water has been banked in lieu of pumping valuable ground water.

Mr. Williams is a director of the Central Valley Project Water Association and serves on the Friant Water Users Authority Operation and Maintenance Committee. He also serves on the Kern County Water Advisory Committee, the Six District Ground Water Committee and is an associate director of the Pond-Wasco-Shafter Resource Conservation District.

Mr. Speaker, it is a great honor to pay tribute to these five gentlemen. Each of these distinguished citizens has dedicated his life to the agriculture and water industries of the San Joaquin Valley and to his community. I ask my colleagues to join me in congratulating these men for their distinguished service to the San Joaquin Valley.

IN MEMORY OF ALAN SHEPARD

HON. TIM ROEMER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. ROEMER. Mr. Speaker, I rise to express my deep sorrow on the death of a true American pioneer and hero, Alan B. Shepard, Jr. As a member of the House Committee on Science and as a long-time fan of the Mercury program, I would like to acknowledge Alan Shepard's service and many contributions to the U.S. space program.

Alan Shepard was known for his determination, his wit and his courage. He was one of seven Mercury astronauts named by NASA in

April 1959, and he holds the distinction of being the first American to travel in space. Alan has been characterized as the most eager to be chosen from among three Mercury astronauts who were selected to fly the famous first space flignt—the Freedom 7 mission.

On that historic day, Alan Shepard—and the entire nation—waited anxiously for more than four hours as NASA worked feverishly to correct problems involving the launch vehicle's electrical system, the ground computer and the rocket's fuel pressure. This first flight in space, which lasted 15 minutes (five of those minutes in space) carried him to an altitude of 116 miles. Alan Shepard and the Freedom 7 mission marked the beginning of our journey into space.

Alan Shepard prophetically referred to this first space mission as ''just the first baby step, aimed for bigger and better things.'' The success of Freedom 7 and the bravery of Alan Shepard resulted in tremendous enthusiasm and excitement about the U.S. space program and future prospects of space travel. Less than three weeks after Alan Shepard's flight, President Kennedy set forth the goal of landing on the moon by the end of the decade. Alan Shepard returned to space and was the fifth astronaut to walk on the Moon during the Apollo 14 Mission in February 1971.

Mr. Speaker, I remember the first space flights of the NASA's Mercury program, and I think we will always remember the lasting impression Alan Shepard made on us and on the rest of the world. We are grateful for Alan Shepard's service to our nation, his invaluable contributions to NASA and we will remember him as a shining star in our early spaceflight missions. Our thoughts and prayers are with his family.

RECOGNIZING CECILIA DUNBAR

HON. GLENN POSHARD

OF ILLINOIS

HON. JERRY F. COSTELLO

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. POSHARD. Mr. Speaker, my colleague, Mr. COSTELLO, and I rise today to commend Mrs. Cecilia A. Dunbar, a distinguished student and leader in Marion, Illinois. She currently attends John A. Logan College in the 19th congressional district and is spearheading an effort to create a national day of recognition for higher education. We applaud and commend her efforts, and offer our support.

Cecilia has been focusing her energy toward devoting a day of recognition to higher education. She has worked diligently to encourage non-traditional students of four-year and community colleges the importance of education. Cecilia has not only experienced the achievement of receiving a higher education, she has also been an inspiration for many non-traditional students to attend college. After confronting many personal hurdles, Cecilia realized that she needed to exceed her high school level education and go back to school. John A. Logan College recognized her potential and gave her the opportunity to enroll as a student. From being the first John A. Logan student trustee to be reelected to improving student life through various student organizations such as being President of Phi Theta Kappa, Cecilia has proven herself to be an excellent asset to John A. Logan College and the higher education community.

As a result, Cecilia has been pushing for a national day of higher education recognition as a way to thank her colleagues, and her mentors at John A. Logan College as well as stress the importance of higher education to others who face unique circumstances such as herself. Cecilia's proclamation has been recognized by Illinois Governor Jim Edgar, and she is now in the process of having it recognized by additional governors through the National Governors Association. The first day of observance is September 16, 1998 which coincides with John A. Logan's birthday.

Mr. Speaker, it has been an honor to meet this inspiring student, and it is a pleasure to have her recognized for her various achievements. Higher education is essential for our citizens, and having people such as Cecilia recognizing the urgency of this opportunity is refreshing. Please help us in commending Mrs. Cecilia Dunbar for her persistent efforts in recognizing the importance of higher education.

CHILD NUTRITION AND WIC REAUTHORIZATION AMENDMENTS OF 1996

SPEECH OF

HON. MARGE ROUKEMA

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Monday, July 20, 1998

Mrs. ROUKEMA. Mr. Speaker, I am pleased that we are reauthorizing the WIC program here today.

The WIC program is a program that works, and in the longer-term, actually saves federal money. For every one-dollar used in the prenatal segment of the WIC program, Medicaid saves untold monies and gives healthy productive lives to these children and cannot be measured in dollars and cents.

WIC works. It reduces the instances of infant mortality, low birthweight, malnutrition and the myriad other problems of impoverished children. The WIC program also provides valuable health care counseling for expectant mothers for both mothers and children.

Within the past year, Time and Newsweek magazines have written feature articles on the importance of the years from birth to age three. These articles validate long-standing research based on up-to-date studies of prenatal and early childhood development. WIC funding is a big part of the future development of these infants.

We want all of our children to have a good start. Proper nutrition is essential for healthy growth, the ability to learn, and the chance for a future as a productive citizen.

This is a wise investment.

SALUTE TO THE ''FALCONS''

HON. BOB SCHAFFER

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. BOB SCHAFFER of Colorado. Mr. Speaker, I rise today to recognize the efforts of some very special constituents, the Friends of Arrowhead Lodge and Conservators of Nature Society (the ''FALCONS''). This group of dedicated volunteers worked to save an historic lodge and outbuildings and operated the facility as a successful visitors center on national forest land in the mountains of Colorado for several productive years.

The Arrowhead Lodge, located along the Poudre Canyon in Larimer County, Colorado, has a long and distinguished history. Through the years, church services, 4–H meetings, pancake suppers, dinners, socials and parties echoed from the walls of the Arrowhead Lodge. The Forest Service bought the lodge, but planned to tear down the buildings due to budget constraints several years later. Only the hard work and grass roots efforts of Mrs. Elyse Bliss saved the buildings from destruction. She was instrumental in the designation of the Arrowhead Lodge of the National Register of Historic places and in founding the non-profit FALCONS to see that it continued to play an important role in the local community and the state's booming tourism industry.

Mr. and Mrs. Bliss, in partnership with the Forest Service, operated the lodge for several years. They, along with the other dedicated volunteers, were always there to welcome weary travelers, curious tourists and local passers by with a friendly smile, hot coffee and a wealth of good information. Sadly, management decisions within the Forest Service forced the volunteers to abandon their efforts after years of successful operations.

The loss of the FALCONS is a great loss to the local community and the traveling public. I thank Mr. and Mrs. Bliss for their hard work and dedication and I thank all of the FALCONS for their efforts as well. Their plight has motivated me to investigate how to avoid such troubling consequences in the future. I plan to investigate how to encourage and facilitate, rather than discourage, the efforts of volunteers like the FALCONS. Good volunteer work creates an atmosphere of warmth and friendliness on federal properties. It personalizes visitors' experiences and adds to the wealth and identity of our natural heritage. Moreover, volunteers could save the taxpayers millions of dollars each year. Mr. Speaker, I fully support volunteer activities on federal lands, and again thank the FALCONS for their significant and lasting contribution to the community and to the public. I wish them well and encourage them to explore other ways to continue their good work.

TRIBUTE TO HUBERT H. HUMPHREY

HON. JAMES L. OBERSTAR

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. OBERSTAR. Mr. Speaker, I rise today to pay tribute to former Vice President Hubert H. Humphrey.

Fifty years ago this week, Harry S. Truman was nominated for the Presidential ticket at the Democratic convention in Philadelphia. Another profoundly memorable event occurred at that same convention in 1948; Hubert A. Humphrey, then the Mayor of Minneapolis and candidate for Senate from the State of Minnesota, delivered a speech on civil rights that is remembered today for its eloquence, its vision, and its idealism.

Many events across the country contributed to the advancement of civil rights during the past half century, including Rosa Parks' courageous refusal to sit in the back of the bus, the landmark Civil Rights and Voting Rights Acts, and dramatic acts of civil disobedience in the deep south. But it was Hubert Humphrey's principled challenge at the 1948 Democratic National Convention that catapulted civil rights to the top of the nation's agenda and launched what became a 16-year national dialogue on a race relations and racial injustice, culminating in the passage of the Voting Rights Act of 1965.

Hubert Humphrey's clarion call to conscience on that night 50 years ago rings as fresh and energizing today as it did then, when he challenged convention delegates and the nation to overturn social conventions and traditions that not only deprived a whole segment of the American public their rightful place in our economy and society, but even denied an honest, forthright discussion of race in America.

The galvanizing appeal of then-Mayor Humphrey both inspires and challenges us now today, as it did 50 years ago: ''There are those who say to you—we are rushing this issue of civil rights. I say we are 172 years late. There are those who say—this issue of civil rights is an infringement on states' rights. The time has arrived for the Democratic Party to get out of the shadow of states' rights and walk forthrightly into the bright sunshine of human rights.''

Those words jolted American politics like a lighting strike and stirred the nation's conscience to a national debate on civil rights policy. Although divided, the convention delegates ultimately voted to endorse a new and timely commitment to civil rights. The party's decision to take a strong stand on civil rights inspired citizens throughout the nation and gave new life, purpose and charisma to the civil rights movement.

Last month, the Hubert H. Humphrey Institute of Public Affairs at the University of Minnesota recognized the 50th anniversary of its namesake's landmark speech made by Hubert H. Humphrey at the 1948 Democratic Convention in Philadelphia. Journalist Bill Moyers, NAACP Chair Julian Bond, Author Richard Rodriguez, and former Mississippi Governor William Winter spoke on the legacy of the civil rights movement since 1948. I am pleased to share with my colleagues the personal remembrance that journalist Bill Moyers offered at the Institute's forum last month on Hubert Humphrey's influence on civil rights.

When Steve Sandell invited me to the Twin Cities for this occasion, I accepted on the spot.

Hubert Humphrey made a difference to my life. He was the friend who toasted me on my 30th birthday and the mentor who nurtured my political sentiments. Some of you will remember that it was Senator Humphrey who first proposed that young Americans be offered the chance to serve their country abroad in peace and not just in war. Newly arrived in Washington, I read his speeches on the subject and liberally borrowed from them for the speech I helped to write for Senator Lyndon B. Johnson during the campaign of 1960 when, at the University of Nebraska, he proposed what we called ''a youth corps.'' Two weeks later, on the eve on the election, Senator John F. Kennedy called for the creation of the Peace Corps. This, too, was a speech that owed its spiritual lineage to Hubert Humphrey.

After the election I finagled my way on to the Peace Corps Task Force, where it was my privilege to work with Senator Humphrey on the legislation that turned the idea from rhetoric to reality. Somewhat later President Kennedy nominated me to be the Peace Corps' Deputy Director. The nomination ran into trouble on the Senate floor when Senator Frank Lausche of Ohio announced that ''a 28-year-old boy recently out of college'' was being given too much responsibility, too fast, at a salary far too high for someone so green behind the ears. Now, Senator Lausche was probably right about that (although I had informed him during the committee hearings that I was not a mere 28, I was 28 and a half!), but it didn't matter; he was no match for Hubert Humphrey, who rushed to the floor of the Senate not only to defend me but to champion the cause of youth in public service: ''I know this man well,'' Senator Humphrey said of me. ''I have spent countless hours with him on the Peace Corps legislation. He was in my office hour after hour working out the details the period of the hearings on the legislation and the markup on the legislation. If I know any one member of this Government, I know Bill Moyers'' (Some of you who knew Hubert H. Humphrey knew there should have been a fourth ''H'' in his name—for hyperbole. But the hyperbole felt good to those on whom it was showered).

And then . . . Hubert Humphrey took off, his words rocketing across the Senate chamber: ''Did not Pitt, the younger, as a rather young man, prove his competence as Prime Minister of Great Britain? He did not have to be 50, 60, or 65. He was in his twenties. I invite the attention of my colleagues to the fact that most of the great heroes of the Revolutionary War period . . . were in their twenties and early thirties . . . That many great men in history, from Alexander to Napoleon, achieved greatness when they were in their twenties . . . that the average age of the signers of our Declaration of Independent was 36. I do not wish to use any invidious comparisons, but I have seen people who have lived a long time who have not learned a great deal, and I have seen people who have lived only a short time who have learned a very great deal. I think we should judge persons, not by the calendar, but by their caliber, by the mind and heart and proven capacity . . . My good friend from Ohio said that when this nomination comes to the floor of the Senate he will be here to speak against [it]. . . just as surely, I say the Senator from Minnesota will be here to speak in favor of [it].''

He was, and he did. And I have been indebted to him ever since. I wish he knew my grandchildren are growing up in his state, and I wish he could see who is here tonight to commemorate one of the great acts of courage in politics, when the mayor of Minneapolis turned the course of American history.

It was the summer of 1948, July . . . three weeks after the Republicans triumphantly nominated Thomas E. Dewey and began measuring the White House for new drapes. The dispirited Democrats met in Philadelphia resigned to renominating their accidental president, Harry Truman. Truman had surprised many Americans earlier that year when he had demanded Congress pass a strong civil rights package, but now he and his advisers had change their tune. A strong civil rights plank in the party platform, they were convinced, would antagonize the South and destroy Truman's changes to reelection. The spectre of a bitter fight dividing the convention was all the more frightening to the Democrats since for the first time ever television cameras were making their debut on the convention floor and the deliberations would be carried out in broad daylight. So the party leaders decided to back away from a strong civil rights stand and offer instead an innocuous plank not likely to offend the South.

The mayor of Minneapolis disagreed. Hubert Humphrey was 37. After graduating magna cum laude from the University of Minnesota he and his young wife Muriel Buck—''Bucky'', he called her—had gone to Louisiana for Humphrey to earn his master's degree. What they saw there of the ''deplorable daily indignities'' visited upon Southern blacks was significantly responsible for his long commitment to the politics of equal opportunity. He came back to Minneapolis to run for mayor . . . was defeated . . . ran a second time . . . and won. Under his leadership the city council established the country's first enforceable Municipal Fair Employment Practices Commission. He sent 600 volunteers walking door to door, to factories and businesses, schools and churches, to expose discrimination previously ignored. Their report, said Mayor Humphrey, was ''a mirror that might get Minneapolis to look at itself.'' He saw to it that doors opened to blacks, Jews, and Indians. He suspended a policeman for calling a traffic violator ''a dirty jew'' and even established a human relations course for police officers at the University of Minnesota. What Humphrey preached about civil rights, he practiced. And what he practiced, he preached.

So he arrived at the Democratic Convention in Philadelphia fifty years ago with convictions born of experience. As a charismatic and articulate spokesman for the liberal wing of the party he was named to the platform committee, and when after a ferocious debate that very committee voted down a strong civil rights plank in favor of the weaker one supported by the White House, Humphrey agonized over what to do. Should he defy the party and carry the fight to a showdown on the convention floor? The pillars of his own party said no. ''Who does this pip-squeak think he is?'' asked one powerful Democrat. President Truman referred to him as one of those ''crackpots'' who couldn't possibly understand what would happen if the south left the party. It was a thorny dilemma.[1] If Humphrey forced the convention to amend the platform in favor of a stronger civil rights plank, the delegates might refuse, not only setting back the fledgling civil rights movement but making a laughing stock of Hubert Humphrey and spoiling his own race for the Senate later that same year. On the other hand, if he took the fight to the floor and won, the southern delegates might walk out and cost Harry Truman the Presidency.

As he wrote in his memoir: ''In retrospect, the decision should have been easy. The plank was morally right and politically right. . . . [But] clearly, it would have grave repercussions on our lives; it could make me an outcast to many people; and it could even end my chances for a life of public service. I didn't want to split the party; I didn't want to ruin my career, to go from mayor to 'pip-squeak' to oblivion. But I did want to make the case for a clear-cut commitment to a strong civil rights program.''

Years later he recalled the dilemma in a conversation with an old friend, who said to him, ''That sounds like the politics of a nunnery—you'd rather have been right than been president.'' ''Not at all,'' Humphrey shot

[1] My own recollections were rekindled by three books I highly recommend: Carl Solberg's biography of Humphrey; Robert Mann's ''The Walls of Jericho'' and Hubert Humphrey's own memoir, ''The Education of a Public Man.'' I am indebted to them and to my colleague, Andie Tucher, for their contributions to this speech.

back. ''I'd rather be right and be president.'' Which might explain in part, said the friend, why he never was.

It sounds like so little now. Here's exactly what the plank said: ''We call upon Congress to support our President in guaranteeing these basic and fundamental rights: (1) the right of full and equal political participation; (2) the right to equal opportunity of employment; (3) the right of security of person; and (4) the right of equal treatment in the service and defense of our nation.''

It sounds like so little. All people, no matter what their skin color, he was saying, had the same right to vote, to work, to live safe from harm, to serve their country. But it's hard to remember now, half a century later, how radical those 50 words really were. In 1948 the South was still a different country. Below the Mason and Dixon line—or, as some blacks called it, the Smith and Wesson line—segregation of the races was rigorously upheld by law and custom, vigorously protected by violence if necessary. To most whites, this system was their ''traditional way of life,'' and they defended it with a holy fervor. To most blacks, ''tradition'' meant terror, oppression, humiliation, and, sometimes, death.

Take a minute to revisit with me what life was like for black Americans in the late nineteen-forties, when Hubert Humphrey was facing the choice between dishonoring his conscience and becoming a pipsqueak. Every day, all over America but particularly in the South, black people were living lives of quiet desperation. The evidence was everywhere.

You see it in the numbers, the raw measurements of the quality of life for black people. Flip open the Census Bureau's volumes of historical statistics and look under any category for 1948 or thereabouts. Health, for instance. Black people died on average six or seven years earlier than whites. Nearly twice as many black babies as white babies died in their first year. And more than three times as many black mothers as white mothers died in childbirth.

Or take education. Young white adults had completed a median of just over twelve years of school, while blacks their age had not gotten much past eighth grade. Among black people seventy-five or older—those who had been born during or just after slavery times—fewer than half of them had even finished fourth grade.

Look at the standard of living. The median family income for whites was $3310, for blacks just over half that. Sixty percent of white agricultural workers were full owners of their farms and about a quarter were tenants, while for blacks, the numbers were almost exactly opposite; only a quarter of blacks owned their own farms, and 70% were tenants. You could go on and on.

You see it throughout the popular culture, full of cartoony creatures like Stepin Fetchit, Amos 'n' Andy, and Buckwheat, but you could look till your eyes ached for a single strong, admirable, human black character in a mainstream book or movie. There's a scene in one of the most beloved movies ever made, Casablanca, in which Bogart's lost love, the beautiful Ingrid Bergman, walks into Rick's Cafe and says to Claude Rains ''The boy who's playing the piano—somewhere I've seen him . . .'' She's referring, of course, to Dooley Wilson, who at nearly fifty was almost twice Bergman's age . . . but in those days, to white eyes, it was okay to call a black man a ''boy''.

You see it in a slim book written by Ray Sprigle, an adventurous reporter for the Pittsburgh Post-Gazette. With a shaven head and a deep Florida suntan he traveled through the south in 1948 posing as a black man to see what life was really like on the other side of the color line. Throughout his trip his black hosts told him horrific stories of indignities, humiliations, lynchings, and murders. While nothing untoward happened to Sprigle himself, it was because, as he put it, ''I gave nobody a chance. That was part of my briefing; 'Don't jostle a white man. Don't, if you value your safety, brush a white woman on the sidewalk.' So I saw to it that I never got in the way of one of the master race. I almost wore out my cap, dragging it off my shaven skull whenever I addressed a white man. I 'sirred' everybody, right and left, black, white and in between. I took no chances. I was more than careful to be a 'good nigger.' ''

You see it in the work of even such thoughtful observers as Willie Morris, who in his memoir of growing up in Mississippi during the '40s recalls his complicated and mysterious relationship with the black people of his town, a relationship that warped and scarred both black and white. As a small child, he says, he had learned the special vocabulary of racism: that '''keeping house like a nigger' was to keep it dirty and unswept. 'Behaving like a nigger' was to stay out at all hours and to have several wives or husbands. A 'nigger street' was unpaved and littered with garbage.'' He writes of casual cruelties like the time he hid in the bushes until a tiny black child walked by, then leaped out to kick and cuff the child. ''My heart was beating furiously, in terror and a curious pleasure,'' he says frankly. ''For a while I was happy with this act, and my head was strangely light and giddy. Then later, the more I thought about it coldly, I could hardly bear my secret shame.'' In the small town where I grew up in East Texas, there were high school kids—classmates of mine—who made a sport out of ''nigger-knocking.'' Driving along a country road they would extend a broom handle out of the rear window at just the right moment and angle to deliver a stunning blow to an unsuspecting black pedestrian. Then they'd go celebrate over a few beers. While I never participated, it was my secret shame that I never tried to stop them.

There was a study done in 1946 by the Social Science Institute at Fisk University, the black college in Nashville, about white attitudes toward black people. In interview after interview, average citizens throughout the south never talked of overt violence or flaming hatred—but their detached and imperturbable calm was in some ways even more grotesque than physical violence. Listen to their voices:

A woman teacher in Kentucky: ''We have no problem of equality because they are in their native environment. If we permitted them to be equal they wouldn't respect us. We never have any riots because their interests are looked after by the white people.''

A housewife in North Carolina: ''They are as lovable as anyone in a lower order of life could be. . . . I had to go see an old sick woman yesterday. We feel toward them like we do about our pets. I have no horror of a black man. Why, some of them are the nicest old black niggers. They are better than a barrel of monkeys for amusement.''

A businessman in North Carolina: ''I have a feeling of aversion toward a rat or snake. They are harmless but I don't like them. I feel the same toward a nigger. I wouldn't kill one but there it is.''

Or a mechanic in Georgia: ''During the war I was stationed at a northern naval yard. The southern Negro was given the same privileges as white men. He was not used to it, and it ruined a good Negro. In the south he is treated as a nigger and is at home here. He knows his treatment is the best for him. . . . We have a good group around here. It's years and years since we've had a lynching. It's not necessary to lynch them. The sheriffs in this county take more care of the darky than the white man.''

By now these words are probably making you twist and cringe in your seats. I have trouble forcing them out of my mouth. But these words, and others like them, were the coin of the realm in 1948. After more than two centuries of slavery and nearly another of Jim Crow segregation, black people were still struggling to realize their most basic rights as human beings, let alone as citizens. The framers of the Constitution made their notorious decision in 1787 that for census purposes each black American—nearly all of whom were, of course, slaves—would count as three-fifths of a person. In the minds of many white Southerners in 1948, that fraction still seemed about right.

Yet something was beginning to change, and the old ways were coming under tough new challenges. The steadfast but quiet resistance long practiced by many southern blacks was now being strengthened by a new development: thousands of black veterans were coming home from Europe and the Pacific.

These men had fought for their country—some had even fought for the right to fight for their country, not just to dig ditches and drive trucks and peel potatoes for their country. They had served in a segregated army that had accepted their labor and their sacrifice without accepting their humanity. Some of them had come home heroes, others had come home embittered, and many had also come home determined that things would be different now—that they had earned the respect of their fellow Americans and it was time they got it. And that started at the ballot box—a tool both practical and symbolic in the struggle to ensure their status as full citizens.

All over the South, where for decades blacks had been systematically harassed, intimidated, or overtaxed to keep them from voting, intense registration drives for the 1946 campaigns had swelled the rolls with first-time black voters. And the white supremacists were fighting back. Sometimes it was brute and random violence: in Mississippi a group of black veterans was dumped off a truck and beaten up. In Georgia two black men, one a veteran, were out driving with their wives when they were ambushed and shot by a mob of whites. The mob then shot the women, too, because they had witnessed the crime. In South Carolina, a black veteran returning home by bus after fifteen months in the South Pacific angered the driver with some minor act that struck the man as uppity. At the next stop the soldier was taken off the bus by the local chief of police and beaten so badly he went blind. Permanently. Under pressure from the NAACP, something unusual happened: the chief was put on trial. Then normalcy returned. The chief was acquitted, to the cheers of the courtroom.

But the demagogues also made deliberate efforts to stop the black vote—by whatever means necessary. In Georgia, Gene Talmadge ran for governor and won, on a frankly, even joyfully racist platform. ''If I get a Negro vote it will be an accident,'' he declared, and his machine figured out ways to challenge and purge the rolls of most of them. The few brave black voters who went to the polls anyway often paid dearly for their rights; one, another veteran, the only black to vote in Taylor County, was shot and killed as he sat on his porch three days after primary, and a sign posted on a nearby black church boasted ''The first nigger to vote will never vote again.''

In Mississippi, Theodore Bilbo was reelected to the Senate with the help of a campaign of threats and violence that kept most black people home on Election Day. ''The

way to keep the nigger from the polls is to see him the night before,'' Bilbo was fond of saying. But this time black voters fought back and filed a complaint with the Senate. Nearly two hundred black Mississippians trekked to Jackson—and its segregated courtroom—to testify about the myriad pressures, both subtle and brutal, that had kept them from voting. But their eloquent testimony failed to convince the honorable members. Bilbo was exonerated by the majority of the committee members—despite (or perhaps because of) having used the word ''nigger'' seventy-nine times during his own testimony. It was a toxic word, a poisonous and deadly word. And it was still prevalent as a term of derision in the early 1960's. In August 1964, following the death of his father, the writer James Baldwin said on television: ''My father is dead. And he had a terrible life. Because, at the bottom of his heart, he believed what people said of him. He believed he was a nigger.''

So when Hubert Humphrey of Minnesota stood up at the Democratic convention in Philadelphia and urged the delegates to support his civil rights plank, he could have had no doubt how ferociously most southern delegates would oppose his words—and how desperately all southern citizens, white and black, really needed to hear them. It was a short speech and it took less than ten minutes to deliver—doubtless some kind of record for the man whose own wife reportedly once told him, ''Hubert, you don't have to be interminable to be immortal.''

Most of the time he couldn't help being interminable. Someone said that when God passed out the glands, Hubert took two helpings. He set records for the number of subjects he could approach simultaneously with an open mouth. One day, at a press conference in California, his first three answers to questions lasted, respectively, 14, 18, and 16 minutes. No one dared ask him a fourth question for fear of missing dinner!

But in Philadelphia in 1948, Hubert Humphrey delivered a short speech. And these not interminable words became immortal because they were right. He had agonized, he had weighed the odds as any politician must—remember he was a politician, and this was a time when the way to get ahead was not to go back on your party. But now he was listening to his conscience, not his party, and he was appealing to the best, instead of the basest, instincts of his country, and his words rolled through the convention hall like ''a swelling wave.''

''There are those who say to you—we are rushing this issue of civil rights. I say we are 172 years late. There are those who say—this issue of civil rights is an infringement on states rights. The time has arrived for the Democratic party to get out of the shadow of state's rights and walk forthrightly into the bright sunshine of human rights.''

We know of course what happened when he finished. A mighty roar went up from the crowd. Delegates stood and whooped and shouted and whistled; a forty-piece band played in the aisles, and the tumult subsided only when Chairman Sam Rayburn ordered the lights dimmed throughout the hall. The platform committee was then overruled and Humphrey's plank voted in by a wide margin, and all of Mississippi's delegate and half of Alabama's stalked out in protest. The renegades later formed the Dixiecrat party on a platform calling for ''the segregation of the races and the racial integrity of each race,'' and nominated Strom Thurmond for their candidate. ''There's not enough troops in the Army to break down segregation and admit the Negro into our homes, our eating places, our swimming pools, and our theaters,'' Thurmond would declare on the campaign trail, and a majority of the voters in South Carolina, Mississippi, Alabama, and Louisiana agreed with him.

But Harry Truman didn't lose. The Minneapolis Star got it right the morning after the convention when it said Humphrey's speech ''had lifted the Truman campaign out of the rut of just another political drive to a crusade.'' Harry Truman won—and the southern walkout to protest civil rights actually ended up helping the civil rights agenda. If a Democrat could go on to win the presidency anyway, even without the solid South behind him, then the segregationist stranglehold on the party was clearly weaker than advertised, and even the most timid politician could see that supporting civil rights might not be a political death sentence after all. Not bad work for the mayor from Minneapolis. The late Murray Kempton once said that ''a political convention is just not a place from which you can come away with any trace of faith in human nature.'' This one was different, because Hubert Humphrey kept the faith. There were other forces at work of course. Just this week the Star Tribune said rightly that it would be misleading to suggest the democratic ship turned on a few eloquent phrases from a young upstart, or that the party had experienced a moral epiphany. Politics is rarely that simple or intentions that noble. There were other forces at work—the need of America during the Cold War to put its best face forward, the need for Democrats to consolidate their hold on the northern industrial states, those returning black veterans. But it would be equally wrong to underestimate what Hubert Humphrey did. An idea whose time has come can pass like the wind on the sea, rippling the surface without disturbing the depths, if there is no voice to incarnate and proclaim it. In a democracy a moral movement must have its political moment to crystalize and enter the bloodstream of the nation, so there can be no turning back. This was such a moment, and Humphrey its embodiment.

But nineteen forty-eight wasn't the end of the struggle, of course; it turned out to be just the beginning. Sixteen years later, in 1964, Lyndon Johnson, another accidental president, staked his reputation on getting a comprehensive Civil Rights bill passed into law. And Hubert Humphrey, now Senator Humphrey, was the man assigned the gargantuan challenge of shepherding the bill through Congress in the face of a resolute southern filibuster. Once again I was privileged to work with him. By now I had become President Johnson's policy assistant, and the Civil Rights Act of 1964 was our chief imperative.

By then the face of the segregated South had changed—somewhat. The landmark Supreme Court decision Brown vs. Board of Education had given legal aid and comfort to the long moral crusade to open the public schools to all races, while courageous activists were putting their own bodies on the line in determined efforts to desegregate the buses, the lunch counters, the beaches, the rest rooms, the swimming pools, and the universities of the South.

But all the court decisions and sit-ins in the world had not changed the determination of the diehard segregationists to defend their vision of the South ''by any means necessary,'' and the few federal laws on the books were too weak to stop them. A lot of this story, while awful, is familiar; we may think we have a pretty good idea what was at stake when Hubert Humphrey made his second great stand for civil rights. We've all seen the photographs and the television images; we all know about the ugly mobs taunting the quiet black teenagers outside the schools and inside the Woolworths, we know about the beatings and attack dogs and fire hoses, we know about the murders. During Freedom Summer—the very same summer the Senate completed work on the civil rights bill—Mississippi endured 35 shootings, the bombing or burning of 65 homes and churches, the arrest of one thousand activists and the beating of eighty, and the killing of three volunteers with the active connivance of the Neshoba County sheriff's department, their bodies bulldozed into an earthen dam.

But we don't know as much about another, more silent tactic of white resistance that was just as oppressive, and in some ways maybe even more effective than the violence. I mean the spying, the smearing, the sabotage, the subversion, all carried out by order of the highest officials in states across the south.

We were reminded of the twisted depths of official segregation just this spring, when after decades of court battles Mississippi was ordered to open the secret files of something called the State Sovereignty Commission. This was an official government agency, bountifully funded with taxpayer money, lavished with almost unlimited police and investigative powers, and charged with upholding the separation of the races. Most of the southern states had similar agencies, but Mississippi had a well-deserved reputation as the worst of the bad.

I've seen some of those Sovereignty Commission files. I've read them. And I understand how a longtime activist in Jackson could recently tell a reporter I know, ''These files betray the absolute paranoia and craziness of the government in those times. This was a police state.''

The Commission devoted astonishing amounts of effort, time, and money to snooping into the private lives of any citizens who supported civil rights, who might be supporting civil rights, or whom they suspected of stepping over the color line in any way. It tracked down rumors that this northern volunteer had VD and that one was gay. It combed through letters to the editor in local and national newspapers, and wrote indignant personal replies to anyone who held a contrary opinion. It sent agents to a Joan Baez concert at a black college to count how many white people came, and posted people at NAACP meetings to write down the license numbers of every car in the parking lot. It stole lists of names from Freedom Summer activists and asked the House Un-American Activities Committee to check on them. It went through the trash at the Freedom Houses and paid undercover informants to report on leadership squabbles and whether the white women were fornicating with the black men.

The most incriminating documents were purged long ago, but buried deep in those files is still ample evidence of violence and brutality. I am haunted by the case of a black veteran named Clyde Kennard. When he insisted on applying to the local college, one that happened to be for whites only, he was framed on trumped-up charges of stealing chicken feed and sent to Parchman, the infamous prison farm, for seven years. While there he developed colon cancer and for months was denied treatment. Eventually, after prominent activists brought public pressure to bear on the governor, Kennard was released, but it was too late. In July 1963, a year before the passage of the Civil Rights Bill, Clyde Kennard died following surgery. He was 36 years old.

Reading these files you are struck not only by the brutality but by the banality of the evil. You find in them the story of a divorced mother of two who was investigated after the Commission heard a rumor that her third child was fathered by a black man. An agent arrived to interview witnesses, confront the man, and look at the child. ''I had

a weak feeling in the pit of my stomach,'' he reported; he and the sheriff ''were not qualified to say it was a part Negro child, but we could say it was not 100 percent Caucasian.'' After that visit, the woman's two older boys were removed from her custody.

You can read about how a local legislator reported to the Commission that a married white woman had given birth to a baby girl with ''a mulatto complexion, dark hair that has a tendency to 'kink,' dark hands, and light palms.'' A doctor and an investigator were immediately dispatched to examine the child, then shelled out $62 for blood tests to determine its paternity. The tests came back inconclusive but a couple of months later shots were fired at night into the family's home and a threatening letter signed by the KKK, referring to ''your wife and Negro child,'' showed up on their doorstep. They moved out immediately.

It was crazy—and it was official. This was the rampant and unchecked abuse of state power turned against citizens of the United States of America. And this was the background music to Lyndon Johnson's 1964 Civil Rights bill, which called for the integration of public accommodations, authorized the attorney general to sue school districts and other segregated facilities, outlawed discrimination in employment, and further protected voting rights. When Hubert Humphrey accepted the assignment as floor manager for this bill, he knew how crucial as well as how difficult it would be to gather enough votes to end the southern filibuster; no one had ever managed to invoke cloture with a civil rights bill before. He also knew his own career was again on the line, since LBJ was using the assignment to test Humphrey's worth as his vice presidential candidate.

The filibuster began on March 9 and went on, it seemed, forever. But Humphrey was prepared and organized. A couple of times during those long months of debate I slipped into the gallery of the Senate to watch him lead the fight. The same deep fire of justice that burned in him at the 1948 convention, burned within him still. He was utterly determined. He had regular strategy meetings. He issued a daily newsletter. He enlisted one colleague to focus on each title of the bill. He schmoozed and bargained with and coaxed and charmed the key men whose support he needed. He persuaded the Republican Leader, Everett Dirksen, to retreat from at least 40 amendments that would have gutted the bill. He orchestrated the support of religious organizations until it seemed the corridors and galleries of Congress were overflowing with ministers, priests, and rabbis). ''The secret of passing the bill,'' he said, ''is the prayer groups.'' But the open secret was Hubert Humphrey. As Robert Mann reminds us in The Walls of Jericho,'' his good humor and boundless optimism prevented the debates from dissolving into personal recrimination. Once again he kept the faith. As he told his longtime supporters at the ADA after more than two months of frustration and delay, ''Not too many Americans walked with us in 1948, but year after year the marching throng has grown. In the next few weeks the strongest civil rights bill ever enacted in our history will become the law of the land. It is not saying too much, I believe, to say that it will amount to a second Emancipation Proclamation. As it is enforced, it will free our Negro fellow-citizens of the shackles that have bound them for generations. As it is enforced, it will free us, of the white majority, of shackles of our own—for no man can be fully free while his fellow man lies in chains.''

As we know, his skills and commitment paid off. Seventy-five days later, on June 10, the Senate finally voted for cloture with four votes to spare. A California senator, ravaged with cancer, was wheeled in to vote and could manage to vote yes only by pointing to his eye. After cloture ended the filibuster, the bill passed by a wide margin. On July 2 President Johnson signed it.

During all that time Hubert Humphrey broke only once—on the afternoon of June 17, two days before the historic vote. Summoned from the Senate floor to take an urgent call from Muriel, he learned their son Robert had been diagnosed with a malignant growth in his throat and must have immediate surgery. There in his office, Hubert Humphrey wept. As his son struggled for his life and the father's greatest legislative triumph was in sight, Hubert Humphrey realized how intermingled are the pleasure and pain of life.

We talked about this the last time I saw Hubert Humphrey. It was early in the summer of 1976. He came to our home on Long Island where I interviewed him for Public television. We talked about many things . . . about his father who set such high standards for the boy he named Hubert Horatio; about his granddaughter Cindy (a little pixie, he called her); about waking up on the morning after he had lost to Richard Nixon by fewer than 511,000 votes out of 63 million cast; about the tyrannies of working for Lyndon Johnson (Said Humphrey of Johnson: ''He often reminded me of my father-in-law and the way he used to treat chilblains. Grandpa Buck would get some chilblains and he said the best way to treat them was put your feet first in cold water, then in hot water. And sometimes [with LBJ] I'd feel myself in hot water, then I'd be over in cold water. I'd be the household hero for a week and then I'd be in the dog house.'')

We talked about the necessity of compromise and the obligation to stand firm against the odds, and the difficulty of making the distinction. We talked about the life-threatening illness he had himself recently endured and what kept him going through the vicissitudes of life. Growing up out here on the great northern plains had made a difference, he said: ''I used to think as a boy that in the Milky Way each star was a little place, a sort of light for somebody that had died. . . . I used to go pick up the milk—we didn't have milk delivery in those days—I'd go over to Dreyer's Dairy and pick up a gallon of milk—I can remember those cold, wintry nights and blue sky, and I'd look up and see that Milky Way and I'd think every time anybody died they got a star up there. And all the big stars were for the big people. You know, like Caesar or Lincoln. It was a childhood fantasy. But it was a comforting thing.''

He was called ''The Happy Warrior'' because he loved politics and because of his natural ebullience and resiliency. I asked him: ''Some people say you're too happy and that this is not a happy world.'' He replied: ''Well, maybe I can make it a little more happy . . . I realize and sense the realities of the world in which we live. I'm not at all happy about what I see in the nuclear arms race . . . and the machinations of the Soviets or the Chinese . . . the misery that's in our cities. I'm aware of all that. But I do not believe that people will respond to do better if they are constantly approached by a negative attitude. People have to believe that they can do better. They've got to know that there's somebody that's with them that wants to help and work with them, and somebody that hasn't tossed in the towel. I don't believe in defeat, Bill.''

He lost some elections in his long career, but Hubert Humphrey was never defeated. More than any man I know in politics, he gave me to believe that in time, justice comes . . . not because it is inherent in the universe but because somewhere, at some place, someone will make a stand, and do the right thing, and seizing the helm of history will turn the course of events.

So the next time you look up at the Milky Way, look past the big stars, beyond the brilliant lights so conspicuous they can't be missed . . . the Caesars and the Lincolns . . . and look instead for the constant star, a sure and steady light that burns from some deep inner core of energy . . . and remember how it got there and for whom it shines. He was one of your own.

THANKS FOR ''RIGHT TO LIFE'' SUPPORT

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. SHIMKUS. Mr. Speaker, today I rise for two purposes. First to honor three women who have dedicated their lives to the rights of the unborn, and secondly to thank the 296 Members of this body that voted yesterday to protect the right to life. Felicia Goeken, Mary F. Jones, and Christy Holt have served the Illinois Federation for Right to Life in countless ways, and it is women like these that made yesterday's vote to ban partial birth abortions possible. I have had the pleasure of knowing each of these women personally, and I have witnessed first hand their dedication, compassion, and leadership.

Tomorrow these women will be honored for their outstanding service and I wish them the utmost congratulations and thanks for their efforts. It is through the work of caring individuals like Felicia, Mary, and Christy, that the rights of the most vulnerable members of our society will be protected. I know the hard work these women have contributed to the fight, and on their behalf I am proud to say that a overwhelming majority of this Congress has finally proven its dedication to the unborn.

IN SUPPORT OF THE SHIPPING RELIEF FOR AGRICULTURE ACT, H.R. 4236

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. SMITH of Michigan. Mr. Speaker, I rise in support of the Shipping Relief for Agriculture Act, H.R. 4236. U.S. domestic maritime law is embodied in section 27 of the Merchant Marine Act, known as the Jones Act. The Jones Act requires that all cargo transported from one U.S. port to another (even via a foreign port) must travel on vessels built, owned, manned, and flagged in the United States. While initially sounding pro-American, the Jones Act has not protected the fleet. According to the U.S. Maritime Administration, there are only 119 deep-sea ships left in the domestic fleet (down from over 2,500 in 1945) and only three of these are dry bulk vessels.

Only two bulkers have been built in U.S. shipyards in the last 35 years. To contract for a new ship would cost an American operator over three times the international market rate before any type of export subsidy was applied. This practically assures no new bulkers will be

built in this country. It is time that we stop fooling ourselves that a renaissance in U.S. shipbuilding is just around the corner.

Because of the Jones Act, U.S. agricultural producers today do not have access to domestic deep-sea transportation options available to their foreign competitors. There are no bulk carriers operating on either coast of the United States, in the Great Lakes, nor out to Guam, Alaska, Puerto Rico, or Hawaii. This puts American producers at a competitive disadvantage because foreign producers are able to ship their products to American markets at competitive international rates whereas U.S. producers are not.

American agricultural producers also need access to deep-sea transportation options because other modes of transportation are saturated. Last year's rail woes would have been averted if just 2% of domestic agricultural production could have traveled by ocean-going vessel. With an expected record harvest on the way, the bottlenecks and congestion of last year will in all likelihood be revisited. Burlington and Union Pacific have already notified agricultural shippers to expect delays. This raises rail rates to artificially high levels at a time when commodity prices are already depressed—directly impacting farm income.

The Shipping Relief for Agricultural Act will eliminate the U.S. build requirement for deep-water dry bulk vessels for the carriage of agricultural products, dry bulk cargo, and forest products. All vessels would still be required to obey all U.S. law, including environmental, safety, labor, and tax regulations. This bill brings more ships to the U.S. fleet, allows U.S. Agricultural shippers access to ships, and will also provide much needed jobs for the American Merchant Marine.

PERSONAL EXPLANATION

HON. JUANITA MILLENDER-McDONALD

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Ms. MILLENDER-McDONALD. Mr. Speaker, on Friday, July 17, and Monday, July 20, 1998, I filed an official leave of absence and was not available to cast votes on either of those days. However, had I been present on Friday, July 17, I would have voted ''aye'' on rollcall vote 295, and ''nay'' on rollcall vote 296.

Had I been present on Monday, July 20, I would have voted ''aye'' on rollcall votes 297, 298, 299, 300, 301, 303, 304, 305, and ''nay'' on rollcall votes 302, 306, 307, 308.

TRIBUTE TO SUSAN GAIL YOACHUM

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Ms. ESHOO. Mr. Speaker, I rise today to honor Susan Gail Yoachum, a magnificent human being and extraordinary journalist of the San Francisco Bay Area who passed away on June 22, 1998. She was the devoted wife of Mike Carlson, the daughter of Betty and the late Charles G. Yoachum, and the sister and relative of Charles Yoachum and his family of Dallas.

Susan Yoachum was a star from the moment she was born in Dallas, Texas on May 12, 1955. Her passion for writing emerged early in her life as she became the National Spelling Champion in 1969. She pursued her talent at Southern Methodist University in Dallas, from which she graduated in 1975 with Bachelor of Arts degrees in journalism and political science.

She was a reporter for the Dallas Morning News, the Independent Journal in Marin County, the San Jose Mercury News, and the San Francisco Chronicle, covering some of the largest political stories of her era. Her talent for seeking out and delivering breaking stories went unmatched in political journalism. This talent was recognized in 1990, when she was part of a team that won a Pulitzer Prize for breaking news, and again in 1994, when she was honored as Journalist of the Year by the Northern California chapter of the Society of Professional Journalists. She earned a reputation amongst her peers and those about whom she wrote as a tenacious, witty, and sophisticated reporter, armed always with a penetrating question and a warm smile. Since 1990, she had covered national, state, and local politics for the San Francisco Chronicle, where she was promoted to Political Editor in 1994. As a popular political analyst, she was often a guest on TV and radio programs, from CNN's ''Inside Politics'' to a myriad of Bay Area radio shows.

In 1991, Susan Yoachum was diagnosed with metastatic breast cancer. During her seven-year struggle with breast cancer, she not only continued to produce brilliant work, but she also became a breast cancer activist. In an effort to raise awareness about this horrible disease, she frequently spoke to women's organizations, political groups, and fellow victims. In 1997, she courageously wrote about her own battle with cancer, announcing that after being in remission since 1992, her cancer had returned. She strove to humanize the statistic that 180,000 women get breast cancer every year, personalizing the cold facts with her own face.

Mr. Speaker, Susan Yoachum was an inspiration to us all. She educated us with her sharp journalistic talent, she personalized and publicized what breast cancer is about, she fought for a cure, and she made lasting contributions to our community and our country.

Mr. Speaker, I ask my colleagues to join me in paying tribute to a woman who lived a remarkable yet all too brief life. We extend our deepest sympathy to Mike Carlson and the entire Yoachum family. Susan Yoachum's life was an example of the strength of the human spirit, and because of her, hope lives on.

A SALUTE TO COLONEL JOSEPH A. HAIG (U.S. ARMY, RET.)

HON. THOMAS M. BARRETT

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. BARRETT of Wisconsin. Mr. Speaker, today I am pleased to recognize a patriot and honorable American from Milwaukee, Wisconsin. As family and friends gather today to honor Colonel Joseph A. Haig on the occasion of his 100th birthday, I would like to take a moment to acknowledge Colonel Haig's long-time service to our country.

Joseph A. Haig was born in Milwaukee, Wisconsin on August 24, 1898, and enjoyed a typical turn of the century boyhood. In the summer of 1918, however, with the ''war to end all wars'' still raging in Europe, Joseph crossed the threshold into manhood, and joined the United States Army, as part of the Officers Candidate School. As one of the ''60 day wonders'', he received his commission when he was only twenty years old.

After the war, Joseph returned to civilian life, but remained active as a reservist. In 1923, he became a charter member of the Reserve Officers Association. Today, he is the sole surviving charter member.

In the summer of 1940, before the United States officially entered World War II, Joseph was called to active duty as a major. He was made the assistant commanding officer of the Recruit Reception Center at Fort Sheridan, Illinois. During the next three years, he processed nearly a quarter of a million draftees. In 1945, then Major Joseph Haig was assigned to a camp in Pennsylvania as deputy post commander. In that position, he had the pleasant duty of facilitating the discharge of about 400,000 men, until he was discharged from active duty.

Once again, the end of active duty did not mean the end of his military career. Now Colonel Joseph Haig continued on as a reservist and remained involved and prepared to serve his country, when needed, until his mandatory retirement forty years ago.

Colonel Haig still attends the annual Reserve Officers Association meetings. Ten years ago, when he was a mere 90 years old, Colonel Haig was honored at the Association's annual meeting, as hundreds of generals and admirals greeted him with a tremendous standing ovation.

Another source of pride for Colonel Haig is his family, which includes his children Janet, Douglas, and Jerry, along with 20 grandchildren and 22 great-grandchildren. Colonel Haig's sons share in their father's sense of service to country and have served in the military. Douglas is a retired Air Force colonel. Jerry is a retired Naval Lieutenant Commander. The Haig family's combined years of military service is a staggering 176 years.

I ask my colleagues in the House of Representatives to join me in extending my appreciation to Colonel Joseph A. Haig for his many years of service to the people of the United States and in offering a hearty congratulations on the occasion of his 100th birthday.

POLITICALLY DRIVEN MANAGED CARE REFORM DEBATE

HON. JAMES L. OBERSTAR

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. OBERSTAR. Mr. Speaker, I rise today to express my grave concern that the debate today on managed care reform has deteriorated into a politically-driven exercise to serve the narrow and partisan goals of the majority party.

Neither the Republican leadership bill nor the Dingell/Ganske substitute were subjected

to the cleansing legislative process, in which the American people expect public hearings, open and full debate, a committee amendment process, and a meaningful opportunity to make specific changes to the legislation.

At each of these normal checkpoints of legislative procedure, the public and their elected representatives were denied the opportunity to participate fully in the legislative process, to offer and debate amendments and vote on them to produce a legislative output that hopefully reflects a solid consensus, or, at least, the end result of a democratic process.

Instead, we are engaged in a debate without the opportunity to make substantive and necessary changes to either piece of legislation through floor amendments, and we will be compelled to vote these competing measures either up or down without meaningful change.

Given the opportunity, I would have preferred that both bills be neutral on the issues of abortion and assisted suicide.

While there has been a good faith attempt in the Dingell/Ganske legislation to address these two matters, I strongly believe that the language on such issues must be so clear as to withstand judicial scutiny that health care plans are not required to provide assisted suicide or abortion services.

Given the opportunity, I would have offered the following language that would achieve this important objective:

Amend Section 108 and 109 of H.R. 3605 by adding the following new subsection (c):

''(c) Nothing in this Act shall be construed as requiring a group health plan or health insurance coverage to provide, pay for, refer for, or ensure the availability of or access to any benefit or service, including the use of facilities, related to an abortion or any item or service for which use of Federal funds is prohibited under the Assisted Suicide Funding Restriction Act of 1997. Nothing in the preceding sentence shall be construed as allowing a group health plan or health insurance converge to deny any benefit or service related to treatment for medical complications resulting from an abortion.''

Amend Section 141 of H.R. 3605 by adding the following new subsection (b)(3):

''(b)(3) Nothing in this Act shall be construed to cause a group health plan or health insurance issuer to violate its ethical, moral or religious benefits.''

I have been assured by the distinguished gentleman from Michigan, Mr. DINGELL, the Ranking Democrat of the Commerce Committee, that it is his intent that the legislative history should reflect that his legislation seeks to be neutral on these two issues.

With that statement of legislative intent, I plan to support the Dingell/Ganske substitute.

I want to make it clear on this point that I will seek inclusion of the legislative language that I have just referenced in any further managed care legislation that this Congress may consider.

CHILD NUTRITION AND WIC REAUTHORIZATION AMENDMENTS OF 1998

SPEECH OF

HON. JOSEPH P. KENNEDY II

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Monday, July 20, 1998

Mr. KENNEDY of Massachusetts. Mr. Speaker, I rise today in strong support of H.R. 3874, the Child Nutrition and WIC Reauthorization Act. This bill gives our states more opportunity to fight against a problem that plagues our nation even in these prosperous times—child hunger.

This bill is linked to almost every issue we struggle with on this House floor. Every year, we discover stronger links between child nutrition and all the indicators of a child's future. Better nutrition means better learning, better test scores, better health, better discipline.

But child hunger is alive and well in America. I've traveled all over my home state of Massachusetts hearing about how and why children go without adequate nutrition. And I've heard about the safety net that keeps many of our kids from going hungry—healthy meals at school, after school, and at summer feeding sites.

We can protect our children from hunger. We can guarantee that every child has an opportunity to get good quality nutrition year round. This bill doesn't do everything I'd like, but it takes big steps in the right direction.

This bill would allow more of our states to experiment with universal free breakfast. In districts that have tried free breakfast—in Philadelphia, Baltimore, and parts of Minnesota—more kids are showing up for breakfast, kids are doing better in school, and kids are behaving better.

This bill allows more sites to participate in the summer feeding service, and makes it easier for the states to administer those programs. It allows more schools to use federal funds to serve meals at after-school programs. And it allows teenage children to get free after-school snacks in low-income communities.

Mr. Speaker, this bill not only provides more meals for more children, but it makes it easier for the states to use federal money in their own efforts to fight child hunger. I strongly urge my colleagues to support this bill.

WAXMAN AMENDMENT REMARKS

SPEECH OF

HON. CHARLES E. SCHUMER

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. SCHUMER. Mr. Chairman, I rise in support of the Waxman amendment.

The Hudson River is drowning and we need to throw it a life jacket.

It is time to put an end to Congress's interference in the cleaning up of our communities and eliminate the alarming language attached to the VA–HUD appropriations report that will suffocate public health and bulldoze environmental protections.

It is time to demand of our federal government that they not kowtow to big companies like General Electric, big companies who need to start taking responsibility for the deleterious effect their factories are having on our society.

The Hudson River is now contaminated with toxic PCBs—one of the most harmful pollutants known, in large part because General Electric and other companies allowed these dangerous poisons to seep into our waterways.

General Electric maintains that the PCBs are entombed under silt—that the river is cleaning itself. Today there is new evidence that the situation is worse than our worst nightmare. PCBs are escaping from the sediments in the Hudson River and are being carried downstream and settling in other parts of the river contaminating more and more fish and more and more people.

The New York regional administrator of the EPA stated today that ''the fact that these PCBs are so rapidly reentering the river system is startling. Given what we know about the health risks of eating contaminated fish, this information is even more startling.''

Based upon all of the evidence, the EPA is convinced, and so am I, that PCB contamination is a significant threat to public health and the environment.

How much more evidence do we need? How many more experts need to tell us that something needs to be done? How many more New Yorkers need to suffer from immediate and long-term health problems posed by toxic PCB pollution?

Mr. Chairman, we need to dredge the polluted waters of the Hudson and we need to do it now. New York City is built on islands surrounding water, water which cannot be utilized to its fullest potential because of the lethal levels of contaminants. We need to seize this moment and make a last ditch effort to clean up the Hudson River waterfront and make it the jewel it once was.

It is imperative that the Hudson not be sent down the river and New Yorkers not be forced to walk the plank.

Support the Waxman amendment. Eliminate these dangerous riders.

U.N. DUES ARE A LEGAL OBLIGATION

HON. LEE HAMILTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. HAMILTON. Mr. Speaker, some observers have argued that we do not owe to the United Nations the dues we have been assessed by that organization. I would like to set the record straight.

I recently posed a series of questions to the Department of State regarding the nature of our international legal obligations to the United Nations. The reply I received to those questions indicates that while Congress can refuse to pay the bills we owe, that in no way relieves our responsibility to pay those bills.

I ask permission to include in the RECORD my correspondence with the Department of State on this subject, and encourage my colleagues to review it.

DEPARTMENT OF STATE,
Washington, DC, July 8, 1998.

Hon. LEE H. HAMILTON
House of Representatives

DEAR MR. HAMILTON: Thank you for your letter of May 15, raising several important

questions regarding the character and extent of the obligations of the United States under international law to pay amounts assessed by the United Nations.

The Office of the Legal Adviser has prepared the enclosed document, which responds to your questions.

Please let us know if we can provide further information.

Sincerely,

BARBARA LARKIN,
Assistant Secretary,
Legislative Affairs.

Enclosure: As stated.

RESPONSE TO REPRESENTATIVE HAMILTON'S QUESTIONS REGARDING THE STATUS OF UNITED STATES DUES TO THE UNITED NATIONS

(1) On what basis does the United States owe money to the United Nations?

In what document does the obligation arise?

Does Article 17 of the United Nations Charter, which states ''the expenses of the Organization shall be borne by the Members as apportioned by the General Assembly,'' impose a treaty obligation?

From a legal perspective, how does Congress' power of the purse under the Constitution square with any legal obligation to pay dues to the United Nations?

When a treaty and a law conflict, which prevails?

Does the power of Congress to withhold funds release it from treaty obligations to pay dues?

Does the lack of an enforcement mechanism on the part of the United Nations to compel payment nullify any legal U.S. obligation to pay dues to that institution?

Answer: The international legal obligation to pay such assessments arises under the United Nations Charter, a treaty made with the advice and consent of the Senate. The Charter is binding on the United States under international law. Article 17(2) of the Charter states that: ''The expenses of the Organization *shall be borne by the Members* as apportioned by the General Assembly'' (emphasis added). The consistent position of the United States has been that Article 17 creates an obligation under international law to pay amounts assessed by the United Nations. While any particular assessment is not itself a treaty, it is made pursuant to treaty (the Charter), and legal obligation to pay it derives from that treaty.

In the early 1960's, when the former Soviet Union, France and some other States refused to pay assessments for Congo and Mid-East peacekeeping operations, the United States insisted that they had an obligation to do so under international law. The United States at that time said that:

The language of the provision [Article 17(2)] is mandatory: expenses ''*shall* be borne.'' (Emphasis added.) Accordingly, the General Assembly's adoption and apportionment of the Organization's expenses create a binding international legal obligation on the part of States Members to pay their assessed shares.

The history of the drafting of Article 17(2) demonstrates that it was the design of the authors of the Organization's constitution that the membership be legally bound to pay apportioned expenses.

Written Statement of the United States, at 193, *I.C.J. Pleadings, Certain Expenses of the United Nations (Article 17, paragraph 2, of the Chapter*) (1962). When the International Court of Justice gave an advisory opinion affirming the international legal obligation to pay such assessments in the *Certain Assessments* case, Congress passed a resolution expressing its satisfaction with the International Court of Justice's opinion, 22 U.S.C. 287k, and a resolution calling on the United Nations to take ''immediate steps to give effect'' to the Court's opinion. 22 U.S.C. 2871.

This has remained the consistent legal position of the United States and has been reaffirmed by successive administrations. For example, a 1978 published opinion of the State Department's Legal Adviser reiterated that Article 17(2) of the United Nations Charter imposes a legally binding obligation on Member States to pay the amount assessed to them by the General Assembly. Nash, *Digest of United States Practice in International Law 1979*, 225 (1979).

While nothing in the Constitution compels the Congress to refrain from passing a law inconsistent with an existing international legal obligation of the United States, U.S. courts when faced with a conflict have—as a matter of domestic law—applied the later-in-time rule. Thus, Congress can, as a matter of U.S. law, decline to appropriate amounts sufficient to pay United States assessments made pursuant to Article 17 of the Charter. However, such action by Congress does not relieve the United States of its responsibility under international law. Instead, the failure to pay renders the United States in breach of its international obligations.

Article 19 of the Charter establishes that, where a Member of the United Nations is two years in arrears in paying its financial contributions, it shall lose its vote in the General Assembly. The United Nations Secretariat determines when a State is two years in arrears such that this sanction applies. No vote of the General Assembly is involved. Indeed, the United States has insisted that Article 19 should operate automatically and without a vote or other implementing action by the General Assembly.

(2) A portion of the arrears owed by the United States to the United Nations result from ''policy withholdings'' by the executive branch, not legislatively mandated withholdings. In addition, the Administration has recognized, through seeking the creation of a ''contested arrear'' account, that we simply intend to ''write off'' some $400 million in arrears to the U.N.

Why does this portion of U.S. arrears not constitute a legal treaty obligation?

By what rationale do we argue that some arrears are legally binding and others are not?

Do past U.N. actions in suspending the requirement for payment of arrears by other countries provide a precedent for our arguments?

Answer: As your letter notes, the United States has not paid certain assessments because of differences with the United Nations regarding matters of policy. A significant amount of these non-payments reflects an ongoing dispute between the United States and the United Nations as to the specific amounts that the United States is to provide with respect to certain tax reimbursements. Other non-payments reflect policy differences regarding particular UN programs or actions. Some of these ''policy withholdings'' have been implemented by the Executive Branch. Others, such as the 25% ceiling on the amount the United States will pay for peacekeeping operations, arise under statute. Whatever their policy justification, these withholdings do not relieve the United States of its continuing international legal obligation to pay the amount assessed.

(3) What are the legal consequences of our failure to pay our arrears?

Who determines what the U.S. legal obligation is, the U.S. or the U.N.?

Answer: The only legal sanction for failure to pay arrears specified in the Charter is the loss of vote under Article 19, as previously mentioned. Some governments have urged that the United Nations adopt additional measures to sanction countries that are significantly in arrears, such as limitations on procurement or on recruitment of their nationals. The United States has opposed all of these proposals. Thus far, none has been adopted. However, sustained U.S. non-payment of its assessments has lead to growing criticism that the United States does not abide by international law.

COMMITTEE ON
INTERNATIONAL RELATIONS,
Washington, DC, May 15, 1998.

Hon. MADELEINE K. ALBRIGHT,
Secretary of State, Department of State, Washington, DC.

DEAR MADAM SECRETARY: I want to ask clarification of the status of United States dues to the United Nations.

Some commentators have suggested increasingly that the United States may not be obligated legally to pay its assessed dues to the United Nations. The Administration has stressed that these dues are international legal treaty obligations of the United States. I would appreciate answers to the following questions, in hopes of clarifying discussion of this issue.

(1) On what legal basis does the United States owe money to the United Nations?

In what document does the obligation arise?

Does Article 17 of the United Nations Charter, which states ''the expenses of the Organization shall be borne by the Members as apportioned by the General Assembly,'' impose a treaty obligation?

From a legal perspective, how does Congress' power of the purse under the Constitution square with any legal obligation to pay dues to the United Nations?

When a treaty and a law conflict, which prevails?

Does the power of Congress to withhold funds release it from treaty obligations to pay dues?

Does the lack of an enforcement mechanism on the part of the United Nations to compel payment nullify any legal U.S. obligation to pay dues to that institution?

(2) A portion of the arrears owed by the United States to the United Nations result from ''policy withholdings'' by the executive branch, not legislatively mandated withholdings. In addition, the Administration has recognized, through seeking the creation of a ''contested arrear'' account, that we simply intend to ''write off'' some $400 million in arrears to the U.N.

Why does this portion of U.S. arrears not constitute a legal treaty obligation?

By what rationale do we argue that some arrears are legally binding and others are not?

Do past U.N. actions in suspending the requirement for payment of arrears by other countries provide a precedent for our arguments?

(3) What are the legal consequences of our failure to pay our arrears?

Who determines what the U.S. legal obligation is, the U.S. or the U.N.?

I appreciate your cooperation in providing answers to these questions.

With best regards,

Sincerely,

LEE H. HAMILTON,
Ranking Democratic Member.

FAMINE IN SUDAN

HON. TONY P. HALL

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. HALL of Ohio. Mr. Speaker, I rise today to let our colleagues know about the people in

southern Sudan, who are dying of starvation by the tens of thousands. The prospects are especially dim for the million Sudanese who are facing deaths in the next three months.

I was in Sudan a few weeks ago, visiting people in the famine-stricken region and meeting with aid workers and government officials. Since then, one of the feeding centers I went to has been bombed, and a village—where I watched the United Nations' biggest humanitarian airlift in history in operation—has been attacked. The small amount of food captured was turned into a funeral pyre for the people who were too weak to run from the raiders. It was a small village, and I'm sure that some of the people I met were among those who either died or fled.

As all of us know who visit people in such situations, their faces stay with you long after their bodies surely have failed. The faces of Ethiopians I saw during that country's great famine inspired the humanitarian work that I am privileged to do. Since then I have seen others suffer similar fates. Many other Africans, Koreans, Bangladeshis, too many other countries' citizens. Many of them elderly people; many more of them children.

But for me, nothing had rivaled Ethiopia in the depth of its famine, until I saw the people of southern Sudan a few weeks ago. It was not my first trip to that country, so I know what is happening is extraordinary.

The feeling of slowly starving is unimaginable for most of us. Thankfully, so is the agony of watching our own children slide into the nightmare of famine. But the wrenching images of their fate confront us more and more in our media, and we all are diminished by the fact that this tragedy was not prevented.

The problems that have brought famine to 2.6 million Sudanese people are complex. Sudan's civil war has not merely split the nation into two groups; it has splintered it into many factions. The hatreds are racial and religious, and atrocities committed on all sides have deepened the divisions.

Some observers blame Sudan's problems on the National Islamic Front, which controls its government; but all parties to this conflict have blood on their hands. But blame won't save the people of southern Sudan—and time spent trying to parcel it out threatens to distract us. The only endeavor that can ease these innocent people's suffering is whatever can get relief to them immediately. Beyond that, our time would be best spent in pressing for a political settlement, so that this famine does not spill into next year.

The United States has led the international community in humanitarian aid to Sudan this year, I am proud to report. European nations, except for Great Britain, have lagged shamefully. And nations such as Japan and those in the Middle East—who have ample resources to share, and whose own security is threatened by turmoil in Sudan—have been downright niggardly. Our allies and others should do far more to respond to this crisis, and America's generosity gives us the moral authority to press them harder. We have contributed nearly half of the total raised so far by the United Nations, and an even greater share of the assistance delivered by Christian and other charities.

Of course, the percentages that well-fed nations use to track progress toward filling United Nations appeals mean little to people who are starving. In the end, what it means—that half of the appeal remains unmet, that the United Nations is struggling to get food to those in need—is that ''stick people'' who have walked for days to reach feeding centers are being turned away every day.

Two more facts are equally clear. First, a million more people are likely to die—as many as in Ethiopia's two-year famine. Second, our nation and our citizens can do far more. We have given generously, but the amount of food still needed is well within our capacity to provide.

The grain-purchase initiative that President Clinton announced last week may help some American farmers significantly, but it will be the difference between life and death for hundreds of thousands of people facing starvation and malnutrition. In Sudan, our donation will be welcome relief, because war has prevented planting throughout much of this fertile region and so food shortages will continue even after the fall harvest. But it will not save those facing starvation, because it will arrive too late.

The only aid that will make a difference to these people is food that can be purchased in the region, and the urgent immediate loan of additional cargo planes to Operation Lifeline Sudan, so that the United Nations can get the food to those in need. Our law permits such action, and the urgency of this crisis certainly warrants it.

In addition to aid, though, the people of Sudan sorely need peace. This is the second catastrophic famine to strike the same area this decade. We cannot let ''donor fatigue'' dampen our response to the plight of so many people, but neither can we ignore what observers have been saying for years: that humanitarian aid cannot be a substitute for a political solution to Sudan's war. We have a moral obligation to respond generously to the immediate needs, but we have an equal obligation to step up our efforts to help end the war that has caused—and sustained—this famine and the last one.

Frank Wolf and I, along with other Members who share our concern, have called on President Clinton to make peace in Sudan a higher priority. When the need for peace in Northern Ireland became acute, President Clinton sent one of our nation's leading negotiators. Former Senator George Mitchell traveled to that country 100 times to secure an agreement. In Bosnia, and again in Kosovo, Richard Holbrooke was dispatched. Former Secretary of State James Baker III is making superb progress in western Sahara's dispute.

But when it comes to black Africa, our ''A Team'' has remained on the bench. Those Americans who are involved are dedicated, but they do not move in the high-level circles where decisions are made that can make a difference in Sudan. Our allies in Kenya and Britain (the regional leader and the former colonial power, respectively) are doing their best to press for peace. But they lack the high-level American counterpart that could lend momentum to their work.

A few days ago, Sudan's government and rebels agreed to a cease-fire. This might help aid workers do their jobs—if they can get the food and medical supplies they need. But this first cease-fire in four years also dangles the possibility that this three-month truce could be extended into a lasting one, or allow confidence-building measures on which to base peace talks.

Next month, Sudan and its neighbors will return to peace negotiations. It is an opportunity we should not squander. Naming a well respected special envoy—someone with stature who can work with our allies toward peace, and who can inform policy making in our country—would let us seize that opportunity.

It would show that Sudan is on the priority track that the situation warrants. And it would uphold the commitment that President Clinton made on his historic trip to Africa earlier this year. He promised then that the United States would never again let atrocities like we saw in Rwanda go unanswered. Yet the slavery and butchery that happens every day in Sudan rival Rwanda's violence. And the number of people who already have died is three times the number of Rwandan dead.

Mr. Speaker, a peaceful Sudan could feed its own people—and much of Africa. It almost certainly would stop undermining the fragile progress of its many neighbors. Peace would allow Sudan to flourish without relying on terrorists and their client states for support. Most importantly, peace would cap Sudan's rising death toll, which already has passed the two million mark.

Mr. Speaker, it is in America's national interest to help provide such hope to Africa's largest nation, and especially to the 2.5 million people there who face starvation this year. We cannot afford to see Khartoum continue to be the ''viper's nest of terrorists'' that Secretary of State Albright has described. We should not consign ourselves to merely continuing to support Sudan's neighbors in their battles against it—until we exhaust the opportunities for peace. And we certainly cannot afford to feed Sudan and vast areas of Africa that Sudan's people could feed without U.S. aid if they were left in peace.

In have found that when Americans learn about what is happening in Sudan, they agree that helping to ease suffering there is in keeping with their own values. Christians in particular hear this call to help, because it was our missionaries brought our faith to the people of Sudan. We cannot turn our back on their suffering now, because it is in part inflicted on them because their religion differs from their fundamental Islamic enemies.

I have appreciated the kind offers of help that have been extended by our colleagues, Mr. Speaker, as well as the many concerned Americans who have contacted me. There are strong, responsible humanitarian organizations working to relieve suffering in Sudan, and some of the most heroic and dedicated aid workers I have ever met are on the job every day there.

I would like to close by listing these organizations, along with ways for people who share my concern can contact them to learn more about their good work: Adventist Development and Relief Agency; CARE; Catholic Relief Services; Christian Reformed World Relief Committee; Church World Service; Doctors Without Borders; Friends of the World Food Program; International Rescue Committee; Islamic African Relief Agency; Jesuit Refugee Services; Lutheran World Relief; Mercy Corps International; Norwegian People's Aid (c/o U.S. Committee for Refugees); Oxfam International; Oxfam U.S.A.; World Concern Development Organization; World Vision U.S.; U.S. Committee for UNICEF.

For additional information, those interested also can contact Interaction, the American Council for Voluntary International Action, at 202/667–8277.

SECURITIES LITIGATION UNIFORM STANDARDS ACT OF 1998

SPEECH OF

HON. EDWARD J. MARKEY

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 21, 1998

Mr. MARKEY. Mr. Speaker, pursuant to the gentleman from Virginia's unanimous consent request of July 21, 1998 that all Members be given 5 legislative days within which to revise and extend their remarks on H.R. 1689 and to insert extraneous material, I wish to take the opportunity to extend upon my earlier remarks regarding this legislation and to respond to some rather incredible—and I believe inaccurate—remarks made by some of my distinguished colleagues regarding this legislation.

As I have indicated, I oppose this bill. If this bill is to become law, however, it is imperative that we clarify what the scienter requirement will be under the national standards created by H.R. 1689. My colleague from California—Representative Cox—seems to believe that standard should not include recklessness. I strongly disagree.

The federal courts have long recognized that recklessness satisfies the scienter requirement of Section 10(b) and Rule 10b-5—the principal antifraud provisions of the federal securities laws. It is true, as some of my colleagues have noted, that in Ernst & Ernst v. Hochfelder, the Supreme Court left open the question of whether recklessness could satisfy the scienter requirement of Section 10(b) and Rule 10b-5. My colleague from California, however, omits to state that the Court explicitly recognized that ''in certain areas of the law recklessness is considered to be a form of intentional conduct for purposes of imposing liability for some act.'' My colleague from California also neglects to state that since Hochfelder was decided, every court of appeals that has considered the question — ten in number — has interpreted the text of Section 10(b) and Rule 10b–5 to impose liability for reckless misconduct.

And these courts had good reason to so hold. Recklessness is vital to protect investors and the integrity of the disclosure process. Without liability for reckless misstatements, injured investors would be able to recover only if they were able to prove that a defendant had intentionally lied. This would enable defendants who deliberately disregarded available information to avoid liability for investor losses, and would encourage corporate chieftains to bury their heads in the sand.

The recklessness standard promotes meaningful disclosure. Our securities laws are premised on disclosure. Issuers of securities must make full and fair disclosure of material facts to investors when offering their securities. If issuers of securities are liable for misstatements and omissions only when they consciously make false disclosures, they will have less incentive to conduct a probing inquiry into any potentially troublesome areas they discover in the course of preparing their disclosure documents. The recklessness standard helps ensure that disclosure is thorough and meaningful because it encourages issuers to know what is taking place in their own companies.

Finally, the recklessness standard helps bring deliberate securities violators to justice by preventing them from hiding behind evidentiary hurdles. Proving a defendant's actual knowledge of fraud in a securities case is often not possible. Defendants in securities fraud cases do not as a matter of course admit their fraudulent intent. Proving actual knowledge is particularly daunting when, as is often true in securities cases, the evidence relating to the defendant's state of mind is entirely circumstantial. As the U.S. Court of Appeals for the Second Circuit—one of the ten courts of appeals to have put their stamp of approval on recklessness—has noted: ''Proof of a defendant's knowledge or intent will often be inferential . . . and cases thus of necessity [are] cast in terms of recklessness. To require in all types of 10b–5 cases that a factfinder must find a specific intent to deceive or defraud would for all intents and purposes disembowel the private cause of action under § 10(b).''

I do agree with my colleague from the state of California that the 1995 Private Securities Litigation Reform Act did not change the scienter requirement for liability. I am deeply troubled, however, by his attempt to attribute to the Reform Act Conference Committee—of which I was a member—an intention to raise the pleading standard beyond that of the Second Circuit—which, at the time of the Reform Act was the strictest pleading standard in the nation. That clearly was not my understanding nor my intent. Indeed, not only is my colleague attempting to revise history, he is doing so in a manner that would create an illogical result. Because the antifraud provisions allow liability for reckless misconduct, it follows that plaintiffs must be allowed to plead that the defendants acted recklessly. To say that defrauded investors can recover for reckless misconduct, but that they must plead something more than reckless misconduct defies logic.

Likewise, I must take strong exception to the suggestion of my colleague from California about the Conference Committee's intentions regarding a footnote in the Statement of Managers. That footnote, inserted at the last minute without my knowledge and without any discussion of the matter by the Members during the Conference Committee meetings, states that the Committee chose ''not to include in the pleading standard certain language relating to motive, opportunity, or recklessness.'' Contrary to my colleague's statements, this footnote—and make no mistake about it, that's all it is, merely a footnote—does not mean that recklessness has been eliminated either as a basis for liability or as a pleading standard. Existence of this footnote in no way mandates that courts not follow the Second Circuit approach to pleading. The Conference Committee and the Congress that passed the Reform Act also chose not to expressly include conscious behavior in the pleading standard. Yet surely no one would suggest that in doing so, the Conference Committee and Congress intended to eliminate liability for conscious misconduct.

My colleague points to the fact that the President vetoed the bill because of his concerns that the conferees intended to adopt a pleading standard higher than the Second Circuit's. Members in both the House and the Senate following the veto made clear that we did no more than adopt the Second Circuit standard. In this regard, I strongly agree with my colleague from California, Congresswoman LOFGREN, who stated in the legislative history following President Clinton's veto: ''The President says he supports the second circuit standard for pleading. So do I. That is what is included in this bill.''

I would suggest that it is the gentleman from California, rather than myself and other opponents of this legislation, that are trying to rewrite history. I continue to feel that both the Reform Act of 1995 and the present legislation are bad for investors and bad for our financial markets. We do not need to compound the harm done by this legislation with revisionist histories that seek to surreptitiously eliminate liability for reckless behavior.

DISAPPROVAL OF MOST-FAVORED-NATION TREATMENT FOR CHINA

SPEECH OF

HON. TIM ROEMER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 22, 1998

Mr. ROEMER. Mr. Speaker, I rise in strong opposition to H.J. Res. 121, disapproving Most Favored Nation trading status with China. I rise in strong support of normal trade relations and continued constructive engagement with China. I support constructive engagement with China as a method of improving our critically important bilateral relationship and pursuing our foreign policy goals to advance human rights and religious freedom. While progress is at times slow and painful, talks and diplomacy are key aspects of this bilateral relationship.

Last year's trip by President Jiang Zemin to the United States to participate in the first U.S.-China Summit in a decade was the first step in achieving our goals through constructive engagement. President Clinton's highly successful trip to China last month demonstrated that constructive engagement is the most effective way to advance our national interests and promote our values. The United States is committed to improving human rights conditions in China, and I strongly believe human rights should remain a firm pillar of U.S. foreign policy.

Under our policy of constructive engagement, China has acted forthrightly to address our differences, including human rights, both privately and publicly, advancing American values and principles of freedom and democracy. Within the past year, Chinese authorities released numerous political dissidents including Wei Jingsheng and Wan Dan as well as religious leaders like Bishop Zhou. China also signed the United Nations Covenant on Economic and Social Rights and has pledged to sign the UN Covenant on Civil and Political Rights in the fall. This has resulted in meaningful improvements in the lives of millions of Chinese.

Despite official restrictions, the number of religious adherents in China is growing rapidly, with tens of thousands of churches, both registered and unregistered, and with tens of millions of worshipers. I am pleased that Presidents Clinton and Jiang agreed to continued exchanges among officials and religious leaders to improve our mutual understanding of the role of religion in each country. The Chinese government has hosted several delegations of U.S. and foreign religious leaders and the UN Working Group on Arbitrary Detention.

These are positive steps and clearly demonstrate that China is working to expand cooperation with us. We must continue to press for more religious freedom in China. As Billy Graham has written, ''Do not treat China as an adversary but as a friend.'' Revoking normal trade relations and disengaging China will not help its people achieve religious freedom or improved human rights conditions.

Our policy of constructive engagement has also helped expand cooperation with China in critical areas important to our national security: improving financial stability in Asia, preventing the spread of chemical and biological agents on ballistic missiles, combating international crime and drug trafficking, protecting the environment and expanding free trade. China's resistance to devaluing its currency is a prime example of China's efforts to work with the international community to help slow the financial crisis in Asia. This is how the United States benefits from constructive engagement with China.

It is also important to recognize that revoking normal trade relations could actually increase our $15.7 trade deficit. At this time, China represents the fastest growing market for U.S. exports and accounts for more than $150 million of exports from my State of Indiana alone. Since every other major trading partner extends normal trade relations to China, revoking this status would give our competitors in Europe and Asia a competitive edge in developing markets from the ground up, thereby placing at risk more than 400,000 high-paying U.S. jobs and billions of dollars worth of future exports. The best way to reduce our trade deficit with China is to use our trade laws to our advantage in order to tear down China's tariff barriers and to help U.S. exporters to compete in China's markets. We must continue to support policies consistent with fair and free trade.

Mr. Speaker, I am confident that constructive engagement with China will lead to more positive results, advancing our trade interests and foreign policy goals regarding improved religious freedom and human rights conditions. I strongly encourage my colleagues to support constructive engagement and vote against this resolution to disapprove normal trade relations.

STRUCTURED SETTLEMENT PROTECTION ACT

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. SHAW. Mr. Speaker, Mr. Speaker, today I rise along with my colleague Mr. STARK and a broad bipartisan group of our colleagues from the Ways and Means Committee to introduce the Structured Settlement Protection Act.

The Act addresses serious public policy concerns that are raised by transactions in which so-called factoring companies purchase recoveries under structured settlements from injured victims.

Recently there has been dramatic growth in these transactions in which injured victims are induced by factoring companies to sell off future structured settlement payments intended to cover ongoing living and medical needs in exchange for a sharply-discounted lump sum that then may be dissipated, placing the injured victim in the very predicament the structured settlement was intended to avoid.

As long-time supporters of structured settlements and the congressional policy underlying such settlements, we have grave concerns that these factoring transactions directly undermine the policy of the structured settlement tax rules. The Treasury Department shares these concerns.

Because the purchase of structured settlement payments by factoring companies so directly thwarts the congressional policy underlying the structured settlement tax rules and raises such serious concerns for structured settlements and injured victims, it is appropriate to deal with these concerns in the tax context.

Accordingly, we are proposing legislation to impose a substantial excise tax on the factoring company that purchases the structured settlement payments from the injured victim. The excise tax would be subject to an exception for genuine court-approved hardship cases to protect the limited instances of true hardship.

The following is a detailed discussion of the bill's provisions.

BACKGROUND

In acting to address the concerns over factoring companies that purchase structured settlement payments from injured victims the Treasury Department noted that: ''Congress enacted favorable tax rules intended to encourage the use of structured settlements—and conditioned such tax treatment on the injured person's inability to accelerate, defer, increase or decrease the periodic payments—because recipients of structured settlements are less likely than recipients of lump sum awards to consume their awards too quickly and require public assistance.'' (U.S. Department of the Treasury, General Explanations of the Administration's Revenue Proposals (Feb. 1998), p. 122).

Treasury then observed that by enticing injured victims to sell off their future structured settlement payments in exchange for a heavily discounted lump sum that may then be dissipated: ''These 'factoring transactions' directly undermine the Congressional objective to create an incentive for injured persons to receive periodic payments as settlements of personal injury claims.'' (*Id.*, at p. 122 [emphasis added].)

The Joint Tax Committee's analysis of the issue echoes these concerns: ''Transfer of the payment stream under a structured settlement arrangement arguably subverts the purpose of the Code to promote structured settlements for injured persons. (Joint Committee on Taxation, Description of Revenue Provisions Contained in the President's Fiscal Year 1999 Budget Proposal (JCS–4–98), (February 24, 1998), p. 223).

The Treasury Department in the Administration's FY 1999 Budget has proposed a 20-percent excise tax on factoring companies that purchase structured settlement payments from injured victims. Under the Administration's proposal, ''any person purchasing (or otherwise acquiring for consideration) a structured settlement payment stream would be subject to a 20 percent excise tax on the purchase price, unless such purchase is pursuant to a court order finding that the extraordinary and unanticipated needs of the original recipient render such a transaction desirable.'' (Treasury General Explanation, at p. 122). The proposal would apply to transfers of structured settlement payments made after date of enactment.

DESCRIPTION OF THE ACT

1. STRINGENT EXCISE TAX ON PERSONS WHO ACQUIRE STRUCTURED SETTLEMENT PAYMENTS IN FACTORING TRANSACTIONS

In its analysis of the Administration's proposal, the Joint Tax Committee notes the potential concern that in some cases the imposition of a 20-percent excise tax may result in the factoring company passing the tax along by reducing even further the already-heavily discounted lump sum paid to the injured victim for his or her structured settlement payments. The Joint Committee notes that ''[o]ne possible response to the concern relating to excessively discounted payments might be to raise the excise tax to a level that is certain to stop the transfers (perhaps 100 percent). . . .'' (Joint committee on Taxation, Description of Revenue Provisions Contained in the President's Fiscal Year 1999 Budget Proposal (JCS–4–98) (February 4, 1998), p. 223).

Factoring company purchases of structured settlement payments so directly subvert the Congressional policy underlying structured settlement and raise such serious concerns for structured settlement and the injured victims that it is appropriate to impose on the factoring company a more stringent excise tax rate applied against the amount of the discount reflected in the factoring transaction (subject to a limited exception described below for genuine court-approved hardships).

Accordingly, the Act would impose on the factoring company that acquires structured settlement payments directly or indirectly from the injured victim an excise tax equal to 50 percent of the difference between (I) the total amount of the structured settlement payments purchased by the factoring company, and (ii) the heavily-discounted lump sum paid the by the factoring company to the injured victim.

Similar to the stiff excise taxes imposed on prohibited transactions in the private foundation and pension context—which can range as high as 100 to 200 percent—this stringent excise tax is necessary to address the very serious public policy concerns raised by structured settlement factoring transactions.

Unlike the Administration's proposed tax imposed on the purchase price paid by the factoring company, the excise tax imposed on the factoring company under the Act would use a more stringent tax rate of 50 percent and would apply to the excess of the total amount of the structured settlement payments purchased by the factoring company over the heavily-discounted lump sum paid to the injured victim.

The excise tax under the Act would apply to the factoring of structured settlements in tort cases and in workers' compensation.

A structured settlement factoring transaction subject to the excise tax is broadly defined under the Act as a transfer of structured settlement payment rights (including portions of payments) made for consideration by means of sale, assignment, pledge, or other form of alienation or encumbrance for consideration.

2. EXCEPTION FROM EXCISE TAX FOR GENUINE, COURT-APPROVED HARDSHIP

The stringent excise tax would be coupled with a limited exception for genuine, court-approved financial hardship situations. Drawing upon the hardship standard enunciated in the Treasury proposal, the excise tax would apply to factoring companies in all structured settlement factoring transactions except those in which the transfer of structured settlement payment rights (1) is otherwise permissible under applicable Federal and State law and (2) is undertaken pursuant to the order of a court (or where applicable, an administrative authority) finding

that ''the extraordinary, unanticipated, and imminent needs of the structured settlement recipient or his or her spouse or dependents render such a transfer appropriate.''

This exception is intended to apply to the limited number of cases in which a genuinely ''extraordinary, unanticipated, and imminent hardship'' has actually arisen and been demonstrated to the satisfaction of a court (e.g., serious medical emergency for a family member). In addition as a threshold matter the transfer of structured settlement payment rights must be permissible under applicable law including State law. The Act is not intended by way of the hardship exception to the excise tax or otherwise to override any Federal or State law prohibition or restriction on the transfer of the payment rights or to authorize factoring of payment rights that are not transferable under Federal or State law. For example, the States in general prohibit the factoring of workers' compensation benefits. In addition, the State laws often prohibit or directly restrict transfers of recoveries in various types of personal injury cases, such as wrongful death and medical malpractice.

The relevant court for purposes of the hardship exception would be the original court which had jurisdiction over the underlying action or proceeding that was resolved by means of the structured settlement. In the event that no action had been brought prior to the settlement, the relevant court would be that which would have had jurisdiction over the claim that is the subject of the structured settlement or which would have jurisdiction by reason of the residence of the structured settlement recipient. In those limited instances in which an administrative authority adjudicates, resolves, or otherwise has primary jurisdiction over the claim (e.g., the Vaccine Injury Compensation Trust Fund), the hardship matter would be the province of that applicable administrative authority.

3. NEED TO PROTECT TAX TREATMENT OF ORIGINAL STRUCTURED SETTLEMENT

In the limited instances of extraordinary and unanticipated hardship determined by court order to warrant relief under the hardship exception, adverse tax consequences should not be visited upon the other parties to the original structured settlement. In addition, despite the anti-assignment provisions included in the structured settlement agreements and the applicability of a stringent excise tax on the factoring company, there may be a limited number of non-hardship factoring transactions that still go forward. If the structured settlement tax rules under I.R.C. §§72, 130 and 461(h) has been satisfied at the time of the structured settlement, the original tax treatment of the other parties to the settlement—i.e., the settling defendant (and its liability insurer) and the Code section 130 assignee—should not be jeopardized by a third party transaction that occurs years later and likely unbeknownst to these other parties to the original settlement.

Accordingly, the Act would clarify that if the structured settlement tax rules under I.R.C. §§72, 130, and 461(h) had been satisfied at the time of the structured settlement, the section 130 exclusion of the assignee, the section 461(h) deduction of the settling defendant, and the Code section 72 status of the annuity being used to fund the periodic payments would remain undisturbed.

That is, the assignee's exclusion of income under Code section 130 arising from satisfaction of all of the section 130 qualified assignment rules at the time the structured settlement was entered into years earlier would not be challenged. Similarly, the settling defendant's deduction under Code section 461(h) of the amount paid to the assignee to assume the liability would not be challenged. Finally, the status under Code section 72 of the annuity being used to fund the periodic payments would remain undisturbed.

The Act provides the Secretary of the Treasury with regulatory authority to clarify the treatment of a structured settlement recipient who engages in a factoring transaction. This regulatory authority is provided to enable Treasury to address issues raised regarding the treatment of future periodic payments received by the structured settlement recipient where only a portion of the payments have been factored away, the treatment of the lump sum received in a factoring transaction qualifying for the hardship exception, and the treatment of the lump sum received in the non-hardship situation. It is intended that where the requirements of section 130 are satisfied at the time the structured settlement is entered into, the existence of the hardship exception to the excise tax under the Act shall not be construed as giving rise to any concern over constructive receipt of income by the injured victim at the time of the structured settlement.

4. TAX INFORMATION REPORTING OBLIGATIONS WITH RESPECT TO A STRUCTURED SETTLEMENT FACTORING TRANSACTION

The Act would clarify the tax reporting obligations of the person making the structured settlement payments in the event that a structured settlement factoring transaction occurs. The Act adopts a new section of the Code that is intended to govern the payor's tax reporting obligations in the event of a factoring transaction.

In the case of a court-approved transfer of structured settlement payments of which the person making the payments has actual notice and knowledge, the fact of the transfer and the identity of the acquirer clearly will be known. Accordingly, it is appropriate for the person making the structured settlement payments to make such return and to furnish such tax information statement to the new recipient of the payments as would be applicable under the annuity information reporting procedures of Code section 6041 (e.g., Form 1099–R), because the payor will have the information necessary to make such return and to furnish such statement.

Despite the anti-assignment restrictions applicable to structured settlements and the applicability of a stringent excise tax, there may be a limited number of non-hardship factoring transactions that still go forward. In these instances, if the person making the structured settlement payments has actual notice and knowledge that a structured settlement factoring transaction has taken place, the payor would be obligated to make such return and to furnish such written statement to the payment recipient at such time, and in such manner and form, as the Secretary of the Treasury shall by regulations provide. In these instances, the payor may have incomplete information regarding the factoring transaction, and hence a tailored reporting procedure under Treasury regulations is necessary.

The person making the structured settlement payments would not be subject to any tax reporting obligation if that person lacked such actual notice and knowledge of the factoring transaction.

Under the Act, the term ''acquirer of the structured settlement payment rights'' would be broadly defined to include an individual, trust, estate, partnership, company, or corporation.

The provisions of section 3405 regarding withholding would not apply to the person making the structured settlement payments in the event that a structured settlement factoring transaction occurs.

5. EFFECTIVE DATE

The provisions of the Act would be effective with respect to structured settlement factoring transactions occurring after the date of enactment of the Act.

ELECTIONS IN LEBANON

HON. LEE H. HAMILTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. HAMILTON. Mr. Speaker, I would like to call my colleagues' attention to correspondence Congressman GILMAN and I had with the Department of State regarding the importance of the elections scheduled in Lebanon in 1998.

First, Lebanon had largely free and fair local elections this past May and June. For the first time in 35 years, Lebanon conducted municipal elections, signaling the existence of a vibrant democracy at the local level.

The State Department commends the Lebanese in their efforts to implement a democratic and constitutional process. It is hoped that these changes will bring about reforms in the current system and expand the basic rights of the Lebanese.

Second, presidential elections in Lebanon are scheduled for this fall. We hope they will follow the trend of the municipal elections and be another encouraging sign of the Lebanese Government's commitment to the will of its citizens. The United States should continue to support steps in Lebanon to further meaningful representation and solidify the country's democratic institutions and practices.

The correspondence between the State Department and Congressman GILMAN and myself, including a letter of May 13, 1998 and a State Department reply of July 21, 1998, concerning the elections in Lebanon follows:

U.S. DEPARTMENT OF STATE,
Washington, DC, July 21, 1998.

Hon. LEE H. HAMILTON,
House of Representatives.

DEAR MR. HAMILTON: Thank you for your letter of May 13 to Secretary Albright concerning elections in Lebanon.

The municipal elections concluded on June 14. Thus far, Lebanese from all confessional groups have participated in great numbers—in some municipalities upwards of 75% of registered voters—reinforcing our belief that the Lebanese remain committed to the democratic ideals they share with us. That the polls have occurred with few disturbances speaks volumes about the greatly improved security situation in Lebanon and the control the government maintains in most areas of the country.

The Administration has been very active in encouraging free and fair elections in Lebanon. Since the Lebanese government first discussed holding these first municipal elections in 35 years, the Ambassador and Embassy in Beirut have encouraged the political leadership to demonstrate their commitment to democracy and hold the elections.

This is true for the presidential election as well, to take place in the fall. We have been forceful in asserting that the Lebanese should support democracy and constitutional processes. We would like to see a president who represents not only his confessional group but all Lebanese.

In President Clinton's National Day message to President Hrawi last November, he said: ''In the past year, Lebanon has proceeded along the path towards reconstruction, reconciliation and support for democratic institutions and human rights. In the

coming year, I anticipate these trends will continue as your country holds presidential and municipal elections.''

In the May 21 State Department press briefing, Spokesman James Rubin said in response to a question: ''With respect to Lebanon's first municipal elections in 35 years, we welcome these elections. The United States and Lebanon share democratic traditions, and we have long urged the Lebanese to uphold democracy and support their own constitutional processes. We anticipate that these elections will be free and fair, and we urge the participation of all Lebanese in these elections. It's an opportunity for all Lebanese to make their voices heard in this first opportunity for two generations of Lebanese to determine their local leadership.''

Like you, Mr. Hamilton, we remain committed to the goals of Lebanon's full independence, sovereignty and territorial integrity. We look forward to the day when Lebanon, at peace with her neighbors and free of all foreign forces, resumes her traditional place in the community of nations. We hope that the strong showing of support for democracy on the part of all Lebanese will help make that possible.

We hope this has been of help. Please let us know if there is any further information we can provide.

Sincerely,

BARBARA LARKIN,
Assistant Secretary, Legislative Affairs.

COMMITTEE ON INTERNATIONAL RELATIONS,
HOUSE OF REPRESENTATIVES,
Washington, DC, May 13, 1998.

Hon. MADELEINE K. ALBRIGHT,
Secretary of State, Department of State, Washington, DC.

DEAR MADAM SECRETARY: We write regarding United States policy toward Lebanon and important events that are meant to take place there.

First, we want to commend the Government of Lebanon for scheduling municipal elections, which we understand are to be held on four consecutive Sundays, beginning on May 24. Municipal elections have not been held in Lebanon for over thirty years. We hope that the United States will express publicly the great importance we attach to these elections and to their being held as scheduled.

Second, we write regarding the Presidential elections scheduled to be held in Lebanon this fall. As you recall, in 1995 the term of President Elian Hrawi, the current President, was extended for an additional three years. Syrian President Asad announced that extension on October 11, 1995 while on a trip to Cairo, after almost all of Lebanon's major politicians publicly opposed modifying the constitution to permit the President to serve more than one six-year term.

We have heard some reports that President Hrawi's term will again be extended an additional three years. We urge you to engage in quiet, advance diplomacy for the purpose of trying to preempt another subversion of Lebanon's constitution. We also believe that the United States should make clear publicly that we expect the Presidential elections to occur as scheduled.

We appreciate your consideration of these two issues regarding Lebanon.

With best regards,

Sincerely,

BENJAMIN A. GILMAN,
Chairman.
LEE H. HAMILTON,
Ranking Democratic Member.

Friday, July 24, 1998

Daily Digest

HIGHLIGHTS

Senate passed Transportation Appropriations, 1999.

Senate

Chamber Action

Routine Proceedings, pages S8953–S9000

Measures Introduced: Five bills were introduced, as follows: S. 2351–2355. **Pages S8995–96**

Measures Reported: Reports were made as follows:

S. 1883, to direct the Secretary of the Interior to convey the Marion National Fish Hatchery and the Claude Harris National Aquacultural Research Center to the State of Alabama, with amendments. (S. Rept. No. 105–263) **Page S8995**

Measures Passed:

Transportation Appropriations, 1999: By 90 yeas to 1 nay (Vote No. 235), Senate passed S. 2307, making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, as amended. **Pages S8953–56**

Pursuant to the order of Thursday, July 23, 1998, the Chair appointed the following conferees: Senators Shelby, Domenici, Specter, Bond, Gorton, Bennett, Faircloth, Stevens, Lautenberg, Byrd, Mikulski, Reid, Kohl, Murray, and Inouye. **Page S8956**

Federal Credit Union Reform Act: Senate began consideration of H.R. 1151, to amend the Federal Credit Union Act to clarify existing law with regard to the field of membership of Federal credit unions, to preserve the integrity and purpose of Federal credit unions, and to enhance supervisory oversight of insured credit unions, with an amendment in the nature of a substitute, taking action on amendments proposed thereto, as follows: **Pages S8956–82, S8987–88**

Pending:

Gramm Amendment No. 3336, to strike provisions requiring credit unions to use the funds of credit union members to serve persons not members of the credit union. **Pages S8968–76**

A unanimous-consent agreement was reached providing for further consideration of the pending amendment, on Monday, July 27, 1998, with a vote on a motion to table the amendment to occur at 5:30 p.m. **Pages S8975–76**

Communications: **Pagess S8994–95**

Statements on Introduced Bills: **Pages S8996–99**

Additional Cosponsors: **Page S8999**

Amendments Submitted: **Page S8999**

Notices of Hearings: **Page S8999**

Additional Statements: **Pages S8999–S9000**

Record Votes: One record vote was taken today. (Total—235) **Page S8956**

Adjournment: Senate convened at 9:15 a.m., and adjourned at 3:30 p.m., until 12 noon, on Monday, July 27, 1998. (For Senate's program, see the remarks of the Acting Majority Leader in today's Record on page S9000.)

Committee Meetings

No committee meetings were held.

House of Representatives

Chamber Action

Bills Introduced: 10 public bills, H.R. 4326–4335; and 2 resolutions, H. Con. Res. 308–309, were introduced. **Page H6453**

Reports Filed: Reports were filed as follows:

H.R. 379, a private bill, for the relief of Larry Errol Pieterse (H. Rept. 105–644);

H.R. 2744, a private bill, for the relief of Chong Ho Kwak (H. Rept. 105–645);

S. 1304, a private bill, for the relief of Belinda McGregor (H. Rept. 105–646);

Conference report on H.R. 4059, making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999 (H. Rept. 105–647);

H.R. 4328, making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999 (H. Rept. 106–648); and

H.R. 3254, to amend the Individuals With Disabilities Education Act to clarify the requirements relating to reducing or withholding payments to States under that Act, amended (H. Rept. 105–649). **Pages H6427–51, H6453**

Patient Protection Act: The House passed H.R. 4250, to provide new patient protections under group health plans by a yea and nay vote of 216 yeas to 210 nays, Roll No. 339. **Pages H6306–H6417**

Rejected the Berry motion to recommit the bill to the Committee on Education and the Workforce with instructions to report it back to the House with an amendment dealing with medical necessity by yea and nay vote of 205 yeas to 221 nays, Roll No. 338. **Pages H6415–16**

Earlier, a point of order was sustained against the Berry motion to recommit the bill to the Committees on Ways and Means and Education and the Workforce with instructions to report it back to the House with sundry amendments. Agreed to table the motion to appeal the ruling of the Chair by a recorded vote of 222 ayes to 204 noes, Roll No. 337. **Pages H6412–15**

Rejected the Dingell amendment in the nature of a substitute that sought to establish standards to protect access to care and contain the text of H.R. 3605, Patients' Bill of Rights Act by yea and nay vote of 212 yeas to 217 nays, Roll No. 336. **Pages H6382–H6412**

H. Res. 509, the rule that provided for consideration of the bill, was agreed to by a yea and nay vote of 279 yeas to 143 nays, Roll No. 335. **Pages H6297–H6306**

Late Reports: Conferees received permission to have until midnight on July 24 to file a conference report on H.R. 4059, making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999. Also, the Committee on Appropriations received permission to have until midnight on July 24 to file a report on H.R. 4328, making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999. **Page H6395**

Bipartisan Commission on the Future of Medicare: The Chair announced the Speaker's appointment of Mrs. Colleen Conway-Welch of Tennessee to the National Bipartisan Commission on the Future of Medicare. **Page H6418**

Legislative Program: Representative Thomas announced the Legislative Program for the week of July 27. **Pages H6417–18**

Meeting Hour: Agreed that when the House adjourns today, it adjourn to meet at 10:30 a.m. on Monday, July 27. **Page H6418**

Calendar Wednesday: Agreed to dispense with Calendar Wednesday business of July 29. **Page H6418**

Senate Message: Message received from the Senate appears on page H6297.

Amendments: Amendments ordered printed pursuant to the rule appear on pages H6454–55.

Quorum Calls—Votes: Four yea and nay votes, and one recorded vote developed during the proceedings of the House today and appear on pages H6306, H6412, H6414–15, H6416, and H6416–17. There were no quorum calls.

Adjournment: Met at 9:00 a.m. and adjourned at 4:38 p.m.

Committee Meetings

DISTRICT OF COLUMBIA APPROPRIATIONS

Committee on Appropriations: Subcommittee on the District of Columbia approved for full Committee action the District of Columbia appropriations for fiscal year 1999.

FINANCIAL DERIVATIVES SUPERVISORY IMPROVEMENT ACT

Committee on Banking and Financial Services: Continued hearings on H.R. 4062, Financial Derivatives Supervisory Improvement Act of 1998. Testimony was heard from the following officials of the Department of the Treasury: John D. Hawke, Under Secretary; Michael Brosnan, Deputy Comptroller, Risk Evaluation, Office of the Comptroller of the Currency; and Kenneth Ryder, Executive Director, Research, Statistics, and Analysis, Office of Thrift Supervision; Alan Greenspan, Chairman, Board of Governors, Federal Reserve System; Brooksley Born, Chairperson, Commodity Futures Trading Commission; Douglas H. Jones, Senior Deputy General Counsel, FDIC; and public witnesses.

ENHANCING RETIREMENT SECURITY

Committee on Commerce: Subcommittee on Finance and Hazardous Materials held a hearing on Enhancing Retirement Security Through Individual Investment Choices. Testimony was heard from public witnesses.

TEAMSTERS GOVERNANCE AND PRACTICE

Committee on Education and the Workforce: Subcommittee on Oversight and Investigations held a hearing on International Brotherhood of Teamsters Governance and Practice. Testimony was heard from Aaron Belk, Vice President, International Brotherhood of Teamsters.

MISCELLANEOUS MEASURES; HUMAN RIGHTS IN INDONESIA

Committee on International Relations: Subcommittee on International Operations and Human Rights approved for full Committee action amended the following measures: H.R. 4083, to make available to the Ukrainian Museum and Archives the USIA television program "Window on America"; H.R. 633, to amend the Foreign Service Act of 1980 to provide that the annuities of certain special agents and security personnel of the Department of State be computed in the same way as applies generally with respect to Federal law enforcement officers; H. Con. Res. 185, expressing the sense of the Congress on the occasion of the 50th anniversary of the signing of the Universal Declaration of Human Rights and recommitting the United States to the principles expressed in the Universal Declaration; and H.R. 4309, Tortures Victim Relief Act of 1998.

The Subcommittee also concluded hearings on Human Rights in Indonesia, Part II. Testimony was heard from John Shattuck, Assistant Secretary, Bureau of Democracy, Human Rights and Labor, Department of State; and Franklin D. Kramer, Assistant Secretary, International Security Affairs, Department of Defense.

SPECIAL INVESTIGATIVE AUTHORITY TO COMMITTEE

Committee on Rules: Held a hearing on H. Res. 507, providing special investigative authority for the Committee on Education and the Workforce. Testimony was heard from Representatives Goodling, Parker, Clay and Mink of Hawaii.

SSA—LABOR-MANAGEMENT RELATIONS

Committee on Ways and Means: Subcommittee on Social Security concluded hearings to examine labor-management relations at the SSA. Testimony was heard from Paul D. Barnes, Deputy Commissioner, Human Resources, SSA; and a public witness.

FUTURE IMAGERY ARCHITECTURE

Permanent Select Committee on Intelligence: Met in executive session to hold a hearing on Future Imagery Architecture. The Committee was briefed by departmental witnesses.

CONGRESSIONAL PROGRAM AHEAD

Week of July 27 through August 1, 1998

Senate Chamber

On *Monday* and *Tuesday,* Senate will resume consideration of H.R. 1151, Federal Credit Union Reform Act.

During the balance of the week, Senate may consider S. 2334, Foreign Operations Appropriations, 1999, S. 2333, D.C. Appropriations, 1999, S. 2330, HMO reform, conference report on H.R. 4059, Military Construction Appropriations, and any cleared legislative or executive business.

(Senate will recess on Tuesday, July 28, 1998, from 12:30 p.m. until 2:15 p.m. for respective party conferences.)

Senate Committees

(Committee meetings are open unless otherwise indicated)

Committee on Agriculture, Nutrition, and Forestry: July 29, to hold oversight hearings on the Department of Agriculture's progress in consolidating and downsizing its operations, 9 a.m., SR–332.

July 30, Full Committee, to hold hearings to review a recent concept release by the Commodity Futures Trading Commission on over-the-counter derivatives, and on related proposals by the Treasury Department, the Board of Governors of the Federal Reserve System, and the Securities and Exchange Commission, 9 a.m., SD–106.

July 31, Full Committee, to hold hearings on pending nominations, 9 a.m., SR–332.

Committee on Banking, Housing, and Urban Affairs: July 29, business meeting, to mark up S. 1405, to provide for improved monetary policy and regulatory reform in financial institution management and activities, to streamline

financial regulatory agency actions, and to provide for improved consumer credit disclosure, 10 a.m., SD–538.

Committee on Commerce, Science, and Transportation: July 28, to hold hearings on the nominations of Ritajean Hartung Butterworth, of Washington, and Diane D. Blair, of Arkansas, each to be a Member of the Board of Directors of the Corporation for Public Broadcasting, and Kelley S. Coyner, of Virginia, to be Administrator of the Research and Special Programs Administration, Department of Transportation; to be followed by hearings to examine why cable rates continue to increase, 9:30 a.m., SR–253.

July 29, Full Committee, business meeting, to consider pending calendar business, 9:30 a.m., SR–253.

July 30, Subcommittee on Communications, to hold hearings to examine international satellite reform, 9:30 a.m., SR–253.

Committee on Energy and Natural Resources: July 28, to hold hearings to examine the March 31, 1998 Government Accounting Office report on the Forest Service, focusing on Alaska region operating costs, 9:30 a.m., SD–366.

July 29, Full Committee, business meeting, to consider pending calendar business, 9:30 a.m., SD–366.

Committee on Environment and Public Works: July 29, business meeting, to consider pending calendar business, 9:30 a.m., SD–406.

July 30, Subcommittee on Clean Air, Wetlands, Private Property, and Nuclear Safety, to hold oversight hearings on activities of the Nuclear Regulatory Commission, 9 a.m., SD–406.

July 30, Full Committee, to hold hearings on the nominations of Romulo L. Diaz, Jr., of the District of Columbia, to be Assistant Administrator for Administration and Resources Management, and J. Charles Fox, of Maryland, to be Assistant Administrator for Water, both of the Environmental Protection Agency, 2 p.m., SD–406.

Committee on Finance: July 28, business meeting, to consider a proposed amendment to S. 442, the Internet Tax Freedom Act, 10 a.m., SD–215.

July 29, Subcommittee on Social Security and Family Policy, to hold hearings on S. 1858, to provide individuals with disabilities with incentives to become economically self-sufficient, 2 p.m., SD–215.

Committee on Governmental Affairs: July 27, Subcommittee on Oversight of Government Management, Restructuring and the District of Columbia, to hold hearings to examine safety issues relating to the District of Columbia, 3 p.m., SD–342.

July 29, Subcommittee on International Security, Proliferation and Federal Services, to hold hearings to examine the satellite export licensing process, 2 p.m., SD–342.

July 30, Full Committee, to hold hearings to examine issues in preparation for the Year 2000 Census, 10 a.m., SD–342.

Committee on the Judiciary: July 29, to hold hearings on S. 1554, to provide for relief from excessive punitive damage awards in cases involving primarily financial loss by establishing rules for proportionality between the amount of punitive damages and the amount of economic loss, 9:30 a.m., SD–226.

July 29, Subcommittee on Immigration, to hold oversight hearings on enforcement activities of the Immigration and Naturalization Service, Department of Justice, 2 p.m., SD–226.

July 30, Full Committee, business meeting, to consider pending calendar business, 9:30 a.m., SD–226.

July 30, Full Committee, to hold hearings on pending nominations, 1 p.m., SD–226.

July 31, Full Committee, to hold hearings to examine issues with regard to physician assisted suicide, 10 a.m., SD–226.

Committee on Labor and Human Resources: July 28, to hold hearings to examine the science of addiction and options for substance abuse treatment, 10 a.m., SD–430.

July 29, Full Committee, business meeting, to mark up S. 1380, Charter Schools Expansion Act, and S. 2213, Education Flexibility Amendments of 1998, 9:30 a.m., SD–430.

Committee on Rules and Administration: July 29, to hold hearings on S. 2288, to provide for the reform and continuing legislative oversight of the production, procurement, dissemination, and permanent public access of the Government's publications, 9:30 a.m., SR–301.

Committee on Veterans Affairs: July 28, business meeting, to consider pending calendar business, 3:30 p.m., SR–418.

Committee on Indian Affairs: July 29, business meeting, to consider pending calendar business, 2 p.m., SR–485.

Select Committee on Intelligence: July 29, to hold closed hearings on intelligence matters, 10 a.m., SH–219.

July 29, Full Committee, to hold closed hearings on intelligence matters, 2:30 p.m., SH–219.

Special Committee on Aging: July 27, to hold hearings to examine allegations of neglect in certain California nursing homes and the overall infrastructure that regulates these homes, 1 p.m., SH–216.

July 28, Full Committee, to continue hearings to examine allegations of neglect in certain California nursing homes and the overall infrastructure that regulates these homes, 10 a.m., SH–216.

Special Committee on the Year 2000 Technology Problem: July 31, to hold hearings to examine telecommunication issues with regard to the Year 2000 information problem, 9:30 a.m., SD–192.

House Chamber

To be announced.

House Committees

Committee on Agriculture, July 28, hearing on H.R. 4149, Forest Service Cost Reduction and Fiscal Accountability Act of 1998, 2 p.m., 1300 Longworth.

July 30, hearing to review the state of the farm economy, 10 a.m., 1300 Longworth.

Committee on Banking and Financial Services, July 28, hearing to review the Use of Deceptive Practices to Gain Access to Personal Financial Information, 10 a.m., 2128 Rayburn.

July 30, Subcommittee on Capital Markets, Securities and Government Sponsored Enterprises, hearing on a GAO Study of HUD's Role as Mission Regulator of Fannie Mae and Freddie Mac, 10 a.m., 2128 Rayburn.

Committee on Commerce, July 27, Subcommittee on Energy and Power, hearing on Progress on Uranium Mill Tailings Cleanup, 2 p.m., 2123 Rayburn.

July 29, full Committee, hearing on Electronic Commerce: The Global Electronic Marketplace, 10:30 a.m., 2123 Rayburn.

Committee on Education and the Workforce, July 28, Subcommittee on Early Childhood, Youth, and Families, hearing on School Financing and the Federal Role in Compensatory Education, 10 a.m., 2175 Rayburn.

July 29, full Committee, to mark up the following bills: H.R. 4241, Head Start Amendments of 1998; H.R. 4271, Community Services Authorization Act of 1998; and H.R. 4037, to require the Occupational Safety and Health Administration to recognize that electronic forms of providing Material Safety Data Sheets provide the same level of access to information as paper copies and to improve the presentation of safety and emergency information on such Data Sheets, 10:30 a.m., 2175 Rayburn.

July 30, Subcommittee on Oversight and Investigations, hearing on "The Independent Review Board Oversight of the International Brotherhood of Teamsters: Is It Effective?", 1:30 p.m., 2175 Rayburn.

July 30, Subcommittee on Workforce Protections, hearing to review the Federal Mine Safety and Health Act of 1997, 10 a.m., 2175 Rayburn.

Committee on Government Reform and Oversight, July 28, Subcommittee on Government Management, Information, and Technology, hearing on H.R. 3921, Federal Financial Assistance Management Improvement Act of 1998, 1 p.m., 2247 Rayburn.

July 28, Subcommittee on National Economic Growth, Natural Resources, and Regulatory Affairs, hearing on "State and Local Governments v. Clinton/Gore", 10 a.m., 2154 Rayburn

July 29, Subcommittee on Human Resources, hearing on Job Corps Oversight Part II: Vocational Training Standards, 10 a.m., 2154 Rayburn.

July 30, full Committee, hearing on the Need for an Independent Counsel in the Campaign Finance Investigation, 10 a.m., 2154 Rayburn.

July 31, hearing on Solving the Cancer Crisis: Comprehensive Research, Coordination and Care, 10 a.m., 2154 Rayburn.

Committee on House Oversight, July 30, to consider pending business, 10:30 a.m., 1310 Longworth.

Committee on International Relations, July 29, hearing on Recent Developments in the Middle East, 10 a.m., 2172 Rayburn.

July 29, Subcommittee on International Operations and Human Rights and the Subcommittee on Africa, joint hearing on the Crises in Sudan and Northern Uganda, 1:30 p.m., 2172 Rayburn.

July 29, Subcommittee on Western Hemisphere, hearing on Conflict Resolution: Chiapas, Mexico and the Search for Peace, 1:30 p.m., 2200 Rayburn.

Committee on the Judiciary, July 28, to continue mark up of H.R. 3789, Class Action Jurisdiction Act of 1998 and to mark up the following: H.R. 4006, Lethal Drug Abuse Prevention Act of 1998; H.R. 3843, to grant a Federal charter to the American GI Forum of the United States; H.R. 218, Community Protection Act of 1997; and private immigration bills, 10 a.m., 2141 Rayburn.

July 29, hearing on H.R. 4277, Quality Health-Care Coalition Act of 1998, 10 a.m., 2141 Rayburn.

July 30, Subcommittee on Commercial and Administrative Law, hearing on the following bills: H.R. 3396, Citizens Protection Act of 1998; and H.R. 692, to amend the independent counsel provisions of title 28, United States Code, to authorize the appointment of an independent counsel when the Attorney General determines that Department of Justice employees have engaged in certain conduct, 10 a.m., Rayburn.

July 30, Subcommittee on Crime, oversight hearing on the use of controlled substances used to commit date rape, 9:30 a.m., 2226 Rayburn.

July 30, Subcommittee on Immigration and Claims, to mark up pending legislation, 9:30 a.m., B–352 Rayburn.

Committee on Resources, July 28, hearing on H.R. 3987, Deer and Elk Protection Act, 2 p.m., 1324 Longworth.

July 28, Subcommittee on National Parks and Public Lands, hearing on the following bills: H.R. 2125, to authorize appropriations for the Coastal Heritage Trail Route in New Jersey; H.R. 3950, Otay Mountain Wilderness Act of 1998; H.R. 3963, to establish terms and conditions under which the Secretary of the Interior shall convey leaseholds in certain properties around Canyon Ferry Reservoir; H.R. 4144, Cumberland Island Preservation Act; H.R. 4211, to establish the Tuskegee Airmen National Historic Site, in association with the Tuskegee University, in the State of Alabama; H.R. 4230, El Porto Administrative Site Land Exchange Act; and a measure to make technical corrections and minor adjustments to the boundaries of the Grand Staircase-Escalante National Monument in the State of Utah, 10 a.m., 1324 Longworth.

July 28, Subcommittee on Water and Power, hearing on the following bills: H.R. 3478, Colorado Ute Settlement Act Amendments of 1998; and H.R. 745, to deauthorize the Animas-La Plata Federal reclamation project, and to direct the Secretary of the Interior to enter into negotiations to satisfy, in a manner consistent with all Federal laws, the water rights interests of the Ute Mountain Ute Indian Tribe, 2 p.m., 1334 Longworth.

July 29, full Committee, to mark up the following measures: H. Res. 494, expressing the sense of the House of Representatives that the United States has enjoyed the loyalty of the United States citizens of Guam, and that the United States recognizes the centennial anniversary of the Spanish-American War as an opportune time for Congress to reaffirm its commitment to increase self-government consistent with self-determination for the people of Guam; H.R. 1110, Sudbury, Iceboat, and Concord Wild and Scenic Rivers Act; H.R. 2370, Guam Judicial Empowerment Act of 1997; H.R. 2776, to amend the Act entitled "An Act to provide for the establishment of the Morristown National Historical Park in the State of New

Jersey, and for other purposes'' to authorize the acquisition of property known as the Warren property; H.R. 3445, Oceans Act of 1998; H.R. 4068, to make certain technical corrections in laws relating to Native Americans; H.R. 4079, to authorize the construction of temperature control devices at Folsom Dam in California; and H.R. 4326, Oregon Public Lands Transfer and Protection Act of 1998; and to hold a hearing on H.R. 2743, Indian Land Consolidation Amendment Act of 1997, 11 a.m., 1324 Longworth.

July 30, Subcommittee on Fisheries Conservation, Wildlife and Oceans, hearing on the status of oceanographic monitoring and assessment efforts on both global and local scales, 10 a.m., 1324 Longworth.

July 30, Subcommittee on Forests and Forest Health, oversight hearing on NEPA Parity, 10 a.m., 1334 Longworth.

Committee on Rules, July 27, to consider the following: the Transportation appropriations for fiscal year 1999; and the Conference Report to accompany H.R. 629, Texas Low-Level Radioactive Waste Disposal Compact Consent Act; and to mark up H. Res. 507, providing special investigative authority for the Committee on Education and the Workforce,4 p.m., H–313 Capitol.

Committee on Science, July 28, Subcommittee on Energy and Environment, hearing on S. 1418, Methane Hydrate Research and Development Act of 1998, 10 a.m., 2318 Rayburn.

Committee on Small Business, July 27, to continue hearings on Kyoto Protocol: The Undermining of American Prosperity? Part 2—The Science, 1 p.m., 2360 Rayburn.

July 30, Subcommittee on Tax, Finance, and Exports, hearing on ''Helping Small Businesses—Will Tax Relief Make a Difference?'' 10 a.m., 311 Cannon,

Committee on Transportation and Infrastructure, July 29, Subcommittee on Coast Guard and Maritime Transportation, hearing on the Needs of the U.S. Marine Transportation System: The Waterways, Ports, and Their Intermodal Connections, 10 a.m., 2167 Rayburn.

July 30, Subcommittee on Aviation, hearing on the Department of Transportation's African Aviation Initiative, H.R. 3741, Aviation Bilateral Accountability Act of 1998, and European Commission's preliminary position on 2 transatlantic alliances, 9:30 a.m., 2167 Rayburn.

Committee on Ways and Means, July 28, Subcommittee on Trade, hearing on Trade Relations with Europe and the new Transatlantic Economic Partnership, 11 a.m., 1100 Longworth.

July 29, full Committee, to mark up the following measures: the Miscellaneous Trade and Technical Corrections Act of 1998; and H. Con. Res. 213, expressing the sense of the Congress that the European Union is unfairly restricting the importation of United States agriculture products and the elimination of such restrictions should be a top priority in trade negotiations with the European Union, 10:30 a.m., 1100 Longworth.

July 30, Subcommittee on Human Resources, hearing on Fatherhood and Welfare reform, 11 a.m., B–318 Rayburn.

Permanent Select Committee on Intelligence, July 28, executive, briefing on Korean Peninsula, 10 a.m., H–405 Capitol.

July 28, Subcommittee on Technical and Tactical Intelligence, executive, hearing on Support to Military Operations, 2 p.m., H–405 Capitol.

Joint Meetings

Commission on Security and Cooperation in Europe: July 30, to hold joint hearings with the House Committee on International Relations to examine issues relating to religious intolerance in Europe, 10 a.m., 2172 Rayburn Building.

Next Meeting of the SENATE

12 noon, Monday, July 27

Senate Chamber

Program for Monday: After the transaction of any morning business (not to extend beyond 1 p.m.), Senate will resume consideration of H.R. 1151, Federal Credit Union Act.

Next Meeting of the HOUSE OF REPRESENTATIVES

10:30 a.m., Monday, July 27

House Chamber

Program for Monday: To be announced.

Extensions of Remarks, as inserted in this issue

HOUSE

Barrett, Thomas M., Wisc., E1436
Becerra, Xavier, Calif., E1428
Berman, Howard L., Calif., E1426
Conyers, John, Jr., Mich., E1425, E1426
Costello, Jerry F., Ill., E1431
Eshoo, Anna G., Calif., E1436
Ford, Harold E., Jr., Tenn., E1425
Ganske, Greg, Iowa, E1419
Gilman, Benjamin A., N.Y., E1429
Gingrich, Newt, Ga., E1421
Hall, Tony P., Ohio, E1438
Hamilton, Lee H., Ind., E1437, E1442
Harman, Jane, Calif., E1424
Kennedy, Joseph P., II, Mass., E1437
Kucinich, Dennis J., Ohio, E1419
Lipinski, William O., Ill., E1424
Maloney, Carolyn B., N.Y., E1426
Markey, Edward J., Mass., E1440
Meek, Carrie P., Fla., E1428
Millender-McDonald, Juanita, Calif., E1436
Neal, Richard E., Mass., E1419
Norton, Eleanor Holmes, D.C., E1429
Oberstar, James L., Minn., E1431, E1436
Poshard, Glenn, Ill., E1419, E1428, E1431
Radanovich, George P., Calif., E1428, E1430
Roemer, Tim, Ind., E1421, E1430, E1440
Roukema, Marge, N.J., E1428, E1431
Sanders, Bernard, Vt., E1426
Schaffer, Bob, Colo., E1429, E1431
Schumer, Charles E., N.Y., E1437
Sensenbrenner, F. James, Jr., Wisc., E1419
Shaw, E. Clay, Jr., Fla., E1420, E1441
Shimkus, John, Ill., E1435
Smith, Nick, Mich., E1435
Stark, Fortney Pete, Calif., E1424
Young, Don, Alaska, E1425

Congressional Record The public proceedings of each House of Congress, as reported by the Official Reporters thereof, are printed pursuant to directions of the Joint Committee on Printing as authorized by appropriate provisions of Title 44, United States Code, and published for each day that one or both Houses are in session, excepting very infrequent instances when two or more unusually small consecutive issues are printed at one time. ¶Public access to the Congressional Record is available online through *GPO Access,* a service of the Government Printing Office, free of charge to the user. The online database is updated each day the Congressional Record is published. The database includes both text and graphics from the beginning of the 103d Congress, 2d session (January 1994) forward. It is available on the Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is http://www.access.gpo.gov/su_docs, by using local WAIS client software or by telnet to swais.access.gpo.gov, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required). For general information about *GPO Access,* contact the *GPO Access* User Support Team by sending Internet e-mail to gpoaccess@gpo.gov, or a fax to (202) 512–1262; or by calling Toll Free 1–888–293–6498 or (202) 512–1530 between 7 a.m. and 5 p.m. Eastern time, Monday through Friday, except for Federal holidays. ¶The Congressional Record paper and 24x microfiche will be furnished by mail to subscribers, free of postage, at the following prices: paper edition, $150.00 for six months, $295.00 per year, or purchased for $2.50 per issue, payable in advance; microfiche edition, $141.00 per year, or purchased for $1.50 per issue payable in advance. The semimonthly Congressional Record Index may be purchased for the same per issue prices. Remit check or money order, made payable to the Superintendent of Documents, directly to the Government Printing Office, Washington, D.C. 20402. ¶Following each session of Congress, the daily Congressional Record is revised, printed, permanently bound and sold by the Superintendent of Documents in individual parts or by sets. ¶With the exception of copyrighted articles, there are no restrictions on the republication of material from the Congressional Record.