

My bill would promote greater fairness and equity in franchise relationships by establishing minimal standards of conduct for franchise practices, by prohibiting the most abusive acts by franchisors, by clarifying the legal rights of franchise owners, and by nullifying procedural devices intended to block available legal remedies.

In addition, the bill incorporates basic prohibitions against fraud, misrepresentation and discrimination elsewhere in Federal law and applies them to franchise sales and business practices. It protects the right of franchisees to organize franchisee trade associations and to engage in collective legal action to protect their financial interests. And it provides a private right of actions for violations of Federal franchise disclosure requirements—something the FTC has requested for 18 years.

Mr. Speaker, franchising has undergone tremendous growth in the past two decades and now dominates our nation's retail and services sectors. But Federal law and regulation have failed to keep pace. Federal guidelines intended to protect the public from false or misleading franchise promotions are sadly out of date and only marginally enforced. Legal rights and standards taken for granted in other business relationships continue to be debated and denied in franchising arrangements.

It is time Congress acted to provide basic protections in Federal law to discourage fraudulent and abusive franchising practices and to help strengthen the American dream of small business ownership. I believe the proposals I am introducing could constitute landmark legislation. In much the same way that the Wagner Act helped revolutionize labor-management relations in the industrial economy of the 1930's this legislation can help restore fairness and balance in the growing franchising sector of the services-based economy of the 1990's.

I recommend this legislation to the consideration of my colleagues and I urge its adoption by the Congress.

TRIBUTE TO BILL AND DALE
BELCHER

HON. ELTON GALLEGLY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Mr. GALLEGLY. Mr. Speaker, I would like to recognize Bill and Dale Belcher on being chosen as Golden Condor Award winners for their many years of outstanding service to their community and Scouting.

Their work with the Scouts has spanned decades and has had a tremendous impact on the many young people they have worked with over the years. Their sense of community extends far beyond the boundaries of Scouting. For some, that would be enough public service, but not for Bill and Dale. Each of them has dedicated their life to a variety of service organizations. Both Bill and Dale have been very involved in their church and served as executives with United Way.

Dale is active with Soroptimist International, Oxnard Women's Club, and a host of other organizations. Bill is a 20-year veteran of the U.S. Navy, and a longtime member of the Rotary Club, just to name a few.

Mr. Speaker, Bill and Dale Belcher stand as shining examples of the difference two people

can make in the lives of many. I would like to extend my sincere congratulations to Dale and Bill on having been chosen as Golden Condor Award winners and thank them for their work in our community.

ROUGH DRAFT OF LEGISLATION
TO IMPROVE QUALITY OF CARE
IN NATION'S DIALYSIS CENTERS

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Mr. STARK. Mr. Speaker, I am today including in the CONGRESSIONAL RECORD the rough draft of a bill which represents several years of hard work within the kidney disease community on how to improve the quality of care for our Nation's nearly 250,000 kidney disease patients.

I am asking that the bill be printed in the RECORD in the closing hours of this session of the 105th Congress, so that interested parties can study the proposal over the next several months and offer suggestions and changes. I will be working on the bill over the coming months to develop a consensus on this effort to improve the quality of life of the Nation's kidney disease patients, and I hope to introduce it formally, with appropriate changes, when the second session meets in January.

Basically, the draft bill would create a continuous quality improvement [CQI] program that requires all providers treating end-stage renal disease patients under Medicare to provide data on the outcomes and quality of life of their patients, and to seek to improve that quality.

Those who achieve outstanding quality outcomes will be recognized for their special contributions. Those who fail to meet agreed-upon quality standards will be counseled and worked with to improve. Patients in most communities where there is more than one dialysis provider will be empowered to switch to centers which provide the better outcomes and quality. All the care givers, including the doctors, will be part of the new effort of measurement and improvement.

The result should be improved mortality and morbidity rates, improved energy levels, improved rates of return to work, and of transplantation.

Mr. Speaker, for over 23 years Medicare has been paying for the catastrophic expenses of treating end-stage renal disease, through three times a week life-giving dialysis, through transplantation, and through all the extra hospitalizations, tests, and pharmaceuticals needed by these citizens. The cost per patient per year is, counting everything, estimated between \$50,000 and \$60,000.

The program has been a tremendous success. It has saved enormous numbers of lives and in many cases provided a good quality of life for decades in which people have continued to contribute to their communities and loved ones.

Yet, after 23 years experience, we can and should do better. There are enormous differences between dialysis centers. After adjusting for every imaginable factor, scholars continue to find that some dialysis centers have death rates much higher than the average. To be blunt, some dialysis centers should

be avoided as dangerous to one's health. Some dialysis centers seldom or never refer patients—on whom they make some money—to transplantation so that they will never again need dialysis. Some centers' patients spend many more days per year in the hospital than the "best practice" centers. Some centers are able to get their patients back to work; in others, a lifetime of disability and welfare becomes the norm. And as the GAO reported to Congress on September 26, the number of appropriate lab tests given to ESRD patients vary enormously among centers, raising questions of quality and of fraud and abuse.

With Medicare—not total—expenditures on ESRD patients likely to be about \$9 billion in the coming year, we need to do better. We need to reduce the hospitalization rates and the unexplained death rates. We need to increase the opportunities for transplantation and for the return to work and a full range of normal activities. The draft bill would—I believe—help patients and providers work together to achieve these goals.

Finally, managed care has become a fact of life for most Americans, but most ESRD patients are not in managed care. Indeed, currently there is a prohibition on patients who reach ESRD status joining a managed care plan—although a person already in a managed care plan who reaches ESRD can stay in his or her plan. The fear has been that a managed care company could so cut access to services and quality care for these very vulnerable patients that it could lead to greatly increased patient death and illness. Until we have strong quality standards in place and know how to measure ESRD outcomes, it is dangerous to place these patients in systems designed to reduce utilization. The CQI legislation I am introducing will help ensure that for those few ESRD patients in managed care, there is a guarantee of quality. The lessons learned from this legislation will help permit the day when we could confidently entrust this population to disease management programs.

I want to thank all of the rental and patient associations who have been working with HCFA to improve quality and who have been offering suggestions for CQI legislation. In particular, I want to thank the Renal Physicians Association. This draft legislation builds on many of the ideas that are already underway in the renal community and at HCFA, and I believe it is a bill that can achieve consensus support throughout the renal community.

To repeat, I welcome additional suggestions and refinements to this proposal—and hope it is legislation that we can move forward in 1998.

TO HONOR AMERICA'S VETERANS

HON. JAMES H. MALONEY

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Mr. MALONEY. Mr. Speaker, I rise today to honor our Nation's veterans.

When in 1958 President Eisenhower signed the bill proclaiming November 11th Veteran's Day, he called for Americans everywhere to rededicate themselves to the cause of a lasting peace. He proclaimed that day an occasion for honoring all Veterans of all wars, a group that currently includes more than 27 million Americans, over 50,000 of whom reside in

the 5th district of Connecticut which I represent.

The 11th day of the 11th month originally was known as Armistice Day, commemorating the signing of the Armistice ending World War I. The 1958 law changed one word, Armistice to Veterans' day, and created a day for our Nation to honor all its veterans. Also on Veterans' Day in 1958, two unidentified soldiers, one killed in Korea and one killed in World War II were brought to Arlington Cemetery and interred at the Tomb of the Unknown Soldier.

Although the name of this day has changed, the central purpose has remained consistent, the 11th day of the 11th month remains a day to honor those who have served their country on the battle fields of Europe, Korea, South East Asia, in the Persian Gulf, and in many other locations around the world. But this is not only a day to remember those who did not return. This is also a day to reaffirm our commitment to the men and women who served and returned, and to the sons and daughters, wives and husbands of those who were left behind, whether for a while or forever.

We must commit ourselves to provide our veterans with full access to the best medical care available; we must ensure that the survivors of American veterans always have adequate provision for their needs; and we must commit ourselves to bringing home those soldiers who have not yet returned from the battlefield.

Mr. Speaker, we can never forget the sacrifices our veterans have made so that we may live in peace today. And this, Mr. Speaker, is what President Eisenhower was referring to when he called for Americans everywhere to rededicate themselves to the cause of peace on this, the 11th day of the 11th month. We need to rededicate ourselves to the peace which these brave Americans have fought to secure and defend.

Mr. Speaker, on behalf of the 5th congressional district, the State of Connecticut, and Americans everywhere, I thank the veterans for their service, dedication and loyalty to our country.

PRESERVING PATIENT ACCESS TO
METERED DOSE INHALERS

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Mr. SMITH of New Jersey. Mr. Speaker, when most of us think about the Food and Drug Administration [FDA], we envision an agency that works diligently to expand the universe of safe and effective medications. So when I discovered that the FDA was actually proposing to reduce the number of proven medicines available to treat asthma and cystic fibrosis patients, I knew Congress had to act on behalf of patients. As a legislator representing thousands of asthma patients, and as a father of two daughters with asthma, I am appalled that FDA might ban proven medicines patients need to survive.

As a result of these efforts by the FDA, today I am introducing legislation that will preserve access to metered dose inhalers [MDIs] for those patients suffering from respiratory conditions—particularly children suffering from

asthma and cystic fibrosis. This bill will ensure that those who rely upon MDI's to breathe, will not be denied access to their lifeline by an overzealous FDA. Joining me in this effort is my good friend Florida, Representative CLIFF STEARNS. Together, Mr. STEARNS—who is the author of H.R. 2221—and I have worked together in an effort to change the FDA's misguided policy.

On March 6, 1997, the FDA initiated the first stage of a plan to phase-out the use of chlorofluorocarbons [CFC's] metered-dose inhalers [MDI's], which are used by asthma and cystic fibrosis patients to breathe. This action was taken ostensibly to protect the ozone layer, despite the fact that less than 1 percent of all ozone-depleting substances in the atmosphere are caused by metered-dose inhalers.

In fact, the amount of CFC's that the EPA allows to be released from automobile air conditioners over 1 year is about the same as 14 years of metered-dose inhaler emissions. If you combined all sources of CFC's allowed by the EPA in 1 year, it would equal 64 years of MDI emissions. And yet the only CFC products targeted for elimination this year are inhalers.

It is also interesting to note that while the FDA and EPA are rushing to eliminate CFC inhalers, they continue to allow the use of a variety of CFC products, including bear-repellent pepper sprays, document preservation sprays, and certain fire extinguishers. This is clearly a case of misplaced priorities—how can historical document sprays be considered more essential than products that protect our children's lives? And while American children and senior citizens will have their treatment regimens disrupted by the FDA's plan, nations like China and Indonesia will be pumping tons of CFC's into the atmosphere from hair sprays and air conditioners until the year 2010.

Not surprisingly, the FDA's plan has generated a firestorm of opposition from patients, respiratory therapists, and physicians: nearly 10,000 letters in opposition have been received to date by the FDA. A coalition of stakeholder organizations reviewed the FDA proposal in May and concluded that the FDA's approach banning therapeutic classes was flawed and must be re-evaluated. The patient and provider organizations also stated that the FDA plan "has the potential to disrupt therapeutic regimens * * * and limit physician treatment options."

It is important to institute a transition strategy that will eventually eliminate the use of CFC's. However, the FDA's proposal is deeply flawed and should be scrapped in favor of a plan that puts patients—not international bureaucrats—first.

To ensure that the interests of patients are upheld throughout the formation of our country's MDI transition strategy, this legislation will temporarily suspend the FDA's proposed framework until a new proposal can be crafted. In addition, this bill would require the FDA to consult with patients, physicians, manufacturers of MDI's and other stakeholders prior to issuing any subsequent proposal. In addition, my legislation requires the Secretary of Health and Human Services to certify to Congress that any alternatives to existing MDI's will be available to all populations of users of such inhalers, are comparable in terms of safety and effectiveness, therapeutic indications, dosage strength, cost, and retail availability.

Mr. Speaker, this past week we held a press conference in an effort to educate the public and media about the dangers of the FDA's proposal. Participating in this press conference was Tommy Farese, who is 9 years old, and lives in Spring Lake, NJ, and has had asthma since the age of 2. One of the asthma inhalers Tommy uses to breathe—Proventil—would be eliminated under the FDA plan in favor of a non-CFC version that has not been approved by the FDA for use by children. Unless the FDA's proposal is changed, Tommy could lose access to the medicine he needs to breathe and live. Why should Tommy, and 5 million children like him have to face this dilemma?

In my view, any plan to remove safe and effective medications from the marketplace needs to place the interests of children like Tommy Farese first and foremost. Sadly, the FDA plan fails in this regard. Indeed, the FDA plan presumes that CFC-free inhalers serve all patient subpopulations—such as children and the elderly—equally well, despite the fact that children have special needs and many drug therapies are not interchangeable.

Therefore, I call upon the FDA to stop their proposed ban of asthma inhalers. If the FDA insists on moving forward with their antipatient plan, I call upon my colleagues to support and pass the Smith-Stearns bill to allow asthma patients like Tommy Farese retain access to their medicine.

HONORING PIETRO PARRAVANO,
"HIGHLINER OF THE YEAR"

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Ms. ESHOO. Mr. Speaker, I rise today to pay tribute to Pietro Parravano, who has recently been named the "Highliner of the Year," the Nation's most respected fishing award. Pietro Parravano has devoted his career to the creation of sustainable fisheries and to the betterment of the lives of fisher men and women. He is a dedicated public servant, currently serving on the San Mateo County Harbor Commission, as a member of the Local Fisheries Impact Program, on the California Seafood Council, and as president of the Pacific Coast Federation of Fisherman's Associations. Pietro Parravano has been a goodwill ambassador for the fishing fleet, and will soon travel to New Delhi, India to represent the United States at the World Forum of Fish Harvesters and Fishworkers.

Pietro Parravano is an exceptional man, and I ask that we honor him in the House of Representatives on the eve of this most auspicious occasion.

COMMUNITY RECREATION AND
CONSERVATION ENDOWMENT ACT

HON. JOHN J. DUNCAN, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Mr. DUNCAN. Mr. Speaker, the land and water conservation fund [LWCF] was established in 1964 to increase recreational opportunities. It does this by using money, collected