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House of Representatives

The House met at 10 a.m.

The Reverend Michael A. Nagy, Faith Evangelical Congregational Church, York, Pennsylvania, offered the following prayer:

Our Father and our God, it is with great joy, thanksgiving, and humility that we enter into Your presence this day as we lift up the Members of the 106th Congress to You. We ask that, as they govern, they will do so with divine grace, mercy, wisdom, and direction.

As You are ruler of all nations, we pray that You would rule in us today. As a nation, may we recover our awe of You. Refresh us with Your unfailing love. Revive our hearts. Renew our vision. Revitalize our sense of national purpose. Rekindle within us patriotism's flame. Restore in us our Founding Fathers' convictions of justice and equality.

This we pray through Him who reigns with You, both now and evermore. 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.

Mr. DOGGETT. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER. The question is on the Chair's approval of the Journal.

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

Mr. DOGGETT. 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. Pursuant to clause 8, rule XX, further proceedings on this question will be postponed.

The point of no quorum is considered withdrawn.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Texas (Mr. DOGGETT) come forward and lead the House in the Pledge of Allegiance.

Mr. DOGGETT 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.

INTRODUCTION FOR PASTOR MICHAEL A. NAGY

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

Mr. GOODLING. Mr. Speaker, it gives me great pleasure to welcome Pastor Michael Nagy to the U.S. House of Representatives and thank him for his opening prayer this morning.

Pastor Nagy is the current full-time pastor of Faith Evangelical Congregational Church in York County, Pennsylvania, a position that he has enjoyed for the past 2½ years.

Pastor Nagy has been ministering to his congregation in a variety of ways. Aside from his duties as pastor, he teaches adult Sunday school, provides home care and counseling needs, and tends to the needs of his assembly. The pastor is also continuing his education at the Evangelical School of Theology in Myerstown, Pennsylvania, where he hopes to earn his Masters of Divinity degree.

He is joined today by his wife Tracy and their daughters Leona and Sarah.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain 15 one-minute speeches on each side.

30–YEAR RAID ON SOCIAL SECURITY TRUST FUND HAS STOPPED WITH THIS LEADERSHIP

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

Mr. ARMEY. Mr. Speaker, because Republicans have held the line on spending, $115 billion from the Social Security taxes are saved for the trust fund and to pay down debt. Republicans have stopped the 30-year raid on Social Security, and we are determined to make sure that this program is never raided again.

That is why we have announced that we will not schedule any legislation that spends one penny of Social Security Trust Fund. This leadership is committed to ending the 30-year raid on the senior's Social Security plan and to paying down the debt.

It is really a simple proposition. The Democrats have a risky scheme to finance big government spending on the backs of senior retirement plans. Republicans want to lock away every penny of Social Security for seniors.

Mr. Speaker, the President wants to spend the Social Security surplus. That is right. President Clinton wants to spend the Social Security surplus.

The President's budget would spend $57 billion of Social Security in fiscal year 2000 alone. The President's $57 billion Social Security spending spree is equal to the yearly Social Security taxes paid by one out of every eight American workers.

It gets worse, Mr. Speaker. The President's $50 billion Social Security spending spree is equal to the yearly Social Security benefits for one out of every seven senior citizens.

Mr. Speaker, let me repeat. Not one dime of our Social Security taxes will be spent for something other than Social Security. Beginning in fiscal year 2000, we are stopping this 30-year raid.

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REPUBLICANS' MANAGED CARE REFORM BILL WILL SPEND SOCIAL SECURITY TRUST FUND MONEY

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

Mr. GREEN of Texas. Mr. Speaker, I am proud to follow the gentleman from Texas (Mr. ARMEY) and obviously disagree with him because he said there is not going to be a bill scheduled that will spend Social Security trust funds.

Well, I was going to stand up here and talk about the managed care reform bill and the rule that was rigged to make sure that the access bill would pass even if the Dingell-Norwood bill does. Let me tell my colleagues what has been scheduled today, and it is exactly opposite from what the majority leader said. $48 billion of Social Security money will be spent if that access bill passes because there is no way they are paying for that.

So I do not know who to believe, either the numbers I see or what I hear from the 1-minute from the majority leader. Hopefully, the American people will look at what is happening. They are promising one thing from the floor of this House; but in the Committee on Appropriations and everywhere else, they are spending over $18 billion in Social Security funds, and today they have allowed an amendment on this floor that will spend $48 billion that will not be used for Social Security benefits.

KEEP AMERICA STRONG; SUPPORT THE MINING INDUSTRY

(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, just last week the National Research Council released its much-anticipated report about hardrock mining on Federal lands.

Well, I say to my colleagues take a deep breath and grab their bifocals because this report actually shows a glimmer of common sense. It reaffirms what the mining industry in the State of Nevada has known all along; that is, that we do not need more regulation and restrictions. In fact, this report clearly states that existing Federal and State laws regulating mining are effective in protecting our environment.

Unfortunately, there are those in Congress who would like to destroy the mining industry in America by stopping its vital productivity with undue and burdensome Federal regulations.

Mr. Speaker, let me tell my colleagues, they probably do not think about it, but mining touches them, their constituents, and their families every day. Without mining, there would be no computers, no telephones, no automobiles, no modern medicine or technologies that provide all of us a longer and better quality of life.

Unnecessary Federal regulations could put an end to the mining industry and put an end to improving our quality of life. Keep America strong. Keep it moving. Support the mining industry.

PRAYING NOW BANNED FOR FOOTBALL PLAYERS

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

Mr. TRAFICANT. Mr. Speaker, a football team in Texas was overheard saying a prayer. My colleagues guessed it, now there is a lawsuit to ban football players in high school from praying. Unbelievable.

Mr. Speaker, even though the First Amendment states Congress shall make no law prohibiting the free exercise of religion, children cannot pray in school. School functions cannot mention God. Now football teams cannot pray.

What is next? Are they going to ban the Hail Mary pass in football? Beam me up. A Nation that outlaws God, so help me God, is inviting the Devil.

I yield back the trampled rights of the majority of the American people.

SENIOR CITIZENS SCORE VICTORY IN CONGRESS

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

Mr. HILL of Montana. Mr. Speaker, last night, America's senior citizens scored a big victory in the Congress. They may not even be aware of it this morning, but in the first time in decades, this Congress voted to make Social Security more important than foreign aid. Let me repeat. Congress said yesterday that Social Security is more important than foreign aid.

Now, the President has threatened to veto the foreign operations bill because he wants $2 billion of Social Security money to hand out around the world. Yesterday, Mr. Speaker, the Congress said no.

Mr. Speaker, for 40 years, the Democrats controlled this House, and not once did they set aside even a single dollar to save Social Security. If they had their way, they would have continued yesterday to raid the Social Security account. Yesterday it was for foreign aid. But yesterday they lost, and American senior citizens won. Today, Mr. Speaker, Social Security in this Congress is more important than foreign aid.

NORWOOD-DINGELL BILL PUTS THE CARE BACK INTO HEALTH CARE

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

Mrs. CHRISTENSEN. Mr. Speaker, the Republican leadership and managed care companies did not tell the American public the truth about why they oppose the Norwood-Dingell bill. They said that they were concerned that medical necessity provisions went too far. But how can one argue against physicians and their patients using their trained or best judgment?

They said that they were concerned that employers would be liable. But H.R. 2723 makes sure that businesses are protected.

So it came down to what their opposition is really about, the accountability of managed care companies for the medical decisions that they make. Tell me, why should every other business or company be liable for negligence or damages for the products they make, and this one kind of business not be held accountable for the life and death decisions that they make, not the doctors.

The only bill that is real managed care reform that puts the business of medicine back in the proper perspective and puts the care back into health care is the Norwood-Dingell bill. Let us pass that bill today. The American people need and want us to do that.

DAVIS-BACON ACT INFLATES COSTS FOR HURRICANE VICTIMS

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

Mr. BALLENGER. Mr. Speaker, Hurricanes Floyd and Dennis have dealt a devastating blow to the residents along the Eastern Seaboard from Florida to North Carolina to New York. The flood waters have resulted in billions of dollars in damage and left thousands without homes.

Last week, a number of my colleagues and I sent a letter to the President of the United States asking him to relax the Davis-Bacon prevailing-wage requirements in order to facilitate repairs in the States hardest hit by the hurricanes.

The Davis-Bacon Act requires contractors who work on Federal projects to use Federal dollars to pay certain prevailing wages. Economic studies believe that Davis-Bacon inflates the cost of construction projects up to an estimated 38 percent.

Victims of the hurricanes should have the opportunity to use Federal disaster relief in local competitive markets to rebuild their homes and communities. In fact, under the Davis-Bacon Act, a man or woman who receives $2,500 of Federal disaster funding cannot use that relief to rebuild their own house themselves, but must pay the inflated prevailing wage to another contractor because of the use of Federal dollars.

SMALLER SCHOOLS, STRONGER COMMUNITIES ACT WILL STRENGTHEN SENSE OF COMMUNITY IN SCHOOLS

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

Mr. HILL of Indiana. Mr. Speaker, the recent violence we have seen in our schools has made all of us take a serious look at our children, our schools, and ourselves. Too many of our children wake up every day and go to schools that make them feel disconnected and detached from their teachers, their parents, and their communities.

I am introducing a bill tomorrow called the Smaller Schools, Stronger Communities Act which I hope will make our schools smaller and strengthen the sense of community and safety that many of our schools today are lacking.

A principal of a successful small high school recently wrote that small schools ''offer what metal detectors and guards cannot, the safety and security of being where you are well-known by people who care for you.''

I hope this bill will encourage local school districts to find new ways to help their students feel connected to their schools, their communities, and their parents.

DAY 132 OF SOCIAL SECURITY LOCKBOX BEING HELD HOSTAGE

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

Mr. VITTER. Mr. Speaker, this is day 132 of the Social Security lockbox held hostage in the Senate. Today's seniors and the seniors of tomorrow demand that we act as responsible stewards of the hard-earned money that they pay into Social Security.

Now there are two things we need to do to protect Social Security: first, we must act responsibly this year and pass spending bills without dipping into Social Security, and we are; second, we must work to see that institutional protections like the lockbox become law.

This House passed the lockbox bill by a vote of 416 to 12 on May 26. For 132 days, the other body has held this bill hostage.

□ 1015

I hope President Clinton and all who say they are concerned about protecting Social Security call on the Senate for action on the Social Security lockbox bill.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BONILLA). The Chair will remind Members to avoid urging action of the other body, the Senate, in their remarks.

AMERICA WANTS HMO REFORM THAT PUTS PATIENTS AHEAD OF PROFITS

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

Ms. DELAURO. Mr. Speaker, the American public has consistently called for HMO reforms that put patients ahead of profits. Just as we are about to debate the bipartisan Patients' Bill of Rights, the Republican leadership and the insurance industry have set traps to weaken and kill sensible patient protections.

Earlier this week, the Republican leadership held a fund-raiser with insurance industry lobbyists, the most rabid opponents of HMO reform, and filled their pockets with campaign donations. Their motives are transparent: set traps for HMO reform and collect checks from the insurance industry. The Republican leadership is displaying upside-down values that put campaign favors ahead of HMO reform.

Mr. Speaker, I say to the Republican leadership that in this body rank-and-file Democrats and Republicans have come together around a bipartisan piece of legislation that is a good piece of health care reform legislation. The Republican leadership in this House is attempting to thwart the will of the Democrats and the Republicans here, and thwart the will of the American people that wants access to emergency rooms and specialty care, that wants to have prescription drugs, and that allows them to sue an HMO if they have proceeded irresponsibly.

AMERICA NEEDS PATIENTS' BILL OF RIGHTS, NOT LAWYERS' RIGHT TO BILL

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

Mr. HAYWORTH. Mr. Speaker, I really appreciate the outlook of my colleague from Connecticut, and it is unique in her interpretation of what transpires.

For example, the silence is deafening from my friends on the left when it comes to Communist Chinese contributions to their political party and the President of the United States. Very interesting that they do not have a word to say about that. Oh, they do talk about campaign finance reform. But that is akin to Bonnie and Clyde, at the height of their crime spree, calling for a press conference for tougher penalties against bank robbery.

Make no mistake, my friends on the left love trial lawyers, and what they want instead of a true patients' bill of rights is a lawyers' right to bill. The Wall Street Journal opined yesterday that the left has been held hostage by the trial lawyers' lobby.

I know they will get up and be very clever today, but remember the facts: We need a true patients' bill of rights, not a lawyers' right to bill.

APPROVE BIPARTISAN PATIENTS' BILL OF RIGHTS

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

Mr. DOGGETT. Mr. Speaker, of course the gentleman from Arizona (Mr. HAYWORTH) is right. I think all America recognizes it is just a matter of coincidence that the Republican Party here in the House sucked out every dollar it could from the managed care and insurance companies on the eve of the consideration of a meaningful patients' bill of rights.

What I prefer to focus on is not their failure but our success, a success in the Lone Star State. This is experience that this Congress should follow to protect health care consumers across this country. We began in Texas with bipartisan participation in crafting meaningful guarantees for every person in managed health care.

Texas recognized that we have to reject the same sham insurance company talk that is being advanced here today, and the same misinformation that clutters the television airwaves. The result has been what Governor Bush's own insurance commissioner calls one of the most effective consumer laws in the country.

Unfortunately, a Federal law is interfering with the ability of Texas and other States to assure patients full guarantees. Let us approve the bipartisan patients' bill of rights, empower the States, and empower the patients.

REPUBLICANS ARE FIGHTING TO PROTECT SOCIAL SECURITY SURPLUS

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

Mr. TIAHRT. Mr. Speaker, the previous gentleman from Texas spoke very well, as a trial lawyer would. But I want to talk about the throes of a great struggle we are in to restore the integrity of the Social Security Trust Fund.

If the Republicans in the House are successful, not one penny of the Social Security surplus will be spent on wasteful Washington spending. Last night, the Republicans passed a foreign operations bill that cuts the amount of foreign aid Americans send overseas. Why is that good? It reflects disciplined spending, it cuts growth in the Federal Government, and it protects the Social Security surplus.

The President now has threatened to veto the bill. Why? Because he wants to spend $2 billion more on foreign aid. Now, that alone troubles most Americans. But what brings us to despair is that this $2 billion more the President wants to spend will come right out of

the Social Security Trust Fund. The President intends to spend $2 billion more of the Social Security Trust Fund not here in America but overseas.

Mr. Speaker, we are fighting to protect the Social Security surplus not only for this year but for the next year, the year 2000.

MAKING EDUCATION MORE AFFORDABLE

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

Ms. ROS-LEHTINEN. Mr. Speaker, it has been said that education is not the filling of a pail but the lighting of a fire. But, Mr. Speaker, how can our children keep the flames of education alive when for many college education, so necessary in today's job market, seems unaffordable and out of reach.

As a former educator and school administrator, I know of the difficulties that working families encounter with the skyrocketing costs of a college education. While in the Florida legislature, I made it a priority to create the Florida Prepaid College Tuition Plan, helping thousands of Florida's families. In Congress, I have continued to support legislation aimed at providing tax deductions for families of college students, particularly lower-income families.

As legislators, it is our duty to ensure that a college education is made affordable. And tax deductions and incentives are a surefire way of relieving working families who aspire to send their children to college. Our future can only be as good as the education of our children.

Our congressional leadership is making students a priority, and we will work to pass legislation that will enable them to attend college, to reach their goals, and supply them with the necessary tools to create an even better America.

HOUSE FACES HISTORIC OPPORTUNITY IN HMO REFORM

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, today the House of Representatives has an enormously historic opportunity, an opportunity that America has been asking for time, after time, after time. And that is just to provide equity in the health management organizations that provide insurance for a great number of hard-working American families.

All America asks for is that we respond to their desires to emphasize the patient-physician relationship; that we do not have drive-by emergency rooms; that we allow women to use their OB–GYN; and, yes, that we give them the opportunity when an HMO intercedes between a physician-patient relationship and denies coverage or care and our loved one is injured or they are made worse or they die, that they have the opportunity to seek redress of their grievance, similar to the constitutional fathers who came and organized and made this country great.

So I would say, Mr. Speaker, I am hoping that we will not interject poisonous amendments that will take away from the American people the opportunity to see a fair and just HMO plan. We should vote for the Patients' Bill of Rights. Let us do this together as one country, one Nation, and one Congress.

FOREIGN AID ACCOUNTABILITY

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

Mr. CHABOT. Mr. Speaker, Federal investigators are still sorting through the evidence in what may well be the biggest money laundering scandal in U.S. history.

The United States has provided billions of dollars in direct foreign aid to Russia since the breakup of the foreign Soviet Union. Much of the money is missing, unaccounted for. The taxpayers have also underwritten billions more in International Monetary Fund commitments. What we are apparently seeing right now is a pretty good example of what happens when we throw good money after bad. Let us face it, someone has been asleep at the switch.

This Congress is doing the right thing by reducing foreign aid spending, as we voted to do just last night, President Clinton's objections notwithstanding. But we need to do more. We need to make sure that the Clinton administration ensures that our tax dollars are not being diverted inappropriately or outright stolen. We need to ensure that somebody is looking out for the American taxpayers. We need some accountability, finally, at the White House.

CONGRESS NEEDS TO TAKE UP A SCHOOL FACILITIES BILL

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

Mr. THOMPSON of California. Mr. Speaker, modern well-equipped schools in good repair are an important part of a good learning environment, yet we are lacking badly in our efforts to keep up with school facilities needs.

In my home State, California, we need 10,791 classrooms in the next 5 years in order to keep up. That is 6 classrooms per day that we are going to need to build for the next 5 years.

Facilities are necessary to keep up with the new technology that we are putting in schools and to meet the needs of the growing student population, enrollment that grew to a record high last year of 53.2 million students. And it is projected that next year it will grow by another 440,000 students.

Mr. Speaker, it is paramount that we have a school facility bill on this floor to address these needs.

FEDERAL RED TAPE IS STRANGLING AMERICA'S SCHOOLS

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

Mr. PITTS. Mr. Speaker, Federal red tape is strangling America's public schools. As long as the bureaucrats maintain their death grip on school districts across America, schools will struggle with their effort to get better.

So when we talk about how much money we are spending on education, let us also talk about how we are spending that money. Let us stop focusing on process and start focusing on what really matters: Results.

That is what Republican education reform is all about. It is about fewer layers of bureaucracy and more dollars to the classroom. It is about less red tape and more student achievement. It is about allowing parents to take their kids out of bad schools and put them into good ones. It is about putting more decisions into the hands of teachers and parents and fewer decisions in the hands of the bureaucrats. It is about giving America's children the chance for a brighter future.

IN MEMORY OF ARMY SERGEANT JASON PRINGLE

(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, on last Friday, October 1, my hometown suffered a grave loss. A paratrooper, Army Sergeant Jason Pringle, died while serving this country in Kosovo as part of the Army's elite Company A, 1–508th Airborne Battalion Combat Team. Jason, a 24-year-old army medic had served this Nation since his graduation from Palm Bay High School in 1993.

I never had the opportunity to meet Jason, but I wish I had. He was a fine young man with a bright future. I, too, served in the Army in its medical corps, and I met many young people like Jason during my service, and it was always a privilege.

It is tragic that this has happened; that the state of the world is such that we have to have our brave men and women all over the globe. It is tragic that a father has lost his son, a mother has lost her child.

To Jason: Thank you for giving the greatest gift, your life, for our continued freedom and the freedom of others.

PRESIDENT CLINTON AND JAMES RIADY IN NEW ZEALAND

(Mr. TANCREDO asked and was given permission to address the House

for 1 minute and to revise and extend his remarks.)

Mr. TANCREDO. Mr. Speaker, John Huang recently named James Riady as his superior in the campaign finance fiasco who funneled over $4 million, along with the influence of the People's Republic of China, into the pockets of the Clinton-Gore campaign and into the White House.

This man, Mr. Riady, is wanted for questioning by both the House and the Senate, as well as the Department of Justice. On September 24, 1999, the Wall Street Journal reported that ''James Riady, the Indonesian businessman central to Donorgate, used an economic summit in New Zealand last week to chat with President Clinton.''

□ 1030

The White House will not talk about it, but the Indonesians say Riady did not discuss anything sensitive with the President.

Mr. Speaker, Mr. Clinton is the head law enforcement officer of the United States. He and Janet Reno have once again made a mockery of the Congress and the American people.

PATIENTS' BILL OF RIGHTS

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

Mr. PALLONE. Mr. Speaker, I would urge my colleagues today and tomorrow to vote only for the Norwood-Dingell managed care reform, the Patients' Bill of Rights.

Every effort is being made with the rule that we will adopt today in the House to try to mess up the Patients' Bill of Rights and make sure that it is ultimately defeated and does not go on to the Senate.

The Patients' Bill of Rights, the Norwood-Dingell bill, would change the way medical care is provided by guaranteeing that the doctor and the patients make the decisions about what kind of care they get rather than the insurance company and it would provide for enforcement through an external independent review process if their medical care has been denied and ultimately to the federal courts.

The phony access bill that the Republican leadership will put up on the floor today does nothing for the uninsured. It does not help the uninsured at all. All it does is to make it more difficult to pass the Norwood-Dingell Patients' Bill of Rights.

The substitutes that are going to be proposed tomorrow as alternatives to the Norwood-Dingell bill, all they do is basically water down their ability to get adequate patient protections and to enforce what kind of care they should get either in a court of law or through external review.

Vote for Norwood-Dingell. Vote against all the substitutes tomorrow.

MANAGED CARE REFORM IS LONG OVERDUE

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

Mr. SHAYS. Mr. Speaker, I am for malpractice reform. I am for product liability reform. I think we have too many lawsuits. But I do not believe HMOs should cause the injury or death of someone and escape liability, and neither do any or most of my constituents.

I have been having community meetings the last few weeks. I asked Republicans. I asked Democrats. I asked the young. I asked the old. I asked conservatives. I asked moderates. I asked liberals. And almost everyone says HMOs should not escape liability.

I believe we need a patients' health care bill of rights, and I am going to support one. I think it is long overdue that we are addressing this issue.

REJECTION OF PRESIDENTIAL NOMINEE FOR SUPREME COURT JUSTICE

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

Mr. BECERRA. Mr. Speaker, today we see the injustice that the majority party is doing with regard to America's right to be able to go to a hospital and get decent health care.

But yesterday was a further injustice, this time in the other body, the Senate, where the Senate, in the first time for some 20 years, decided to reject the nomination of the President of the United States of a court nomination.

The gentleman in this case was a gentleman named Ronny White, a sitting Supreme Court justice in the State of Missouri. He also happened to be African American, the first African American in that State to sit on the Supreme Court in that State.

He was rejected despite the fact that in committee in the Senate he passed with Republican support. Yet, when his vote came to the Senate floor, the Senators rejected him on the Republican side, including those who had voted for him in committee.

Outrageous because this is the first time in some 20 years that we have seen this happen, but outrageous because it is the first time in my memory that someone has been rejected for reasons other than his qualifications.

We have seen this happen now yesterday. I am afraid it may happen again when we have other judges of minority background who may face the same consequences by this Republican Senate. It is outrageous and we need to stop that. Hopefully the outrage will stop by the year 2000.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BONILLA). The Speaker would remind Members not to characterize actions taken by the other body or to encourage that they take specific action.

PRESIDENT IS GOING TO VETO FOREIGN AID BILL

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

Mr. KINGSTON. Mr. Speaker, I am still confused. The President said in January, let us put Social Security first. So, taking him for his word, the Republican conference says, we agree. We will reserve House Resolution 1, the first bill of the legislative session, for consideration for the President's Social Security reform package.

Well, that was in January. Here we are in October. No bill, no legislation, nothing from the President on Social Security protection.

Here is what we do have. He said he wanted to protect 62 percent of the Social Security Trust Fund. Republicans want to protect 100 percent. He said he is against the lockbox. The lockbox works the same way as a security deposit box in the bank works. They put the money in there and then nothing can get out. But the President is against that.

Now we find out he is going to veto the foreign aid bill because he wants to spend more money but the only surplus that is left is Social Security.

So I am really confused now. The President is going to veto foreign aid so he can spend at its current level, so he can spend Social Security dollars in foreign countries. It does not make sense, Mr. Speaker.

THE JOURNAL

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

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

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

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 340, nays 68, answered ''present'' 1, not voting 24, as follows:

[Roll No. 481]

YEAS—340

Ackerman	Baldacci	Bartlett
Allen	Baldwin	Barton
Andrews	Ballenger	Bass
Archer	Barcia	Bateman
Armey	Barr	Bentsen
Bachus	Barrett (NE)	Bereuter
Baker	Barrett (WI)	Berkley

Berman
Berry
Biggert
Bilirakis
Bishop
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonior
Bono
Boswell
Boyd
Brady (TX)
Brown (FL)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Cardin
Carson
Castle
Chabot
Chambliss
Clayton
Clement
Coble
Coburn
Collins
Combest
Condit
Cook
Cooksey
Coyne
Cramer
Cubin
Cummings
Cunningham
Danner
Davis (FL)
Davis (IL)
Davis (VA)
Deal
DeGette
DeLay
DeMint
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Diaz-Balart
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Emerson
Engel
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Evans
Everett
Ewing
Farr
Fattah
Fletcher
Foley
Forbes
Fossella
Fowler
Frank (MA)
Franks (NJ)
Frelinghuysen
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Gonzalez
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Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green (TX)
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Hall (OH)
Hall (TX)
Hastings (WA)
Hayes
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Hill (IN)
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Isakson
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Jenkins
John
Johnson (CT)
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Kennedy
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Kolbe
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LaHood
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Lewis (CA)
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Lipinski
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Lucas (KY)
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Oxley
Packard
Pascrell
Paul
Pease
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Petri
Phelps
Pickering
Pitts
Pomeroy
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Price (NC)
Pryce (OH)
Quinn
Radanovich
Rahall
Rangel
Regula
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Rogers
Rohrabacher
Ros-Lehtinen
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Ryan (WI)
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Sensenbrenner
Serrano
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Sherwood
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
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Spratt
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Stark
Stearns
Stenholm
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Taylor (NC)
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Watkins
Watt (NC)
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Weiner
Weldon (FL)
Weldon (PA)
Wexler
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Whitfield
Wilson
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Becerra
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Hastings (FL)
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Hill (MT)
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Klink
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LoBiondo
McDermott
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Pallone
Pastor
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Ramstad
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Taylor (MS)
Thompson (CA)
Thompson (MS)
Towns
Udall (CO)
Udall (NM)
Vento
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Waters
Weller

ANSWERED ''PRESENT''—1

Tancredo

NOT VOTING—24

Abercrombie
Boucher
Brown (OH)
Chenoweth-Hage
Conyers
Cox
Delahunt
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Gephardt
Hansen
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LaTourette
Markey
McCrery
McKinney
Meeks (NY)
Norwood
Rogan
Salmon
Scarborough
Waxman
Wicker
Young (AK)

□ 1057

So the Journal was approved.

The result of the vote was announced as above recorded.

□ 1100

PROVIDING FOR CONSIDERATION OF H.R. 2990, QUALITY CARE FOR THE UNINSURED ACT OF 1999, AND H.R. 2723, BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 323 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 323

Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order to consider in the House the bill (H.R. 2990) to amend the Internal Revenue Code of 1986 to allow individuals greater access to health insurance through a health care tax deduction, a long-term care deduction, and other health-related tax incentives, to amend the Employee Retirement Income Security Act of 1974 to provide access to and choice in health care through association health plans, to amend the Public Health Service Act to create new pooling opportunities for small employers to obtain greater access to health coverage through HealthMarts, and for other purposes. The bill shall be considered as read for amendment. The previous question shall be considered as ordered on the bill to final passage without intervening motion except: (1) two hours of debate equally divided among and controlled by the chairmen and ranking minority members of the Committee on Commerce, the Committee on Education and the Workforce, and the Committee on Ways and Means; and (2) one motion to recommit.

SEC. 2. At any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2723) to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed three hours equally divided among and controlled by the chairmen and ranking minority members of the Committee on Commerce, the Committee on Education and the Workforce, and the Committee on Ways and Means. After general debate the bill shall be considered for amendment under the five-minute rule. The amendments printed in part A of the report of the Committee on Rules accompanying this resolution shall be considered as adopted in the House and in the Committee of the Whole. The bill, as amended, shall be considered as read. No further amendment to the bill shall be in order except those printed in part B of the report of the Committee on Rules. Each amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, and shall not be subject to amendment. All points of order against the amendments printed in part B of the report are waived except that the adoption of an amendment in the nature of a substitute shall constitute the conclusion of consideration of the bill for amendment. The Chairman of the Committee of the Whole may: (1) postpone until a time during further consideration in the Committee of the Whole a request for a recorded vote on any amendment; and (2) reduce to five minutes the minimum time for electronic voting on any postponed question that follows another electronic vote without intervening business, provided that the minimum time for electronic voting on the first in any series of questions shall be 15 minutes. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill, as amended, to the House with such further amendments as may have been adopted. The previous question shall be considered as ordered on the bill, as amended, and any further amendment thereto to final passage without intervening motion except one motion to recommit with or without instructions.

SEC. 3. (a) In the engrossment of H.R. 2990, the Clerk shall—

(1) await the disposition of H.R. 2723;

(2) add the text of H.R. 2723, as passed by the House, as new matter at the end of H.R. 2990;

(3) conform the title of H.R. 2990 to reflect the addition of the text of H.R. 2723 to the engrossment;

(4) assign appropriate designations to provisions within the engrossment; and

(5) conform provisions for short titles within the engrossment.

(b) Upon the addition of the text of H.R. 2723 to the engrossment of H.R. 2990, H.R. 2723 shall be laid on the table.

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

Mr. GOSS. Mr. Speaker, for the purpose 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, today the Republican majority makes good on its promise of a full and fair debate on health care reform. We have acceded to the requests of both sponsors, the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL), by separating the two major issues in the managed care debate. This rule ensures that both parts of the debate, the affordable access part and the patient protection part, receive the attention they deserve separately.

Under the rule, we will first debate the access bill, H.R. 2990, introduced by the gentleman from Missouri (Mr. TALENT) and the gentleman from Arizona (Mr. SHADEGG). Because of the tax provisions within H.R. 2990, we have offered the minority a substitute, which I understand they have declined to offer, as well as the traditional motion to recommit.

The rule provides for an ample 2 hours of general debate on this access bill, to be equally divided between the three committees of jurisdiction.

After consideration of the access bill, H.R. 2990, we will proceed to separately debate H.R. 2723, the so-called Norwood-Dingell bill. We provide for 3 hours of general debate, again to be equally divided among the three committees, the Committee on Commerce, the Committee on Education and Work Force, and the Committee on Ways and Means.

Because of the comprehensive nature of this legislation, the rule makes in order only full substitutes to Norwood-Dingell, the underlying bill. There are three such substitutes. Each of the three substitutes will receive an hour of debate time. We have made in order every substitute offered to the Committee on Rules, and a great many of the more than 50 or so perfecting amendments we heard in the Committee on Rules are addressed in one way or another in all of these substitutes. We believe this will ensure timely and full consideration of all points of view on this very important issue.

After considering these substitutes and voting on the underlying bill, the rule provides that the two bills, the access bill and the patient's rights bill, will be enrolled and sent to the Senate together. Since this was precisely the process that the base bill sponsors had requested, we were surprised when the minority objected last night at the last minute to this fair process and even threatened to bring down the rule over it. It should be clear to any objective Member that we have kept our word and prevented so-called ''poison pill'' amendments from even being offered.

I am concerned that by last minute moving of the goalposts and by their statements in opposition to this approach, that the minority now has a desire to have a partisan political debate, rather than to solve a real and growing problem that Americans are asking us to deal with.

Access and affordability are as important as improving patient protection, and we fairly provide for both under this rule, as we have pledged we would do. At the Committee on Rules on Tuesday I was struck by something the gentleman from Michigan (Mr. DINGELL) said on this topic, and I quote him: ''A right without enforcement is no right at all.'' While he was referring to the patient protection side of this debate, I believe those words are even more appropriate in the context of the debate over the uninsured.

This week the Census Bureau reported that the number of uninsured grew by 1 million last year. It is now one in six Americans that do not have health care insurance. This should be devastating news to all Americans, particularly those in the small business community. None of the important patient protections we will debate later today or tomorrow mean anything to those 44 million Americans living without insurance. In this case, to paraphrase my friend from Michigan, a right without insurance is no right at all.

That is why I am pleased that our first order of business today is a well-crafted bill to increase the number of insured, not through more bureaucracy, not ''big brother'' mandates, but through market reform and long overdue tax equity. For the mom and pop and other small business employees in my district in Florida, that means that they can afford quality health care insurance, they can stop using the emergency room as their only source of health care, and they can finally enjoy the same health care advantages that the employees of the IBMs of the world currently have. I will speak in greater length about the patient protection piece during the amendment process. I intend to offer a substitute, along with the gentleman from Oklahoma (Mr. COBURN), the gentleman from Arizona (Mr. SHADEGG), the gentleman from California (Mr. THOMAS), and the gentleman from Pennsylvania (Mr. GREENWOOD) to the Norwood-Dingell bill.

Put simply, our approach seeks to find the responsible middle ground between limited liability for health plans and a trial lawyer bonanza. Our message is simple: If you are harmed, you deserve to be made whole. But we should encourage patients to get the care they need up front from quality medical providers, with a lawsuit as a last resort, not the first choice. I am encouraged by the amount of support we have received, and I look forward to a vigorous debate when the time comes.

Mr. Speaker, I want to finish by reminding all Members what this rule does and does not do. This rule does provide for separate votes on access and patient protection, as requested by the sponsors. This rule does not make in order any poison pill amendments intended to sink the underlying bill.

This is a fair process, and I encourage my friends on the other side of the aisle to keep their word, vote for the rule, and help us improve the quality and affordability of health care for all working Americans.

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

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

Mr. Speaker, this rule is a classic case of caveat emptor, or perhaps it is a pig in a poke. Whatever it is, this rule is a not-too-cleverly-disguised attempt by the Republican leadership to derail meaningful reforms in the managed care industry, reforms that will benefit millions of Americans who are counting on us to help them.

Mr. Speaker, the gentleman from Florida (Mr. GOSS) has told the House that this is a fair rule, a rule which will allow the House to debate a full range of health care issues.

Mr. Speaker, I must respectfully disagree with my friend. While this rule may well allow the House to debate both managed care and a means to expand health care to some 44 million Americans who today have none, this rule is purposefully structured to keep either of those goals from being reached.

It is therefore my intention to oppose the rule. I would hope that the House will defeat this rule so that the Committee on Rules can adopt a new rule to permit the House to pass a real managed care reform package that stands a real chance of becoming law.

Mr. Speaker, clever packaging is often used to disguise the fact that consumers get much less than they pay for, and this rule is just as deceptive.

□ 1115

Thus, I must repeat that this rule is a case of caveat emptor. In this case, Members may think they are getting two for the price of one, but I would submit, Mr. Speaker, that this rule is designed to cheat those of us who are looking for real value.

Mr. Speaker, the Republican majority on the Committee on Rules has recommended to the House a very peculiar procedure which was never supported by the minority. This very peculiar procedure ties together two vastly different topics under the guise of a wide-ranging reform of health care in this country.

Members have to follow the bouncing ball of what they have done. After passage of both bills, presuming both pass, the access bill and HMO reform, the rule provides that the two bills will be combined in the engrossment, thus making the two bills one, without a vote to do that. Let me repeat, after these two separate bills have been passed on separate days, then the Republicans, by operation of this rule, would tie them all together and send

them to conference with the Senate, without actually voting on that proposition.

They know, they know that by doing this, this will jeopardize any piece of legislation from ever emerging from a conference with the Senate. They do so in a very cynical way.

Mr. Speaker, over and above this question about tying the two bills together without a vote to do that, the rule does not allow the House to consider an amendment which would pay for the costs associated with managed care reform. The authors of the Patients' Bill of Rights, the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL) have proposed an amendment to their bill which would offset the cost of higher employer deductions for worker health insurance.

Mr. Speaker, this should be a very simple proposition. Republicans have for days and days on the floor of the House been crying great crocodile tears about not wanting to invade the social security surplus. What happens? Democrats and Republicans who support this bill come to the Committee on Rules and say, make in order an amendment so we do not have to invade the social security surplus, and the Republicans say no. No, we cannot do that. We do not want to invade the social security surplus, and we say that every day four or five times here on the floor, but if you actually give us the chance to vote on that subject, we do not want to vote on it, and we will prevent the House from voting on that. That is why this is a flawed rule, Mr. Speaker.

Mr. Speaker, the reasoning in all of this is somewhat tortured. I do not want to belabor the House. I would only point out that last night on the subject of tying the two bills together, I asked the chairman of the committee, the gentleman from California (Mr. DREIER), I said, why are we doing this? Why are we combining these two bills at the end without a vote? Is there some rule of the House that requires us to do that? The chairman said, no, there is not a rule of the House, we just want to do it.

Mr. DREIER. Mr. Speaker, will the gentleman yield?

Mr. FROST. I yield to the gentleman from California.

Mr. DREIER. I thank my friend for yielding to me.

Mr. Speaker, the gentleman is correct. As the gentleman knows, that is the prerogative of the majority, to set forth these guidelines. But it is very clear that if we are going to address the question that my friend has accurately raised, the fact that we have gone from 1992, when the President was elected and 38 million Americans were uninsured, to the report we just received this week, that 44.3 million Americans are uninsured, we believe very strongly that unless we provide those things that are in the access bill, that we will not be able to address the concerns of those who will become even more uninsured if we simply have the kind of legislation that the gentleman supports. That is the reason we want to tie these bills together.

Mr. FROST. Reclaiming my time, Mr. Speaker, I thank the chairman for his comments, because the question I raised last night was, is there some reason, some legal reason here on the House floor that we have to do this, in the rules of the House? He said no, it is because they want to.

I would suggest that wanting to may well doom final passage out of a conference committee of either one of these provisions, which may well have merits on their own as separate pieces of legislation, but when combined under one package, no, particularly because the access bill is also not paid for. The Republicans have done nothing to provide the money to pay for the access bill. The estimates are that that bill could wind up costing $40 billion or $50 billion. So we are not paying for anything under the rule that is presented here today. All we are doing is voting on some very nice pieces of legislation.

Democrats are asking that the Patients' Bill of Rights that we have been advocating for years now, and it is final reaching the floor, that we be given the opportunity to offer an amendment which would pay for this bill so that the Republicans could honor their word and honor their pleas of not invading the social security trust fund.

Mr. Speaker, we have a lot of Members who wish to speak at this point. Members I know feel very strongly about passage of a strong Patients' Bill of Rights. We are to the point hopefully where we can do that, but we should do it in an honest way. We should be honest with the American public. I would urge defeat of this rule so we may have an honest procedure here on the floor of the House of Representatives.

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

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

Surely the gentleman from Texas, Mr. Speaker, is not implying that we are doing anything dishonest on this side of the aisle. We have the press gallery watching. We have the whole world watching. There is nothing going on here except a clear, transparent debate on what I believe is a very good rule, which provides for full and fair debate, which is what we have promised.

Mr. Speaker, I yield 3 minutes to the gentlewoman from Ohio (Ms. PRYCE), a distinguished member of the Committee on Rules.

Ms. PRYCE of Ohio. Mr. Speaker, I thank my good friend, the gentleman from Florida, for yielding time to me.

Mr. Speaker, I rise in support of this very fair rule. I would like to take this opportunity to congratulate the gentleman from Florida (Mr. GOSS) on all his hard work to bring people together to find some middle ground on this emotionally charged issue. It was certainly no small feat, and his success will give the House the opportunity to vote on consensus legislation that offers all the patient protections that we agree on without the excessive litigation and Federal regulation that the Norwood-Dingell bill promises.

I hope all my colleagues on both sides of the aisle will give the Goss substitute their very serious consideration.

Mr. Speaker, I have to say that I find it very curious that my Democratic colleagues are opposed to this rule, which I believe is eminently fair. I think all fair-minded people will agree with me when I explain why.

The Democrat leadership and some of our Republican colleagues asked the Republican leadership to bring managed care reform legislation to the House floor for debate. Today, with the passage of this rule, we will be able to. Mind you, we are not bringing just any old managed care bill to the floor. We are taking up the bipartisan bill with so much Democrat support, the Norwood-Dingell bill. This is the base bill under this rule.

Then my Democrat colleagues ask us not to allow any poison pill amendments. We complied by making in order only full substitutes under this rule. But that was not enough. Then they asked us not to add any Republican amendments to the Norwood-Dingell bill that would provide greater affordability and access. We did not.

Now my Democratic friends are upset that we did not save them from themselves, because apparently they just realized that their bill will increase premiums. I am glad that the Democrats have come to terms with reality.

One would think that they would be pleased that this rule allows us to debate another bill that addresses affordability and access, but apparently they are still not satisfied. Now they use the politically charged rhetoric that the Norwood-Dingell bill will spend social security. It is a bit of a stretch, but I guess, in a political pinch, it will do.

So now, at the last minute, the Republican leadership is supposed to fix their policy flaws by adding a last-minute $7 billion tax increase to the Norwood-Dingell bill? I realize we have been accommodating, but that is just a little bit too much for us to swallow. Frankly, their protests are beginning to ring a bill hollow.

If my colleagues are truly concerned about health care policy, I suggest they support this fair rule. This rule will allow the House to debate various proposals to provide patient protections, as well as a bill that will help uninsured Americans and those that will eventually find themselves without insurance when the premium increases in the Norwood-Dingell bill price them out of the market.

Mr. Speaker, this process is eminently fair. It gives all viewpoints a chance to be heard on the important

health care issues facing our Nation. I urge my colleagues to vote for the previous question and the rule.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, by asking us to pass a rigged rule to finally allow a vote on managed care reform, the majority has once again demonstrated that they are out of touch with the American people, and that they are even out of touch with Members of their own Republican conference.

Over 20 Republicans have signed on as cosponsors of the Bipartisan Consensus Managed Care Improvement Act because they recognize that physicians and their patients, not HMO bureaucrats, should be the ones making the decisions on what kind of care we should receive.

The rule before us is a bad rule that is designed to kill the Norwood-Dingell bill and prevent any chance of us having real, meaningful health managed care reform this year. We must defeat this rule so supporters of managed care reform on both sides of the aisle can have the opportunity to have a clean up or down vote on real managed care reform, the Norwood-Dingell bill.

This is not about providing access to care, as the opponents of the Norwood-Dingell bill would have us believe. This rule is about having no access to care even for the insured, and no managed care reform at all.

The American people have told us they want the Norwood-Dingell bill. Vote no on this rule.

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

Mr. GANSKE. Mr. Speaker, I am back on the floor of the House of Congress. I have been here night after night with my colleagues from the other side and colleagues from this side of the aisle, too, in pushing that we finally get a vote on patient protection legislation.

I went before the Committee on Rules with the gentleman from Michigan (Mr. DINGELL) and argued forcefully for the amendments that concern the Democrats on the pay-fors. I understand their concern about that. What we need, though, is we need a vote on access.

I have some concerns about some of the access provisions. I am going to speak about that. We need a vote also on patient protections. I will tell the Members what, we are going to have to run a gauntlet to get the Norwood-Dingell bill passed. The rule is tough, it is really tough, for us to win. At the end of the day, if either of those bills pass, then they go to conference.

I think this is the best we can do. I think it is time that we need to move to this debate. I understand my colleagues on the other side, their concern on this rule, but I honestly think that we can have a good debate in the next 2 days on both the access provisions and things in that access bill that can send a message to conference.

I intend to do that. I intend to work my hardest to get the bipartisan consensus managed care bill passed that will be in the best interests of the people in this country, and will help us move this process along. So I will vote for the rule, but I understand fully the concerns of Members on the other side.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, the House Republican leadership has awarded this fellow in the fedora on the cover of Forbes magazines and all the tax shelter hustlers that he represents a great victory because this rule denies the right to pay for this legislation by calling on tax dodgers. As the gentleman from Georgia (Mr. NORWOOD), our Republican colleague, told the Rules Committee in urging an end to this tax dodging, ''there is a difference between a tax increase and stopping bogus tax loopholes.'' Bogus loopholes, indeed. This is a bogus rule that blocks the shutdown of abusive of corporate tax loopholes.

Additionally, this rule represents fiscal irresponsibility at its worst. These bills are not paid for. It is wrong to dip into Social Security when the corporate tax dodgers should be paying for this legislation. While the costs of managed care reforms have been greatly exaggerated, all of us committed to patient protection believe this must be a fiscally prudent pay-as-you-go approach. The approach we sought in the Rules Committee was to pay for our reforms.

Finally, this so-called Republican access bill is really access to the U.S. Treasury. It would open access to up to $50 billion of tax loopholes to be financed right out of social security. This is wrong, and the rule should be rejected.

□ 1130

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

Mr. Speaker, I find it a little puzzling that the gentleman who just spoke and the distinguished gentleman from Texas (Mr. FROST) both signed a discharge petition that would have precluded the opportunity to discuss this, and now they seem to be very upset with what they signed.

Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Speaker, I thank the gentleman from Florida for yielding me this time.

Mr. Speaker, I think it is very important the American public really gets to see how we got in the mess we find ourselves in with health care. In America today, we have a Soviet-run government-mandated health care system which has resulted in the loss of freedom of choice for millions of Americans. This rule to provide access is hopefully a step in moving back in that direction.

But I also want to make sure that the American people understand the two extremes on this debate. On one side, we have corporate America and small business who is afraid that the costs are going to go through the roof if we change anything. On the other side, we find the legal profession licking its chops to take money away from people who normally act responsibly.

We are going to hear all sorts of things during this debate. The one thing that we are going to hear claimed said many times is we are doing this for patients. We are going to find out if we are really doing this for patients, if we are really trying to restore freedom of choice, if we are really trying to restore accountability, and we are trying to do that at the same time that people do not lose their health care.

The partisanship of this body is terrible, the claims made on the basis of some premier principle when they are really a veiled partisan dig for a political purpose.

We are going to find out if one group or another really cares about people. We are going to find out on these votes if my colleagues really want to have a compromised piece of legislation that solves the problem of accountability, that restores choice and does not bankrupt the payroll of the American people who are supplying health care in this country.

We are going to get to hear all the stories that will touch our hearts that say why we should go one way. We are going to hear all the threats about why we cannot go another because health care is going to be taken away.

But in the long run, what it really comes down to is not the next election, which is what we are going to hear most about but nobody is ever going to say, what it really comes down to is will we have the courage to look and risk our seats to do what is in the best interest of patients in this country, not what is in the best interest of the Democratic party, not what is in the best interest of the Republican Party, but what is in the best interest of the people of this country.

That rings hollow to members who have been here; I understand that. But the only true measure of whether or not we have done our job well is that when we look in the eye of somebody that is out in our district and say, You have more freedom, you still have your health care, and you are still going to get it when this debate is all over.

By the way, access is in the Senate bill. So anything we would merge is already there, and the opposition knows that. So the claim rings very hollow. Without access, no matter which bill in terms of Patients' Bill of Rights is passed, without access provisions, fewer people will have insured coverage in America tomorrow than have it today.

This access bill is not perfect. AHPs are a terrible idea when we think about what it is going to do to disrupt the

private insurance market regardless of the fact that the National Federation of Independent Businesses wants it. We make no adjustment for high-risk pools in the States.

The gentleman from Arizona (Mr. SHADEGG) is actually right. One cannot do AHPs unless one is willing to put something else back there to help take care of the risk.

But, politically, the bill that comes out, although needed, is not in the best interest of patients either. So let us quit playing the game of partisan politics, and let us define this debate back down about what we are really supposed to be here for is the people who need and should get care and choose, and not take it away by something we might foolishly do either for the trial lawyers or for big business.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. STARK).

Mr. STARK. Mr. Speaker, I thank the gentleman from Texas for yielding me this time.

Mr. Speaker, George W. Bush said it yesterday, that his party is putting too much emphasis on economic wealth and too little on social problems, and their candidate is not whistling Dixie.

The gentleman from Oklahoma (Mr. COBURN), the previous speaker, said that we are going to break the payroll of this country. They are not going to break the payroll; they are going to break Social Security system. Because what the Republicans have done is the most dishonest, obscene attempt at almost fascist power to defeat a bill that they know would pass if they allowed the Members of the House to vote to pay for it.

To force Members to be fiscally irresponsible as a Republican ploy to win what they cannot win through honest debate is shameful. To suggest that access is in their bill is sheer nonsense.

Thirty-two million of the 45 million uninsured are in the 15 percent bracket or less, which means they get less than the $700 discount from a $5,000 bill, if they had $5,000 to buy insurance in the first place. Absolute nonsense and drivel.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from Arkansas (Mr. BERRY), a cosponsor of the bill.

Mr. BERRY. Mr. Speaker, I urge my colleagues to vote against this unfair and unreasonable rule, a rule so cynical, so calculated that there is no question of its intent, which is to kill the bipartisan Norwood-Dingell managed care bill.

When we went to the Committee on Rules this week, we presented an amendment version of our bill that included offsets to pay for it. That is right. We wanted to do the fiscally responsible thing and pay for what we proposed.

The Committee on Rules refused to allow us to pay for our bill. What is even more impossible to understand is the Committee on Rules will, if our bill is passed, stick on to it a $48 billion so-called access bill that is also not paid for.

This is a disgrace. Surely the gentleman from Texas (Mr. DELAY) and his colleagues cannot suppose that the American people will be fooled by this nonsense. Just this morning the gentleman from Texas is quoted in the Washington Post as saying, ''We are at a defining moment in the direction of this country. It is the classic battle of tax and spend versus balanced budget and fiscal restraint.''

Ironically, the gentleman from Texas indicated that his leadership was not one to tax and spend.

I refuse to vote for this rule and this $48 billion sound bite. If my colleagues care about balancing the budget, vote no on the rule.

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

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

Mr. DINGELL. Mr. Speaker, it is with real sorrow that I rise to oppose the rule on H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 of which I am a cosponsor, and proudly so, with the gentleman from Georgia (Mr. NORWOOD).

I was initially pleased that the Republican leadership would actually schedule our bill for consideration on the floor, so it is with considerable regret that I find myself in the awkward position of opposing the rule. I do so for a number of real and valuable reasons.

First, the Committee on Rules has chosen to include a requirement to link H.R. 2990, a bill dealing with Medical Savings Accounts and other discredited insurance reforms, which I oppose and which I am certain will trigger a veto, with H.R. 2723, a bill which would protect the rights of patients. All of the tax cuts in H.R. 2990 are unpaid for.

I would note for the benefit of my colleagues that the access provisions here, and this is the reason that they did not make these cuts subject to being identified or subject to being paid for, amount to about $50 billion. So we cannot blame my Republican colleagues for hiding those numbers.

While the House will vote separately on each bill, the rule has determined that these two bills must be joined into a single bill when they are sent to the Senate. No reason for that except, I suspect, politics. In effect, if the first bill prevails, the rule would send the patients' rights bill to the Senate with it attached, like a kind of a ticking time bomb, and unless it is disarmed in conference, the likelihood of enacting patient protections and having them signed by the President into law is highly diminished.

I also oppose the rule because the bill sponsors were not allowed to include a package of revenue offsets, which we tried to offer in the Committee on Rules. I would like to just observe that I thought the Committee on Rules' meeting was a good one. Regrettably, it was all on the surface and not within the real discussions.

Although the revenue offsets are relatively small, about $6 billion and less according to the Congressional Budget Office, they should be paid for so that we do not dip further into Social Security.

Similarly, none of the three substitutes for our bill are paid for. Instead, the rule waives the Budget Act for each substitute.

I have been to the floor in the past to speak of the need for patient protection legislation, but today I want to emphasize the fact that I am proud to be here with a bill that is truly bipartisan. For too long our fight on behalf of the rights of patients has been characterized as partisan. When I joined with CHARLIE NORWOOD on this bill, along with 22 Republican cosponsors, I think we put that myth to an end. We spent long hard hours reaching a compromise, but we did so because we wanted to put patients ahead of politics.

I would hope that we could defeat this rule, which is full of gimmicks and get on to helping patients. Let's feed our patients protection from their HMO, not a poison pill.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. WYNN).

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

Mr. WYNN. Mr. Speaker, I thank the gentleman from Texas for yielding me this time.

Mr. Speaker, I rise in opposition to this rule and express my support for the bipartisan Dingell-Norwood bill.

Someone said in trying to defend this rule, well, it is not exactly dishonest. Well, maybe it is not dishonest; but it is clearly disingenuous, it is clearly cynical, and it is clearly raw partisanship.

It is clearly an attempt to block bipartisan legislation that will provide real HMO reform for American citizens that would give them the right to sue when they are aggrieved.

Now, this rule has two flaws. First of all, we wanted to pay for the Dingell-Norwood bill. We had the offsets. They ruled the offsets out of order, forcing us or attempting to force us to dip into the Social Security Trust Fund.

Second, they attach the access bill. It has some merits. But why is it attached? It is not paid for. It has some undesirable aspects; and it is designed, once again, for one sole purpose, and that is to help kill the bipartisan Dingell-Norwood bill.

This vote today may be the most important in our legislative session. I hope we can defeat this rule and push for real HMO reform.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I am a little bit puzzled, and I rise very strongly opposed to the rule for my puzzlement. I am going to ask the gentleman from Florida (Mr. GOSS) a question in just a moment, or the chairman of the committee.

Last week, my colleagues were criticizing we Democrats for spending Social Security Trust Funds. Last week, we had threats of advertisements being run against several of us. This week we come to the floor, and we only ask for a rule allowing all of the bills to be paid for. My colleagues deny it. Why do my colleagues choose to deny the right of this body to pay for that which we will discuss today?

Mr. GOSS. Mr. Speaker, will the gentleman yield?

Mr. STENHOLM. I am happy to yield to the gentleman from Florida.

Mr. GOSS. Mr. Speaker, we did not deny it. In fact, what we did is respond to the petition, the discharge petition which, in fact, would have precluded it.

Mr. STENHOLM. Mr. Speaker, I reclaim my time. Why would the gentleman from California (Mr. DREIER) at this time not go back to the Committee on Rules and give the minority an opportunity to pay for that?

Mr. DREIER. Mr. Speaker, will the gentleman yield?

Mr. STENHOLM. I am glad to yield to the gentleman from California.

Mr. DREIER. Mr. Speaker, I thank the gentleman for yielding to me. As the gentleman from Texas understands the rules of the House very well, he understands germaneness. It is not germane to do that. The gentleman signed the discharge petition in the well, I suspect, with a lot of people. If that would have moved forward, it would not have been made in order.

Mr. STENHOLM. Mr. Speaker, I did not.

Mr. DREIER. Well, I know the gentleman from Texas (Mr. FROST) did and several other Members. It is not germane.

Mr. FROST. Mr. Speaker, I yield myself 15 seconds.

The gentleman from California (Mr. DREIER), chairman of the Committee on Rules, knows that the Committee on Rules can waive germaneness at any time and often does when it is to the convenience of the majority. We are only asking that it be waived once for the minority.

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

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

Mr. Speaker, it would probably be worth noting at this point in the discussion that we had a whole bunch of amendments. If we made room for one, we would have had to make room for a whole bunch more as well. We made, I think, a very wise decision to have a full fair debate. I am sorry that the folks who are upset about this, paying for what they want to do at the last minute did not think of it a lot sooner. We congratulate them for finally thinking about paying for it.

Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Arizona (Mr. SHADEGG), who has been an instrumental player in this.

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

Mr. SHADEGG. Mr. Speaker, I rise in strong support of this rule; and I want to point out, as one of the original cosponsors with the gentleman from Missouri (Mr. TALENT) of the access bill which provides access, affordability, and choice for the American people; that what we are hearing from the other side is that they do not like our provision, but they do not have one of their own.

There is a saying around this town, one cannot beat something with nothing. Yet, in the area of access, affordability, and choice, the other side tries to beat something that we Republicans are doing for the uninsured with nothing. My colleagues will not hear them today talk about their bill to help the uninsured get access to care.

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Mr. Speaker, we will not hear them talk about their bill to bring down the cost of insurance and make it more affordable. We will not hear them talk about their bill to give those who are insured choice.

I want to stop at this point and talk about the second issue we will hear a lot about today, which is pay-fors. We did not pay for our bill. We cannot afford this legislation. I want to point out that the opposite is true. We simply cannot afford to go on not paying for, that is, not giving care to the uninsured in America.

We are already paying for them. Has everyone lost sight of that in this debate? The uninsured are getting care in emergency rooms all across America. The uninsured are getting care in hospitals all across America, and there is cost shifting to pay for that.

So when we hear the argument that, oh, this is not paid for, this will bust the budget, please recognize that that is a ruse. That is not true because we are already paying for their care. Long ago, fortunately, this society decided that those who are in need should not go without care.

There are 44 million uninsured Americans in this country. The vast majority of those work for small businesses who cannot afford to offer them coverage. Our legislation, the legislation that the gentleman from Missouri (Mr. TALENT) and I wrote, gives those people access to care and it makes it more affordable. It gives them a deduction they do not now have. It allows small businesses to pool together.

Do not let nothing beat something. I urge my colleagues to support this very fair rule.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I heard my Republican colleagues talk about fairness. There is nothing fair about this rule. This is a killer rule.

Basically, what they are doing is abusing their majority position to rig the procedure here today. And I know why. Very simply, if I am a Member and I want to support the Norwood-Dingell bill, which I certainly do, I am forced under this rule basically to vote in favor of spending Social Security money. At the same time I am also forced to vote for MSAs, medical savings accounts, health marts, and all these other poison pills that basically break the insurance pool and increase the cost for the uninsured.

The Republicans say that their access bill is going to help the uninsured. Exactly the opposite; it is going to make it more difficult for people who are uninsured to buy health insurance. That is the poison pill.

They are rigging this rule. They are making it impossible for those of us who want to support managed care reform and true reform to vote for it because we would have to vote for all these awful other things that will hurt the uninsured, and make it more difficult also because of the fact that we are going to be spending Social Security money. It is unfair.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the gentleman from Missouri (Mr. TALENT), who will be managing the access bill.

Mr. TALENT. Mr. Speaker, I thank the gentleman for yielding me this time. Mr. Speaker, in the Baltimore Sun this morning appeared an article which begins as follows: ''She has stood in front of the mirror trying to practice her new smile because Linda Welch-Green can't afford the dentist. She has lost three front teeth. And Bell's palsy has paralyzed the right side of her face, so she struggles to pronounce words that start with ''P.'' She never used to miss annual medical checkups, but now she pretends not to notice when the dates slip by. Green, 50, hasn't had health insurance for two years. Even though she's working full time as a cashier at a downtown garage, the Baltimore woman can't afford the $200 a month to cover herself and her 13-year-old son.''

Mr. Speaker, there are 44 million Linda Welch-Greens around this country whose future depends on passing the accessibility bill that this rule is going to allow us to consider today. We cannot afford not to pass this bill.

Talking about this in terms of what it is going to cost the Federal government has an air of unreality about it. These people are out there suffering. They are paying for it and we are paying for it in the illnesses that they have. We cannot afford not to pass this bill.

I am told the 5-year cost, and it is the arcane way we figure cost out here, is $8 billion. And even the President agrees that we have well over $100 billion over 5 years to spend on tax relief without getting into the Social Security surplus. There is no Social Security surplus issue here.

The other issue regarding linkage of this with health care reform is that health care reform does not do much good if an individual does not have health insurance. That is a linkage in common sense, not a linkage as a result of this rule. So, please, do not say

that we are not doing anything for the uninsured, we are going to try to defeat the other side's attempts to do anything for the uninsured, and if the other side manages to succeed to do something for the uninsured, notwithstanding our opposition, we are going to kill the health care reform bill too.

That is not the right attitude. Let us help the Linda Welch-Greens in this country. We cannot afford not to do that. This is a good rule; it is a natural rule. Let us pass it and then pass this legislation.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. RANGEL).

Mr. RANGEL. Mr. Speaker, I went before the Committee on Rules to try to get an answer to how the health access bill, which is just as much a tax bill as it is a health bill, how it could possibly get to the Committee on Rules without ever seeing the light of day in the tax writing committee.

I know that the Committee on Appropriations can vote on earned-income tax credits, but it has reached the point now on important legislation that the committees of jurisdiction do not even have an opportunity to review the bills. There is one thing that we have appreciated in our committee, unlike the majority on the floor, is that whether someone is a Republican or a Democrat, the gentleman from Texas (Mr. ARCHER) has made certain that those bills are paid for. At least he says that he will.

Now, by any standard this bill, this package, would cost some $43 billion over 10 years. Somebody said, well, it should not make any difference, we are paying for it anyway. Well, we can use that argument by not investing in education and transportation and research and development. There are a variety of things we can say that we are paying for it anyway. But there is no way in the world to believe that the majority is serious about health access by combining it with the Dingell-Norwood bill.

It is clear that when we have a rule like the majority has fashioned today, that for those of us who have worked so hard as Republicans and Democrats, who have tried to work together to get a decent bill, and the fact that so many Republicans have seen the light and walked away from the leadership saying they would rather have a good bill than just good will, that now the majority has done this; they have tried to think of ways just to overthrow this thing.

And what did the majority come up with? Did they give us a fair rule where we can debate the issue? No, they had to think of another bill that is unrelated and attach it and to put it in the rule. So that those of us who just want to support Dingell-Norwood would have to support a bill that has never seen our committee.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Speaker, I rise in strong opposition to the rule.

Republicans and Democrats came together behind the Norwood-Dingell bill and a clear majority of this House supports it. Virtually a unanimous vote of this House supports the idea that the cost of that bill should be paid for without raiding Social Security money. Now, common sense would tell us we would, therefore, have on the floor the Norwood-Dingell bill with offsetting provisions to make sure it is paid for without touching Social Security. That is what common sense would tell us. But that is not what we are permitted to do here today, and that is what is wrong with this rule.

This rule is a conscious attempt to subvert the will of the majority. It is the tyranny of the minority. In urging my colleagues to oppose this rule, I am not certain that we are going to succeed, and perhaps the minority will succeed in having its views prevail today; but I assure my colleagues, Mr. Speaker, the majority of the American public will prevail in the end and this bill will become law despite their best efforts.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from California (Mr. THOMAS), a member of the subcommittee and a very strong player in this matter.

Mr. THOMAS. Mr. Speaker, I thank the gentleman for yielding me this time. I will do my best in the short time I have to cut through the fog that has been laid and walk through the crocodile tears that have been shed in terms of this particular rule.

Number one, the Congressional Budget Office has not scored any of these bills, so we do not have an official cost. For months, the Norwood-Dingell group said their bill did not cost anything. They are now complaining because, notwithstanding not knowing what it really costs as scored by the Congressional Budget Office, a tax provision that has never been looked at by the Ways and Means was not made in order.

Some of us on the Committee on Ways and Means have looked at that tax provision. One portion of that tax provision says that the government-forced wage rate, called Davis-Bacon, would be required to be imposed on every school district in the United States. That probably ought to go through committee so that we can determine if that is an appropriate policy or not. But they do not need to attach dollars to their bill because it has not been scored.

Secondly, when we take a look at their argument about the access provision, it is not married. Watch the vote. The gentleman from New Jersey (Mr. PALLONE) rings his hands over the problem of having to vote for access and then dealing with the patient provisions. Very simple. He will vote ''no'' on access, and he will vote ''yes'' on his choice in terms of patient protection. This rule allows that. The House will work its will.

And what about that access bill? Those tax provisions that the gentleman from New York has said he has not seen, I will have to remind him he voted ''no'' on all of them in committee and on the floor in terms of the comprehensive tax package.

What are some of those tax provisions on access? For the first time people who work for an employer, when the employer does not pay their health insurance, will be able to deduct the cost of that insurance. The uninsured will be covered with these access provisions. I thought that is what we were supposed to be all about.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Ms. SLAUGHTER).

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

Mr. Speaker, I am very sad this morning, because I am persuaded by this rule that this House will never touch insurance reform. This bill, the underlying bipartisan bill, has been doomed to fail after years of work by large numbers of Members on both sides.

Nothing should be clearer to each of us than the fact that our constituents want medical decisions made by medical practitioners and not by their insurance carriers. But the right of action against an insurance company dooms this bill.

State after State has enacted legislation that allows the right of action this bill intends, and it has created no massive rush to the courts. Texas has had four cases in several years under this legislation. Now, if an individual lives in one of those States, then that is good for them, but they are not going to get the protection in the United States if they do not.

Now, why should insurance companies who are culpable to damages be immune from redress? Doctors are not, hospitals are not, ancillary care is not. But insurance companies have to have the immunity.

Never mind about those questions, the clever construction of this rule will once again thwart the people's will.

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We have waited a long time for this day, only to see it lost in this dance of legislation. I urge my colleagues to defeat this rule so that we may try to have a second chance to give Americans what they want and what they deserve for the first time this year.

Mr. GOSS. Mr. Speaker, I am happy to yield 2 minutes to the gentleman from Illinois (Mr. WELLER).

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

Mr. WELLER. Mr. Speaker, I rise in support of this rule. I also rise in support and plan to vote for several of the

initiatives to make health care more affordable and to provide protections for patients.

It is interesting, my colleagues on the other side use a code word called ''pay-fors.'' What the code word ''pay-fors'' really means is tax increase. They always want to increase taxes. That is their first choice every time.

My colleagues, there are a number of facts out here that are so important. In my home State of Illinois, 15 percent of the workers and families and people of my home State lack health insurance. It is an increase over last year. And if we look at it from a national perspective, 44 million Americans do not have health insurance. That is an increase of 1 million over last year. And the question is, why? And the answer to that question is because health care coverage is not affordable and they also do not have access.

In fact, they say that for every 1 percent increase in health care costs 400,000 Americans lose their coverage. And if we look at those 44 million Americans who do not have coverage, 85 percent of them are self-employed people or workers for small businesses unable to find affordable rates of insurance.

That is why this rule is so important, because the access in choice legislation of quality care through the uninsured legislation provides answers and solutions that have been debated over the years in this House but never signed into law. We make it easier for small businesses to go together and in a cooperative fashion purchase health insurance in greater numbers, bringing their rates down through a cooperative purchasing effort, making it more affordable, and helping their workers have health care coverage.

We give something to the self-employed that corporate America already has. We allow the self-employed under this legislation to deduct 100 percent of their health insurance premium costs. We also give uninsured workers who do not have coverage provided by their employers a 100-percent deduction for their health insurance premium costs, too. That is fair.

I was pleased that the Committee on Ways and Means in the House and Senate voted to do this earlier this year. Unfortunately, the President vetoed it.

My colleagues, let us make health care more affordable and more accessible. Vote aye on the rule.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Missouri (Mr. GEPHARDT), the Democratic leader.

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

Mr. GEPHARDT. Mr. Speaker, I rise reluctantly to ask Members to vote against this rule. This is a very important day, perhaps the most important day in the Congress that we are involved in.

We have a chance now, in a bipartisan way, to pass a very good Patients' Bill of Rights, something that I think is desired by all of the American people. I want to commend the gentleman from Michigan (Mr. DINGELL) and the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) and many others on both sides of the aisle who have worked so hard to get to this point. They have worked together. They have worked admirably on a very tough set of issues. And what I wanted to pass this bill today.

Unfortunately the rule, in my view, is lacking in fairness, for two reasons. One, it does not allow an amendment that was desired by both Republicans and Democrats to pay for the patients. Unfortunately, the Congressional Budget Office has said that this bill will cost about $7 billion over 5 years.

Members on both sides of the aisle wanted a chance to pay for this so that they were not seen as voting for something that would invade the Social Security Trust Fund and break the caps and causes budgetary problems. But that amendment which was desired by proponents of Dingell-Norwood was not allowed to be made.

Secondly, the access bill, which is now going to be taken up even though we did not take it up in committee, does not have pay-fors, as well. So if it passes and becomes part of this bill, we have another section of the bill that costs money in the budget and is not paid for. I just think this is unnecessary.

First of all, the Patients' Bill of Rights should be on its own, should not be subsumed under some other bill for access which was not really the subject of this matter to begin with.

Second, if it is going to be subsumed under it, we should be allowed to figure out a way to pay for it. Thirdly, we ought to be able to pay for the Patients' Bill of Rights. None of that is allowed in the bill.

My fear is that, at the end of the day, even if Dingell-Norwood survives, the votes are not going to be there to pass the bill because of these other matters that were not dealt with properly in the rule.

I ask the majority leadership to rethink this matter and to try to get us a rule or a procedure that will allow a fair consideration of patients.

I guess I just end with saying, putting all of this procedural wrangle aside, let us all try to remember what this legislation is about. It is about helping people, children, seniors, women, men, who want to have an enforceable right to have the decisions about their health care made by the doctors and them together to be able to do that, to have an enforceable right that they can bring against their health insurance company or their HMO. That is what is at stake here.

We have a chance as a House of Representatives, in a bipartisan way, to do something that is deeply desired by the American people. I hope that this rule in its present form will be defeated, and I hope we will find a procedure and a rule that will allow fair consideration of this very, very important legislation.

Mr. FROST. Mr. Speaker, I yield 1 minute to the 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 do not know what it will take for my colleagues on both sides of the House to acknowledge, as I said earlier this morning, that more than 83 percent of the American people are asking us to vote for a freestanding, upstanding HMO reform bill today. And I think one of those is little Steve Olson, a 2-year-old who went hiking with his parents. As he was hiking he fell ill, went to an emergency room, and was treated for meningitis. But the little boy still experienced pain, could not express himself. They went back to that emergency room, but they could not get any more care, they could not get him to do a brain scan because the HMO denied it. And now this little boy, because he had a lump on his brain, has cerebral palsy.

The American people are asking us to stop the parliamentary maneuvers that would not allow us to have a freestanding bill on managed care, access to emergency rooms, the sanctity of the physician-patient relationship; and the American people are asking us to deal with the uninsured in a separate manner because there are working poor who cannot pay for their insurance and this bill does not do it. The American people have asked us to have an amendment on $7 billion to ensure that we pay for this.

Mr. Speaker, I just conclude by saying, my colleagues, let us join together and get a real HMO reform bill, the Dingell-Norwood bill.

Mr. Speaker, I rise to strongly oppose the rule for today's managed care bills. The rule is a sham and seeks to undermine these two vital health bills.

Instead of providing a fair and open rule for considering the patients' bill of rights, the majority has written an unreasonable rule that combines the managed care bill with a measure riddled with special interest ''poison pills'' designed to kill the measure. This rule guarantees that we will not be able to offset any potential revenue losses from the measure, and we will not be able to establish the health care services that we hoped to provide for the citizens of this country.

The majority has shown a grave error in judgment by including special interest provisions in the managed care bill. This act is fiscally irresponsible because no funding is provided for these provisions. Worse yet, this rule denies a bipartisan group of members from offering an amendment to pay for this bill.

Because the access bill and managed care bill are combined in one rule, managed care reform may be defeated through parliamentary maneuvering. This is untenable.

Merging these bills into one rule is unacceptable because it combines a bill that helps those who need health care, H.R. 2723, with

a bill, H.R. 2990, that simply helps the Nation's most healthy and wealthy, and not the uninsured. We must separate these two bills so we can ensure that H.R. 2723 provides new patient protections, sets nationwide standards for health insurance, and expands medical liability. These issues are vitally important to all of the American people, not just the privileged.

Yet, these bills, these once glimmering symbols of managed care reform that sought to stretch their healing arms around each of our citizens, have now been twisted and manipulated into one hideous, unrecognizable heap of special interest slag. In particular, poison pill amendments have been offered to the Bipartisan Consensus Managed Care Improvement Act of 1999. The Boehner amendment benefits the healthy and wealth instead of the uninsured, those who need the most help. The Goss-Coburn amendment weakens patient protections, cap non-economic damages, and guts enforcement provisions. The Houghton-Graham amendment provides far too weak federal remedies and internal reveiw procedures.

An open rule would allow us to correct these problems. But by providing only one rule for both HMO bills, we prevent ourselves from doing any good today. Do we want to tell the American public that it will not receive the managed care reform it has so desperately sought because of a procedural bar?

The sobering truth is that our citizens need health care reform—especially those living in poverty. Over one-third of the U.S. population was living in or near poverty in 1996. The majority of African-American (55 percent) and persons of Hispanic origin (60 percent) lived in families classified as poor or near poor. In the southern portions of the United States, the poverty rate is 15 percent. My home State of Texas had poverty rate over 16 percent. Of those suffering from poverty, 44.1 percent are uninsured. 44.4 percent of African-Americans in poverty are uninsured, and 58.7 percent of Hispanics in poverty are uninsured. These numbers are sobering, and we must do something about them.

People living in poverty, and many minority citizens, simply cannot afford health insurance, and, in turn, cannot obtain quality health care. Their lack of access to quality health care has devastating effects because many minority groups and people living in poverty are particularly susceptible to health problems. Racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, yet, they account for nearly 54 percent of all AIDS cases. For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites. The age-adjusted death rate for coronary heart disease for the total population declined by 20 percent from 1987 to 1995; for blacks the overall decrease was only 13 percent.

The Bipartisan Consensus Managed Care Improvement Act of 1999 is also important due to the reforms it provides because even when people do have insurance, quality health care is not guaranteed. Take for instance, Steven Olson—a once healthy, thriving two-year old child. After falling on a stick while hiking with his parents, two-year-old Steven was rushed to the emergency room where he was treated. His mother returned him a week later because he was in great pain. He was treated for meningitis and sent home. Steven continued to complain about pain, but despite his parents' protest, the HMO doctors refused to perform a brain scan, even though it was a covered benefit. Steven eventually fell into a coma due to a brain abscess that herniated. He now has cerebral palsy. An $800 brain scan would have prevented this tragedy.

In an even more tragic case, a woman attempted to switch doctors when it became clear that her original doctor would not fully examine a growing and discolored mole on her ankle. Paperwork and bureaucracy resulted in a six-month wait. Once the woman finally visited a second-doctor, she was immediately sent to a dermatologist who determined that the mole was a malignant melanoma. The woman died one year later.

Both sides of the aisle should be working together to ensure that these stories never surface ever again. Yet, this rule encourages special interest ''gutting'' of the bill, and negates any amendment that would provide the necessary $7 billion in offsets for revenue losses estimated to result from increased deductions for higher medical premiums.

Over 200 organizations support the Bipartisan Consensus Managed Care Improvement Act of 1999—including AIDS Action, the American Academy of Pediatrics, the American Heart Association, the American Medical Association, and the National Association of Public Hospitals. But these organizations cannot support the bill as offered. The special interest additions and weakened bill language undermine the goals of these groups. Without an open rule that would allow us to correct these problems, we will essentially slam the door on the very groups who can provide us with the greatest support and resources.

This rule does not penalize the minority side; it penalizes the very people we represent—the American taxpayers. We need an open rule that will permit the enactment of effective managed care reform.

I urge my colleagues to vote ''no'' against this unfair rule and against this distorted version of the bill.

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

Mr. Speaker, the gentleman from California (Mr. THOMAS), a member of the Committee on Ways and Means, just appeared on the floor and made a statement that there was a provision relating to Davis-Bacon in the amendment the Democrats sought in order.

I have consulted the Committee on Ways and Means staff. That is not true. There is nothing in the amendment that was offered by the Democrats relating to Davis-Bacon.

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

Mr. GOSS. Mr. Speaker, I take great pleasure in yielding 1 minute to the distinguished gentleman from Florida (Mr. SHAW), a member of the Committee on Ways and Means.

Mr. SHAW. Mr. Speaker, I thank my friend for yielding this time to me.

Mr. Speaker, when the gentleman from Missouri (Mr. GEPHARDT) was on the floor talking about wishing that the pay-fors were in the bill, I would like to point out that both he and the gentleman from Michigan (Mr. DINGELL) have signed a discharge petition asking that this bill in its form that it is going to be made in order under this rule be brought directly to the floor.

In that bill, there were no pay-fors. If they would attempt to put a paid-for in as an amendment, it would be nongermane. So they have already asked by way of a discharge petition that this bill be brought to the floor without any pay-fors.

Now, regarding the pay-fors that were requested in the Committee on Rules, one of those, and the largest one of which, has never had a hearing before the Committee on Ways and Means. It is a tax increase.

As long as I have been in this Congress, both under Democrat control and under Republican control, I can never remember a single time when this Congress was so irresponsible as to bringing a tax increase directly to the floor without even so much as a hearing before the Committee on Ways and Means. That would be irresponsible on our side, and it would be equally irresponsible on the Democrats' side.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts (Mr. TIERNEY).

Mr. TIERNEY. Mr. Speaker, I thank the gentleman from Texas for yielding me the time.

Mr. Speaker, the American public is not going to be fooled by clever tactics. This has been a long-standing process with the Patients' Bill of Rights, and the American public is aware of that.

In the 105th session we talked about coming forward with a meaningful Patients' Bill of Rights, and that was put off by people who were carrying water for the special interests and the insurance groups.

We fought all the way through that. We found a way to build a coalition with Republicans and Democrats that were bold enough and strong enough to step forward and give real patients' rights, talking about the idea that insurance companies would be no longer the ones to determine what is medically necessary just on the basis of cost; but we would take this out of that venue and leave it to doctors and patients to decide the issue of medical necessity.

This Patients' Bill of Rights will allow people to determine if they need to go to a specialist and get that care. We have right after right in there that, finally, we have enough Republicans and almost all the Democrats on it that it will pass. And it is at that point in time that the leadership of the majority decides that they now have to get clever.

It is not enough to try to fight it on its merits. It is not enough to try to fight it on a fair rule. It is not enough to bring it forward for a straight up or down vote. Because they know now the political pressure in this country demands Patients' Bill of Rights in the form of Norwood-Dingell. They refuse to do it. They are being clever. The American public will certainly not be fooled by that.

Mr. GOSS. Mr. Speaker, I am very happy to yield 1 minute to the distinguished gentleman from Tennessee (Mr. BRYANT).

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

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

Mr. Speaker, there are two bills, I might remind my colleagues on the floor. One bill that we will discuss later today and tomorrow will consider various ways to provide patient protection to people in America. And many of us support that.

But right now what we are talking about is a rule that also covers an access bill which we are going to debate immediately after this rule. What this access bill does is it provides an opportunity for 44 million people who do not have insurance right now who do not have anything to do with that second bill because they do not have any insurance. They do not need protection from anything.

What we need to do now in this rule and in this bill is pass this so we can deal with those 44 million people and provide them access, the opportunity to see a doctor, go to a hospital, and get good quality care at affordable prices.

What this bill will do, it will not set up another Government entitlement; but it will provide incentives to private businesses, tax deductions, tax credits, and opportunities to pool together in areas that will be able to get them to affordable, quality, insurance coverage.

These folks do not care about this other thing right now until they get that coverage.

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

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

Mr. GREEN of Texas. Mr. Speaker, I am surprised that we have this rule here on the floor today and hear the debate talking about the access bill that will allow 44 million people to have insurance.

We have had a Republican majority for 6 years, and it is the first time I have heard concern for that 44 million. My colleagues talk about these bills did not have a hearing in the Committee on Ways and Means at any time was a decision by the Republican leadership not to have a hearing on any of these bills.

I worked for years on the Committee on Commerce so I could deal with health care. None of the bills had hearings that we are debating today in the decision to bring them to the floor. It is becoming increasingly clear that the leadership does not reflect the views of the majority of this House on many issues.

The Republican leadership is using the Committee on Rules to defeat legislation supported by majority Members of the House and attempting to defeat by subterfuge what they cannot defeat on a straight up or down vote.

The Republican leadership cannot defeat the bipartisan Norwood-Dingell proposal, so it attempts to change the proposal so that it is unacceptable to the bipartisan Members who support a real strong Patients' Bill of Rights. That is why this rule is so wrong. That is why it should be defeated.

By denying the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL) the right to finance the small portion of their legislation, the Republican leadership is trying to create a situation that they can claim that a vote for a Patients' Bill of Rights is an effort to spend the Social Security surplus.

□ 1215

That is not the intent. Hopefully, before the day is through, we will have a chance to pass a clean Norwood-Dingell bill. It is what the people want, what 83 percent of the people in a most recent poll said. I know at all the town hall meetings that I have they say that. They want patient protections just like, Mr. Speaker, we enjoy in Texas for our constituents under Texas law. We need them for all the Americans.

Mr. GOSS. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, I would point out that all but one of the speakers on the other side, according to my records, signed a discharge petition to bring this matter forward, the original bill, the underlying bill, to our attention, without the pay-fors in it.

I would point out that this is a procedure that is designed to end-run the committee system and point out particularly, as one looks at the discharge petition, that the first two signatures on it are the gentleman from Michigan (Mr. DINGELL) and the gentleman from Missouri (Mr. GEPHARDT).

If that does not send a message that this is being done in a way to end-run the regular order and put a partisan aspect to it, I do not know what does.

The other thing I would like to point out is that we have crafted a rule that does, in fact, provide for a full debate on liability, which is the nugget of the patient protection.

We have also done something in this rule, and that is provide for worrying about those Americans who do not have health care insurance, and it is time somebody did worry about them and the Republican majority is doing that and providing a way to help them. That is worthwhile, and if anybody says that is unfair they have a warped sense of what is fair in this country.

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

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

Mr. Speaker, we signed a discharge petition. That is the only way to get the attention of the majority. They have to be hit right between the eyes. It happens all the time around here. When we were in the majority, they signed discharge petitions. We are in the minority. We sign discharge petitions, and that was a successful effort which forced them to bring a bill to the floor they did not otherwise want to bring to the floor.

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

Mr. TURNER. Mr. Speaker, I was proud to join in signing that discharge petition because the truth is, we would not be here today had some of us not been willing to sign that discharge petition to allow this very critical issue to be brought to the floor of this House.

The truth of the matter is, even after it has become apparent to everyone in this body that a majority of the Members of this House, if given the opportunity on a straight up or down vote, will vote for the Norwood-Dingell bill, the Committee on Rules has crafted a very complicated rule that most American people will never understand, whose sole purpose is to try to once again defeat the opportunity to pass strong patient protection legislation.

The trick they have used is to attach another bill that has a nice ring to it, a bill to provide access to health care, that just happens to have a $40 billion to $50 billion price tag on it, a bill that never had any hearings in the Committee on Ways and Means, attached to the Norwood-Dingell bill in the complicated rule that is before this House, simply to weigh it down and try to get some of the folks that are supporting the bill to vote no.

It is not going to work. At the end of the day, we will prevail because the American people want to see strong patient protection legislation.

Mr. FROST. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, all we ask is for an opportunity to consider this legislation under a fair rule. For months and months and months the other side has decried and shed great tears about efforts to invade the Social Security trust fund. All we ask is for an honest approach to this legislation, which would permit this legislation not to take a penny out of the Social Security trust fund.

This is a good bill. Everyone agrees this is a good bill. Let us have this bill considered under a fair procedure so that we can get to the merits of the legislation. Let us not take money away from Social Security in so doing, and let us pass a strong patient protection piece of legislation.

We will oppose the rule and ask for a fair rule on this floor.

Mr. Speaker, I yield back the balance of my time.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the gentleman from California (Mr. DREIER), the distinguished chairman of the Committee on Rules.

Mr. DREIER. Mr. Speaker, I want to congratulate the gentleman from Florida (Mr. GOSS) for the fine job that he has done on this issue.

It is not often that I stand in this well somewhat saddened over the debate that we have gone through. This is one of the first times that I can remember that the gentleman from Florida (Mr. GOSS) used the word ''warped.'' Last night, he pounded on the table upstairs.

If there is any kind of unfairness, it is coming from the rhetoric that we have gotten from the other side of the aisle, using words like ''cynical'' and ''calculated'' to describe what we are doing here.

One hundred and eighty-four Members signed the discharge petition. I have to tell my friends on the other side of the aisle, that is not what it takes to force a bill to the floor.

We very much want a deal, with the fact that there are 44.3 million Americans who do not have insurance, and we want to increase accessibility for them. We also want to make sure that people are accountable when there are problems out there, and that is exactly what we are doing with the reform measure itself. We also want to make sure that affordability is out there, and that is what we are doing with this measure.

This is a very fair bill. My colleagues are screaming about one amendment on the other side of the aisle. Fifty-nine amendments were submitted to our committee. Forty-three Republicans were denied, and the Members on the other side are saying this is an unfair rule because of the six amendments the Democrats submitted, one of them was not made in order. Well, that to me is unfair rhetoric.

We are about to proceed with what I think is going to be a very fair, fair debate. In fact, we have to go back a quarter of a century, 25 years, to the debate in 1974 on the ERISA act to find a rule that is more fair.

Now a lot of people have been complaining, saying that this bill ties together the reform package and the access package. It does not do that. At the end, after the votes are taken, they are engrossed and will be sent to the other body for a conference, which we hope will address each issue.

So if someone does not want to vote for the access bill, they do not have to vote for the access bill. They can still vote for the reform bill and only after both measures pass will they be engrossed and sent to the other side of the Capitol.

So I happen to believe very strongly that we are going to begin an important debate. Everyone acknowledges that there are problems with our health care, in spite of the fact that we have the best health care system on the face of the earth. People come from all over the world to enjoy it, but there are still problems. They need to be addressed and this bill, with three balanced substitutes, will allow for an open debate, a fair debate; and I urge my colleagues to support it.

Mr. COSTELLO. I rise today in strong opposition to the process imposed in the House today by the Republican leaders. Once again the Republican-led Congress has made in order a rule they know will defeat the bipartisan Norwood-Dingell bill, the only bill that could provide real managed care reform for 32 million Americans. This is the Republicans clever way of fooling the public into thinking they would like to pass a real managed care bill.

Mr. Speaker, the rule does not allow the bipartisan Norwood-Dingell bill to be offered in its original form and then links it with another poorly crafted bill that will deny access to the 32 million uninsured individuals in the lowest income bracket. This scheme is unacceptable, the Republican leadership should be ashamed.

The ''access bill'' that will be tied to the real managed care bill is for the healthiest and wealthiest of individuals. By expanding Medical Savings Account (MSAs), the access bill discourages preventive care, and undermines the very purpose of insurance. When we voted on the Kennedy-Kassebaum Health Insurance Portability Protection Act in 1996 I supported the MSA demonstration project. However, this demonstration project turned out to be a failure. Of the 750,000 policies available only 50,000 have been sold. In my own congressional district in southwestern Illinois my constituents do not have access to these policies.

This access bill and the rule is just another attempt by the Republican-led Congress to undermine a bipartisan bill that could provide relief for millions of Americans. I am outraged that the Rules Committee denied Representative DINGELL's request to offer an amendment to pay for this legislation. As a general rule the Republican leadership demands that legislation not bust the budget caps imposed in 1997. While the Norwood-Dingell bill was not expected to require additional spending, the Congressional Budget Office estimated it would cost $7 billion. Representative DINGELL offered to offset the bill so that Members like myself who wish to protect Social Security could cast their vote in support of real managed care reform while ensuring the Social Security Trust Fund would not be touched.

As a cosponsor of the Bipartisan Consensus Managed Care Improvement Act—legislation strongly supported by doctors and by the American Medical Society and the Illinois State Medical Society—I believe it is the only real reform bill that will provide a comprehensive set of consumer rights that includes guaranteed access to emergency care and specialists, choice of providers, and strong enforcement provisions against health plans that put patients' lives in jeopardy. I am pleased the bill protects our small business owners by excluding businesses from liability if they do not make the decisions. This bill contains provisions that create safe harbors to ensure that no trial lawyer will accuse an employer of making a decision by simply choosing what benefits are in a plan or providing a patient benefit not in a plan. I am encouraged by the State of Texas who gave their citizens the right to sue HMOs for the past 2 years. In that time there have only been four cases filed.

I urge my colleagues to oppose this rule and support real managed care reform legislation. Vote for the bipartisan Norwood-Dingell legislation.

Ms. MILLENDER-MCDONALD. Mr. Speaker, our day has been consumed with debate on a desperate rule drafted to derail the bipartisan managed care reform bill. This disheartens me because the Norwood-Dingell bill is a good bill. It is such a good bill; the three alternatives have used it as their base. Why is that? Maybe because over 260 medical organizations have endorsed it. Maybe because many of our constituents want us to pass it. Whatever the reasons may be, they are all for naught if this good bill has to be joined with the poison pill train that the rules committee placed on our tracks.

The Norwood-Dingell bill allows women to obtain routine ob/gyn care from their ob/gyn without prior authorizations or referral. This is a good step in the right direction. As a staunch advocate for women, I prefer women having the opportunity to designate their ob/gyn as their primary care provider but—that is another battle for another time.

Norwood-Dingell also looks out for our children. Parents now have the opportunity to select a pediatrician as a primary care provider. This provision gives parents a level of comfort knowing that their child's doctor understands the health needs of children.

Mr. Speaker, this bill needs a straight up or down vote. It should not be joined and we should not be forced to vote on both bills. When a straight up or down vote—without poison pills—is allowed, I urge my colleagues to vote ''yes'' on the Norwood-Dingell bipartisan managed care reform bill.

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

MOTION TO ADJOURN

Mr. FROST. Mr. Speaker, I offer a privileged motion.

The SPEAKER pro tempore (Mr. LATHAM). The Clerk will report the motion.

The Clerk read as follows:

Mr. FROST moves that the House do now adjourn.

The SPEAKER pro tempore. The question is on the motion to adjourn offered by the gentleman from Texas (Mr. FROST).

The question was taken; and the Speaker pro tempore announced that the noes 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 3, nays 423, not voting 7, as follows:

[Roll No. 482]

YEAS—3

Dingell Kennedy Obey

NAYS—423

Abercrombie
Ackerman
Aderholt
Allen
Andrews
Archer
Armey
Bachus
Baird
Baker
Baldacci
Baldwin
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Becerra
Bentsen
Bereuter
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop
Blagojevich
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonior
Bono
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brady (TX)
Brown (FL)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Capuano
Cardin
Carson
Castle
Chabot
Chambliss
Chenoweth-Hage
Clay
Clayton
Clement
Clyburn
Coble
Coburn
Collins
Combest
Condit
Conyers
Cook
Cooksey
Costello
Cox
Coyne
Cramer
Crane
Crowley
Cubin
Cummings
Cunningham
Danner
Davis (FL)
Davis (IL)
Davis (VA)
Deal
DeFazio
DeGette
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart
Dickey
Dicks
Dixon
Doggett
Dooley
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Ewing
Farr
Fattah
Filner
Fletcher
Foley
Forbes
Ford
Fossella
Fowler
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green (TX)
Green (WI)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (IN)
Hill (MT)
Hilleary
Hilliard
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley
Horn
Hostettler
Houghton
Hoyer
Hulshof
Hutchinson
Hyde
Inslee
Isakson
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kasich
Kelly
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kingston
Kleczka
Klink
Knollenberg
Kolbe
Kucinich
Kuykendall
LaFalce
LaHood
Lampson
Lantos
Largent
Larson
Latham
LaTourette
Lazio
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Luther
Maloney (CT)
Maloney (NY)
Manzullo
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCrery
McDermott
McGovern
McHugh
McInnis
McIntosh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Metcalf
Mica
Millender-McDonald
Miller (FL)
Miller, Gary
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nadler
Napolitano
Neal
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Olver
Ortiz
Ose
Owens
Oxley
Packard
Pallone
Pascrell
Pastor
Paul
Payne
Pease
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickering
Pickett
Pitts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Reyes
Reynolds
Riley
Rivers
Rodriguez
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Royce
Rush
Ryan (WI)
Ryun (KS)
Sabo
Salmon
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Saxton
Schaffer
Schakowsky
Scott
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Spence
Spratt
Stabenow
Stark
Stearns
Stenholm
Strickland
Stump
Stupak
Sununu
Sweeney
Talent
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Thune
Thurman
Tiahrt
Tierney
Toomey
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Upton
Velazquez
Vento
Visclosky
Vitter
Walden
Walsh
Wamp
Waters
Watkins
Watt (NC)
Watts (OK)
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Weygand
Whitfield
Wicker
Wilson
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOT VOTING—7

Brown (OH)
Delahunt
Hunter
Istook
McKinney
Scarborough
Wise

☐ 1246

Messrs. BALLENGER, YOUNG of Alaska, COYNE, Ms. PELOSI, and Messrs. VITTER, MINGE and OWENS changed their vote from ''yea'' to ''nay.''

So the motion to adjourn was rejected.

The result of the vote was announced as above recorded.

☐ 1245

The SPEAKER pro tempore (Mr. BONILLA). Without objection, the previous question is ordered on the resolution.

There was no objection.

The SPEAKER pro tempore. 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, on that I demand the yeas and nays.

The yeas and nays were ordered.

☐ 1252

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BONILLA) during the voting. The Chair has been advised that there is difficulty with some of the votes being displayed to the Members' left, on the far left panel. There have been Members reporting that after they have cast their vote, that on the far left panel their votes are not being accurately reflected, but their votes are being properly recorded.

But Members should be cautious about what they see on the panel and should reconfirm with their cards their actual votes.

PARLIAMENTARY INQUIRY

Mr. DINGELL. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from Michigan is recognized for a parliamentary inquiry relating to the vote.

Mr. DINGELL. Mr. Speaker, I note that the display over on the right and the left of the Chamber give the number of the Members who have voted. I note that there is no display of the names of the Members who have voted in back of the Chair, the presiding officer.

What does this mean with regard to the regularity and the correctness of the vote?

The SPEAKER pro tempore. The Chair would cite Speaker O'Neill's ruling on 19 September 1985. The Speaker has the discretion, in the event of a malfunction of the electronic voting system, to, one, continue to utilize the electronic system, even though the electronic display panels are inoperative, where the voting stations continue in proper operation and Members are able to verify their votes; or, number two, to utilize a backup voting procedure, such as calling the roll.

In this case, the Clerk has indicated that the voting tallies are correct. There is no reason at this time for the Chair to have in doubt that the totals displayed on either side of the Chamber are incorrect.

Mr. DINGELL. Further parliamentary inquiry.

The SPEAKER pro tempore. The Chair will continue to allow Members, if there is a question about a Member's particular vote, the Chair will allow the vote to remain open a little while longer if there is a question any Member has about casting his or her vote.

Mr. DINGELL. Further parliamentary inquiry, Mr. Speaker.

Mr. Speaker, how is a Member to know how he is recorded on this particular vote?

The SPEAKER pro tempore. Any Member can re-insert his or her voting card in any voting station, electronic station.

The monitor indicates that every Republican has voted in favor of this resolution, and all but one Democrat is opposed. So that might also be another indication that the vote, unless there is dispute, is accurate.

Mr. DINGELL. Further parliamentary inquiry. I have noted, Mr. Speaker, that a Member on the majority side had voted no on the rule on the display behind the Chair of the Speaker. I am curious, what does that mean in terms of the reliability of the vote?

The SPEAKER pro tempore. The Clerk is certifying that the vote is being accurately recorded.

Mr. DINGELL. Further parliamentary inquiry. Could the Chair inform the Chamber what the Clerk has done to assure that the vote is reliable and correct? I have great respect for the

Clerk, but we have a malfunction in the electronic system.

My question is, who do we believe, the malfunctioning electronic system or the Clerk of the House?

The SPEAKER pro tempore. The Clerk has responded to every Member and checked every Member's vote of any Member who has come forward to question the recording of their vote.

At this time there is no pending question from any Member about the accuracy of their vote being recorded.

Mr. DINGELL. If the Chair would permit, I believe a check by the Clerk will indicate that there are Members who are no longer listed on the computer anymore. I am advised that that constitutes a problem insofar as Members on this side of the aisle are concerned.

I know the Chair is anxious to have a correct vote. I know the Chair also has the responsibility of assuring a correct vote.

At this particular moment, I would note to the Chair, as part of my parliamentary inquiry, that when I look up there I find that there is a display there and there is no display there, and there is a variance between the display behind the Chair and the display which is at the end of the Chamber.

The SPEAKER pro tempore. The Chair would reaffirm that it is in everyone's interest in this body to have an accurate vote established. That is the intent of every Member of this body.

Mr. DINGELL. I would tell the Chair that the gentleman from Michigan (Mr. BARCIA)——

The SPEAKER pro tempore. The Chair will further state there have been cases in the past where the displays on the boards before the media gallery have been inoperative, but that the votes recorded by the Clerk have been accurate. There is precedent for relying on the running totals.

Mr. DINGELL. Further parliamentary inquiry, Mr. Speaker. Is the gentleman from Michigan (Mr. BARCIA) listed as present and voting? I am informed he is not. I am informed that he was present and that he did vote. I am comforted at the assurances of the Clerk. I am not comforted, however, at apparent discrepancies between his comments and what I see on the displays and what I am advised with regard to the presence and the recording of the name and the vote of one Member.

The SPEAKER pro tempore. The Clerk is checking.

The gentleman from Michigan (Mr. BARCIA) is recorded as voting no.

Mr. DINGELL. Mr. Speaker, I would note, on a hurried addition, that 429 Members are listed as having been present and voting. I would note that there are 435. That means that six Members are not recorded as voting on a matter of this importance. I would assume that those Members would have been here.

I am curious, where are those Members who are not recorded as being present and having voted?

The SPEAKER pro tempore. The RECORD will show those Members not voting. The gentleman understands that occasionally there are Members who are either on leave, absent, or simply do not vote, for whatever reason they choose. It is not unusual.

Mr. DINGELL. Mr. Speaker, it is the duty of the Chair to see that all Members are properly recorded. Could the Chair assure us that somebody other than the Clerk, whose record is not an official one in this matter, has inquired into the presence or absence of these Members?

The SPEAKER pro tempore. The Chair is allowing all Members a sufficient amount of time to verify their votes at this time, if there is a question about their vote.

Mr. DINGELL. I am looking at the numbers, Mr. Speaker. I note that 16 Members are listed as not having been present and voting, or there are six Members listed as unrecorded. Do I have the assurance of the Chair that the vote is correct?

The SPEAKER pro tempore. The Chair can only assure the accuracy in the vote count by electronic device. The Chair could not account for the whereabouts of Members who have not voted, unless they are on leave.

Mr. DINGELL. Further parliamentary inquiry. Is it appropriate to request a recapitulation of the vote?

The SPEAKER pro tempore. If the gentleman would kindly delay his question, the Clerk is researching to see whether the Clerk can certify the vote at this time.

Mr. DINGELL. Would that be the Clerk that certifies it, or the Chair?

The SPEAKER pro tempore. The Chair will report the Clerk's certification or lack thereof.

Mr. DINGELL. I think this matter has been carried as far as it can be, but I would just note with distress, Mr. Speaker, that I believe the events of the last few minutes have raised questions as to the regular order of this vote.

□ 1315

Mr. Speaker, can the Clerk certify with 100 percent accuracy that the record of the votes in the displays above the doors are, in fact, 100 percent?

The SPEAKER pro tempore (Mr. BONILLA). The Chair is checking on the accuracy of the vote at this time.

Mr. DINGELL. Mr. Speaker, is it the practice of the Chair, then, or would it be the practice of the Chair to inform us of whether the Clerk's certification is 100 percent correct when that process has been completed?

The SPEAKER pro tempore. The House will be informed of the accuracy of the vote, and the Chair just asks Members' indulgence.

Mr. DINGELL. I thank the Speaker. I may have further parliamentary inquiries, Mr. Speaker.

The SPEAKER pro tempore. The Chair has been informed that the accuracy of the vote cannot be established with 100 percent accuracy.

On this occasion, the Chair will direct the Clerk to call the roll to record the yeas and nays, as provided in clause 2(b) of rule XX.

PARLIAMENTARY INQUIRY

Mr. ABERCROMBIE. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman from Hawaii will state his parliamentary inquiry.

Mr. ABERCROMBIE. Mr. Speaker, may I take it from the Speaker's remarks that he cannot do anything without me?

The SPEAKER pro tempore. The Clerk will call the roll alphabetically.

Mr. ABERCROMBIE. I thank the Speaker.

The SPEAKER pro tempore. The Chair will inform Members that this is the only valid vote on the resolution, H. Res. 323, on the rule, and this will be the only recorded vote. It is not a recapitulation.

The following is the result of the vote:

[Roll No. 483]

YEAS—221

Aderholt	English	Leach
Archer	Everett	Lewis (CA)
Armey	Ewing	Lewis (KY)
Bachus	Fletcher	Linder
Baker	Foley	LoBiondo
Ballenger	Fossella	Lucas (OK)
Barr	Fowler	Manzullo
Barrett (NE)	Franks (NJ)	McCollum
Bartlett	Frelinghuysen	McCrery
Barton	Gallegly	McHugh
Bass	Ganske	McInnis
Bateman	Gekas	McIntosh
Bereuter	Gibbons	McKeon
Biggert	Gilchrest	Metcalf
Bilbray	Gillmor	Mica
Bilirakis	Gilman	Miller (FL)
Bliley	Goodlatte	Miller, Gary
Blunt	Goodling	Moran (KS)
Boehlert	Goss	Morella
Boehner	Graham	Myrick
Bonilla	Granger	Nethercutt
Bono	Green (WI)	Ney
Brady (TX)	Greenwood	Northup
Bryant	Gutknecht	Norwood
Burr	Hansen	Nussle
Burton	Hastert	Ose
Buyer	Hastings (WA)	Oxley
Callahan	Hayes	Packard
Calvert	Hayworth	Paul
Camp	Hefley	Pease
Campbell	Herger	Peterson (MN)
Canady	Hill (MT)	Peterson (PA)
Cannon	Hilleary	Petri
Castle	Hobson	Pickering
Chabot	Hoekstra	Pitts
Chambliss	Horn	Pombo
Chenoweth-Hage	Hostettler	Porter
Coble	Houghton	Portman
Coburn	Hulshof	Pryce (OH)
Collins	Hunter	Quinn
Combest	Hutchinson	Radanovich
Cook	Hyde	Ramstad
Cooksey	Isakson	Regula
Cox	Istook	Reynolds
Crane	Jenkins	Riley
Cubin	Johnson (CT)	Rogan
Cunningham	Johnson, Sam	Rogers
Davis (VA)	Jones (NC)	Rohrabacher
Deal	Kasich	Ros-Lehtinen
DeLay	Kelly	Roukema
DeMint	King (NY)	Royce
Diaz-Balart	Kingston	Ryan (WI)
Dickey	Knollenberg	Ryun (KS)
Doolittle	Kolbe	Salmon
Dreier	Kuykendall	Sanford
Duncan	LaHood	Saxton
Dunn	Largent	Schaffer
Ehlers	Latham	Sensenbrenner
Ehrlich	LaTourette	Sessions
Emerson	Lazio	Shadegg

Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NAYS—209

Abercrombie
Ackerman
Allen
Andrews
Baird
Baldacci
Baldwin
Barcia
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Forbes
Ford
Frank (MA)
Frost
Gejdenson
Gephardt
Gonzalez
Goode
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (CT)
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Phelps
Pickett
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Smith (WA)
Snyder
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NOT VOTING—4

Delahunt
McKinney
Scarborough
Watts (OK)

□ 1404

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.

MALFUNCTIONS WITH VOTING MACHINE NOT UNPRECEDENTED

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

Mr. THOMAS. Mr. Speaker, to briefly explain what occurred on the machinery, this is not unprecedented. On May 4, 1988, the same situation occurred. As one might guess, it is a human error.

There was a Member who had a card, and we all know that these new cards are much better than the old laminated ones but they do go bad. When that Member's name was adjusted on the visual screen, it was placed first, out of order alphabetically, and so when the votes were recorded they skipped one. They did not match up.

I want to assure every Member that the computer is far more sophisticated than that. These lights are for visual purposes only. The machine records the vote according to a unique identifier number. Regardless of where a Member might be placed alphabetically the unique number from the card records the vote.

However, I want to compliment the gentleman from Michigan (Mr. DINGELL), who is one of the few Members around here who remembers this is the way we used to do business on an ordinary basis, about a quarter of a century it was done under this system, the other half with lights. The votes were recorded accurately, but given the concern over the visual reference it was entirely appropriate to go through this procedure. It was a revisiting of a previous existence of the Congress.

Our hope is that the human errors are now minimized, but the actual vote that is recorded, notwithstanding the visual display, was recorded accurately by the machine.

QUALITY CARE FOR THE UNINSURED ACT OF 1999

Mr. BLILEY. Mr. Speaker, pursuant to House Resolution 323, I call up the bill (H.R. 2990) to amend the Internal Revenue Code of 1986 to allow individuals greater access to health insurance through a health care tax deduction, a long-term care deduction, and other health-related tax incentives, to amend the Employee Retirement Income Security Act of 1974 to provide access to and choice in health care through association health plans, to amend the Public Health Service Act to create new pooling opportunities for small employers to obtain greater access to health coverage through HealthMarts, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The text of H.R. 2990 is as follows:

H.R. 2990

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Quality Care for the Uninsured Act of 1999''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Purposes.
Sec. 3. Findings relating to health care choice.

TITLE I—TAX-RELATED HEALTH CARE PROVISIONS

Sec. 101. Deduction for health and long-term care insurance costs of individuals not participating in employer-subsidized health plans.
Sec. 102. Deduction for 100 percent of health insurance costs of self-employed individuals.
Sec. 103. Expansion of availability of medical savings accounts.
Sec. 104. Long-term care insurance permitted to be offered under cafeteria plans and flexible spending arrangements.
Sec. 105. Additional personal exemption for taxpayer caring for elderly family member in taxpayer's home.
Sec. 106. Expanded human clinical trials qualifying for orphan drug credit.
Sec. 107. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines; reduction in per dose tax rate.
Sec. 108. Credit for clinical testing research expenses attributable to certain qualified academic institutions including teaching hospitals.

TITLE II—GREATER ACCESS AND CHOICE THROUGH ASSOCIATION HEALTH PLANS

Sec. 201. Rules.

''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. 202. Clarification of treatment of single employer arrangements.
Sec. 203. Clarification of treatment of certain collectively bargained arrangements.
Sec. 204. Enforcement provisions.
Sec. 205. Cooperation between Federal and State authorities.
Sec. 206. Effective date and transitional and other rules.

TITLE III—GREATER ACCESS AND CHOICE THROUGH HEALTHMARTS

Sec. 301. 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.

TITLE IV—COMMUNITY HEALTH ORGANIZATIONS

Sec. 401. Promotion of provision of insurance by community health organizations.

(c) CONSTITUTIONAL AUTHORITY TO ENACT THIS LEGISLATION.—The constitutional authority upon which this Act rests is the power of Congress to regulate commerce with foreign nations and among the several States, set forth in article I, section 8 of the United States Constitution.

SEC. 2. PURPOSES.

The purposes of this Act are—

(1) to make it possible for individuals, employees, and the self-employed to purchase and own their own health insurance without suffering any negative tax consequences;

(2) to assist individuals in obtaining and in paying for basic health care services;

(3) to render patients and deliverers sensitive to the cost of health care, giving them both the incentive and the ability to restrain undesired increases in health care costs;

(4) to foster the development of numerous, varied, and innovative systems of providing health care which will compete against each other in terms of price, service, and quality, and thus allow the American people to benefit from competitive forces which will reward efficient and effective deliverers and eliminate those which provide unsatisfactory quality of care or are inefficient; and

(5) to encourage the development of systems of delivering health care which are capable of supplying a broad range of health care services in a comprehensive and systematic manner.

SEC. 3. FINDINGS RELATING TO HEALTH CARE CHOICE.

(a) Congress finds that the majority of Americans are receiving health care of a quality unmatched elsewhere in the world but that 43 million Americans remain without private health insurance. Congress further finds that small business faces significant challenges in the purchase of health insurance, including higher costs and lack of choice of coverage. Congress further finds that such challenges lead to fewer Americans who are able to take advantage of private health insurance, leading to higher cost and lower quality care.

(b) Congress finds that reduction of the number of uninsured Americans is an important public policy goal. Congress further finds that the use of alternative pooling mechanisms such as Association Health Plans, HealthMarts and other innovative means could provide significant opportunities for small business and individuals to purchase health insurance. Congress further finds that the use of such mechanisms could provide significant opportunities to expand private health coverage for individuals who are employees of small business, self-employed, or do not work for employers who provide health insurance.

(c) Congress finds that the current Tax Code provides significant incentives for employers to provide health insurance coverage for their employees by providing a deduction for the employer for the cost of health insurance coverage and an exclusion from income for the employee for employer-provided health care. Congress further finds that some individuals may prefer to decline coverage under their employer's group health plan and obtain individual health insurance coverage, and some employers may wish to give employees the opportunity to do so. Congress further finds that the Internal Revenue Service has ruled that this tax treatment for the employer and employee for employer-provided health care applies even if the employer pays for individual health insurance polices for its employees. Therefore, the Tax Code makes it possible for employers to provide employees choice among health insurance coverage while retaining favorable tax treatment. Congress further finds that the present-law exclusion for employer-provided health care, together with the tax provisions in the bill, will provide more equitable tax treatment for health insurance expenses, encourage uninsured individuals to purchase insurance, expand health care options, and encourage individuals to better manage their health care needs and expenses.

(d) Congress finds that continually increasing and complex government regulation of the health care delivery system has proven ineffective in restraining costs and is itself expensive and counterproductive in fulfilling its purposes and detrimental to the care of patients.

TITLE I—TAX-RELATED HEALTH CARE PROVISIONS

SEC. 101. DEDUCTION FOR HEALTH AND LONG-TERM CARE INSURANCE COSTS OF INDIVIDUALS NOT PARTICIPATING IN EMPLOYER-SUBSIDIZED HEALTH PLANS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 222 as section 223 and by inserting after section 221 the following new section:

''SEC. 222. HEALTH AND LONG-TERM CARE INSURANCE COSTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage shall be determined in accordance with the following table:

''For taxable years beginning in calendar year—	The applicable percentage is—
2002, 2003, and 2004	25
2005	35
2006	65
2007 and thereafter	100.

''(c) LIMITATION BASED ON OTHER COVERAGE.—

''(1) COVERAGE UNDER CERTAIN SUBSIDIZED EMPLOYER PLANS.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer if 50 percent or more of the cost of coverage under such plan (determined under section 4980B and without regard to payments made with respect to any coverage described in subsection (e)) is paid or incurred by the employer.

''(B) EMPLOYER CONTRIBUTIONS TO CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND MEDICAL SAVINGS ACCOUNTS.—Employer contributions to a cafeteria plan, a flexible spending or similar arrangement, or a medical savings account which are excluded from gross income under section 106 shall be treated for purposes of subparagraph (A) as paid by the employer.

''(C) AGGREGATION OF PLANS OF EMPLOYER.—A health plan which is not otherwise described in subparagraph (A) shall be treated as described in such subparagraph if such plan would be so described if all health plans of persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 were treated as one health plan.

''(D) SEPARATE APPLICATION TO HEALTH INSURANCE AND LONG-TERM CARE INSURANCE.—Subparagraphs (A) and (C) shall be applied separately with respect to—

''(i) plans which include primarily coverage for qualified long-term care services or are qualified long-term care insurance contracts, and

''(ii) plans which do not include such coverage and are not such contracts.

''(2) COVERAGE UNDER CERTAIN FEDERAL PROGRAMS.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any amount paid for any coverage for an individual for any calendar month if, as of the first day of such month, the individual is covered under any medical care program described in—

''(i) title XVIII, XIX, or XXI of the Social Security Act,

''(ii) chapter 55 of title 10, United States Code,

''(iii) chapter 17 of title 38, United States Code,

''(iv) chapter 89 of title 5, United States Code, or

''(v) the Indian Health Care Improvement Act.

''(B) EXCEPTIONS.—

''(i) QUALIFIED LONG-TERM CARE.—Subparagraph (A) shall not apply to amounts paid for coverage under a qualified long-term care insurance contract.

''(ii) CONTINUATION COVERAGE OF FEHBP.—Subparagraph (A)(iv) shall not apply to coverage which is comparable to continuation coverage under section 4980B.

''(d) LONG-TERM CARE DEDUCTION LIMITED TO QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—In the case of a qualified long-term care insurance contract, only eligible long-term care premiums (as defined in section 213(d)(10)) may be taken into account under subsection (a).

''(e) DEDUCTION NOT AVAILABLE FOR PAYMENT OF ANCILLARY COVERAGE PREMIUMS.—Any amount paid as a premium for insurance which provides for—

''(1) coverage for accidents, disability, dental care, vision care, or a specified illness, or

''(2) making payments of a fixed amount per day (or other period) by reason of being hospitalized,

shall not be taken into account under subsection (a).

''(f) SPECIAL RULES.—

''(1) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—The amount taken into account by the taxpayer in computing the deduction under section 162(l) shall not be taken into account under this section.

''(2) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount taken into account by the taxpayer in computing the deduction under this section shall not be taken into account under section 213.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this section, including regulations requiring employers to report to their employees and the Secretary such information as the Secretary determines to be appropriate.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new item:

''(18) HEALTH AND LONG-TERM CARE INSURANCE COSTS.—The deduction allowed by section 222.''.

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 222. Health and long-term care insurance costs.

''Sec. 223. Cross reference.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 102. DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.''.

(b) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of such Code is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer (other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

SEC. 103. 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 AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 220(c)(1)(A) of such Code (relating to eligible individual) is amended to read as follows:

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(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 individual'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'' in clause (i) and inserting ''$1,000'', and

(B) by striking ''$3,000'' in clause (ii) and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended to read as follows:

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 1997' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) SPECIAL RULES.—In the case of the $1,000 amount in subsection (c)(2)(A)(i) and the $2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting 'calendar year 1999' for 'calendar year 1997'.

''(3) ROUNDING.—If any increase under paragraph (1) or (2) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

(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) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

SEC. 104. LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) CAFETERIA PLANS.—

(1) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end ''; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(b) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by striking subsection (c).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 105. ADDITIONAL PERSONAL EXEMPTION FOR TAXPAYER CARING FOR ELDERLY FAMILY MEMBER IN TAXPAYER'S HOME.

(a) IN GENERAL.—Section 151 of the Internal Revenue Code of 1986 (relating to allowance of deductions for personal exemptions) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) ADDITIONAL EXEMPTION FOR CERTAIN ELDERLY FAMILY MEMBERS RESIDING WITH TAXPAYER.—

''(1) IN GENERAL.—An exemption of the exemption amount for each qualified family member of the taxpayer.

''(2) QUALIFIED FAMILY MEMBER.—For purposes of this subsection, the term 'qualified family member' means, with respect to any taxable year, any individual—

''(A) who is an ancestor of the taxpayer or of the taxpayer's spouse or who is the spouse of any such ancestor,

''(B) who is a member for the entire taxable year of a household maintained by the taxpayer, and

''(C) who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in paragraph (3) for a period—

''(i) which is at least 180 consecutive days, and

''(ii) a portion of which occurs within the taxable year.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the 39½ month period ending on such due date (or such other period as the Secretary prescribes) a physician (as so defined) has certified that such individual meets such requirements.

''(3) INDIVIDUALS WITH LONG-TERM CARE NEEDS.—An individual is described in this paragraph if the individual—

''(A) is unable to perform (without substantial assistance from another individual) at least two activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

''(B) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least one activity of daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

''(4) SPECIAL RULES.—Rules similar to the rules of paragraphs (1), (2), (3), (4), and (5) of section 21(e) shall apply for purposes of this subsection.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

SEC. 106. EXPANDED HUMAN CLINICAL TRIALS QUALIFYING FOR ORPHAN DRUG CREDIT.

(a) IN GENERAL.—Subclause (I) of section 45C(b)(2)(A)(ii) of the Internal Revenue Code of 1986 is amended to read as follows:

''(I) after the date that the application is filed for designation under such section 526, and''.

(b) CONFORMING AMENDMENT.—Clause (i) of section 45C(b)(2)(A) of such Code is amended by inserting ''which is'' before ''being'' and by inserting before the comma at the end ''and which is designated under section 526 of such Act''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after December 31, 2000.

SEC. 107. INCLUSION OF CERTAIN VACCINES AGAINST STREPTOCOCCUS PNEUMONIAE TO LIST OF TAXABLE VACCINES; REDUCTION IN PER DOSE TAX RATE.

(a) INCLUSION OF VACCINES.—

(1) IN GENERAL.—Section 4132(a)(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

''(L) Any conjugate vaccine against streptococcus pneumoniae.''.

(2) EFFECTIVE DATE.—

(A) SALES.—The amendment made by this subsection shall apply to vaccine sales beginning on the day after the date on which the Centers for Disease Control makes a final recommendation for routine administration to children of any conjugate vaccine against streptococcus pneumoniae, but shall not take effect if subsection (c) does not take effect.

(B) DELIVERIES.—For purposes of subparagraph (A), in the case of sales on or before the date described in such subparagraph for which delivery is made after such date, the delivery date shall be considered the sale date.

(b) REDUCTION IN PER DOSE TAX RATE.—

(1) IN GENERAL.—Section 4131(b)(1) of such Code (relating to amount of tax) is amended by striking ''75 cents'' and inserting ''50 cents''.

(2) EFFECTIVE DATE.—

(A) SALES.—The amendment made by this subsection shall apply to vaccine sales after December 31, 2004, but shall not take effect if subsection (c) does not take effect.

(B) DELIVERIES.—For purposes of subparagraph (A), in the case of sales on or before the date described in such subparagraph for which delivery is made after such date, the delivery date shall be considered the sale date.

(3) LIMITATION ON CERTAIN CREDITS OR REFUNDS.—For purposes of applying section 4132(b) of the Internal Revenue Code of 1986 with respect to any claim for credit or refund filed after August 31, 2004, the amount of tax taken into account shall not exceed the tax computed under the rate in effect on January 1, 2005.

(c) VACCINE TAX AND TRUST FUND AMENDMENTS.—

(1) Sections 1503 and 1504 of the Vaccine Injury Compensation Program Modification Act (and the amendments made by such sections) are hereby repealed.

(2) Subparagraph (A) of section 9510(c)(1) of such Code is amended by striking ''August 5, 1997'' and inserting ''October 21, 1998''.

(3) The amendments made by this subsection shall take effect as if included in the provisions of the Tax and Trade Relief Extension Act of 1998 to which they relate.

(d) REPORT.—Not later than December 31, 1999, the Comptroller General of the United States shall prepare and submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the operation of the Vaccine Injury Compensation Trust Fund and on the adequacy of such Fund to meet future claims made under the Vaccine Injury Compensation Program.

SEC. 108. CREDIT FOR CLINICAL TESTING RESEARCH EXPENSES ATTRIBUTABLE TO CERTAIN QUALIFIED ACADEMIC INSTITUTIONS INCLUDING TEACHING HOSPITALS.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by inserting after section 41 the following:

''SEC. 41A. CREDIT FOR MEDICAL INNOVATION EXPENSES.

''(a) GENERAL RULE.—For purposes of section 38, the medical innovation credit determined under this section for the taxable year shall be an amount equal to 40 percent of the excess (if any) of—

''(1) the qualified medical innovation expenses for the taxable year, over

''(2) the medical innovation base period amount.

''(b) QUALIFIED MEDICAL INNOVATION EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified medical innovation expenses' means the amounts which are paid or incurred by the taxpayer during the taxable year directly or indirectly to any qualified academic institution for clinical testing research activities.

''(2) CLINICAL TESTING RESEARCH ACTIVITIES.—

''(A) IN GENERAL.—The term 'clinical testing research activities' means human clinical testing conducted at any qualified academic institution in the development of any product, which occurs before—

''(i) the date on which an application with respect to such product is approved under section 505(b), 506, or 507 of the Federal Food, Drug, and Cosmetic Act (as in effect on the date of the enactment of this section),

''(ii) the date on which a license for such product is issued under section 351 of the Public Health Service Act (as so in effect), or

''(iii) the date classification or approval of such product which is a device intended for human use is given under section 513, 514, or 515 of the Federal Food, Drug, and Cosmetic Act (as so in effect).

''(B) PRODUCT.—The term 'product' means any drug, biologic, or medical device.

''(3) QUALIFIED ACADEMIC INSTITUTION.—The term 'qualified academic institution' means any of the following institutions:

''(A) EDUCATIONAL INSTITUTION.—A qualified organization described in section 170(b)(1)(A)(iii) which is owned by, or affiliated with, an institution of higher education (as defined in section 3304(f)).

''(B) TEACHING HOSPITAL.—A teaching hospital which—

''(i) is publicly supported or owned by an organization described in section 501(c)(3), and

''(ii) is affiliated with an organization meeting the requirements of subparagraph (A).

''(C) FOUNDATION.—A medical research organization described in section 501(c)(3) (other than a private foundation) which is affiliated with, or owned by—

''(i) an organization meeting the requirements of subparagraph (A), or

''(ii) a teaching hospital meeting the requirements of subparagraph (B).

''(D) CHARITABLE RESEARCH HOSPITAL.—A hospital that is designated as a cancer center by the National Cancer Institute.

''(4) EXCLUSION FOR AMOUNTS FUNDED BY GRANTS, ETC.—The term 'qualified medical innovation expenses' shall not include any amount to the extent such amount is funded by any grant, contract, or otherwise by another person (or any governmental entity).

''(c) MEDICAL INNOVATION BASE PERIOD AMOUNT.—For purposes of this section, the term 'medical innovation base period amount' means the average annual qualified medical innovation expenses paid by the taxpayer during the 3-taxable year period ending with the taxable year immediately preceding the first taxable year of the taxpayer beginning after December 31, 2000.

''(d) SPECIAL RULES.—

''(1) LIMITATION ON FOREIGN TESTING.—No credit shall be allowed under this section with respect to any clinical testing research activities conducted outside the United States.

''(2) CERTAIN RULES MADE APPLICABLE.—Rules similar to the rules of subsections (f) and (g) of section 41 shall apply for purposes of this section.

''(3) ELECTION.—This section shall apply to any taxpayer for any taxable year only if such taxpayer elects to have this section apply for such taxable year.

''(4) COORDINATION WITH CREDIT FOR INCREASING RESEARCH EXPENDITURES AND WITH CREDIT FOR CLINICAL TESTING EXPENSES FOR CERTAIN DRUGS FOR RARE DISEASES.—Any qualified medical innovation expense for a taxable year to which an election under this section applies shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—

(1) IN GENERAL.—Section 38(b) of such Code (relating to current year business credits) is amended by striking ''plus'' at the end of paragraph (11), by striking the period at the end of paragraph (12) and inserting '', plus'', and by adding at the end the following:

''(13) the medical innovation expenses credit determined under section 41A(a).''.

(2) TRANSITION RULE.—Section 39(d) of such Code is amended by adding at the end the following new paragraph:

''(9) NO CARRYBACK OF SECTION 41A CREDIT BEFORE ENACTMENT.—No portion of the unused business credit for any taxable year which is attributable to the medical innovation credit determined under section 41A may be carried back to a taxable year beginning before January 1, 2001.''.

(c) DENIAL OF DOUBLE BENEFIT.—Section 280C of such Code is amended by adding at the end the following new subsection:

''(d) CREDIT FOR INCREASING MEDICAL INNOVATION EXPENSES.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified medical innovation expenses (as defined in section 41A(b)) otherwise allowable as a deduction for the taxable year which is equal to the amount of the credit determined for such taxable year under section 41A(a).

''(2) CERTAIN RULES TO APPLY.—Rules similar to the rules of paragraphs (2), (3), and (4) of subsection (c) shall apply for purposes of this subsection.''.

(d) DEDUCTION FOR UNUSED PORTION OF CREDIT.—Section 196(c) of such Code (defining qualified business credits) is amended by redesignating paragraphs (5) through (8) as paragraphs (6) through (9), respectively, and by inserting after paragraph (4) the following new paragraph:

''(5) the medical innovation expenses credit determined under section 41A(a) (other than such credit determined under the rules of section 280C(d)(2)),''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding after the item relating to section 41 the following:

''Sec. 41A. Credit for medical innovation expenses.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

TITLE II—GREATER ACCESS AND CHOICE THROUGH ASSOCIATION HEALTH PLANS

SEC. 201. RULES.

(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 bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide 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), (2), and (3) 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, through negotiated rulemaking, 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), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such 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, through negotiated rulemaking, for continued certification of association health plans under this part.

''(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).

''(f) CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

''(1) a plan which offered such coverage on the date of the enactment of the Quality Care for the Uninsured Act of 1999,

''(2) a plan 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

''(3) a plan 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 plan in accordance with regulations which the Secretary shall prescribe through negotiated rulemaking, 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.

''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 the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

''(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 subparagraphs (B) and (C), 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) CERTAIN PLANS EXCLUDED.—Subparagraph (A) shall not apply to an association health plan which is in existence on the date of the enactment of the Quality Care for the Uninsured Act of 1999.

''(D) SOLE AUTHORITY.—The board has sole authority under the plan 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.

The Secretary may by regulation, through negotiated rulemaking, define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

''(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) each participating employer must be—

''(A) a member of the sponsor,

''(B) the sponsor, or

''(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

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 such an 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.—In the case of an association health plan in existence on the date of the enactment of the Quality Care for the Uninsured Act of 1999, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

''(2) 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.

''(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, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

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

''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 with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

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 determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation through negotiated rulemaking.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), 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, through negotiated rulemaking, 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 $175,000). The applicable authority may by regulation, through negotiated rulemaking, 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.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

''(1) $500,000, or

''(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority through negotiated rulemaking, 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, through negotiated rulemaking, 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, except that the Secretary shall reduce part or all of such annual payments, or shall provide a rebate of part or all of such a payment, to the extent that the Secretary determines that the balance in such Fund is sufficient (taking into account such a reduction or rebate) to meet all reasonable actuarial requirements. Such determination shall occur not less than once annually. In addition to any such annual payments, such payments may include such supplemental payments as the Secretary may determine to be necessary to meet reasonable actuarial requirements to carry out 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 the applicable authority may prescribe by regulation through negotiated rulemaking) 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 the applicable authority may prescribe by regulation through negotiated rulemaking) 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 the applicable authority may prescribe through negotiated rulemaking) 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 the applicable authority may prescribe by regulation through negotiated rulemaking); 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 the applicable authority may prescribe through negotiated rulemaking.

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Quality Care for the Uninsured Act of 1999, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

''(2) MEMBERSHIP.—The Working Group shall consist of 18 members appointed by the applicable authority as follows:

''(A) 3 representatives of the National Association of Insurance Commissioners;

''(B) 3 representatives of the American Academy of Actuaries;

''(C) 3 representatives of the State governments, or their interests;

''(D) 3 representatives of existing self-insured arrangements, or their interests;

''(E) 3 representatives of associations of the type referred to in section 801(b)(1), or their interests; and

''(F) 3 representatives 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 which shall be prescribed by the applicable authority through negotiated rulemaking, 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 through negotiated rulemaking.

''(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 as may be determined by the applicable authority, by regulation through negotiated rulemaking, 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 by the applicable authority by regulation through negotiated rulemaking. The applicable authority may require by regulation, through negotiated rulemaking, 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). The applicable authority may require by regulation through negotiated rulemaking such interim reports as it considers appropriate.

''(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 by the applicable authority by regulation through negotiated rulemaking.

''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 through negotiated rulemaking) 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 shall be defined by the Secretary by regulation through negotiated rulemaking, 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 prescribed by the Secretary through negotiated rulemaking, 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 by the Secretary by regulation through negotiated rulemaking or required 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 which shall be prescribed by the Secretary through negotiated rulemaking, 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 Quality Care for the Uninsured Act of 1999.

''(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 is 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 806(j), 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 through negotiated rulemaking.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

''(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

''(C) in the case of an association health plan in existence on the date of the enactment of the Quality Care for the Uninsured Act of 1999, a person eligible to be a member of the sponsor or one of its member associations.

''(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 Quality Care for the Uninsured Act of 1999 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) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2004, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) 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. 202. 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 one 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. 203. 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 any 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 prescribed by the Secretary through negotiated rulemaking), 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 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 Quality Care for the Uninsured Act of 1999 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 by the Secretary through negotiated rulemaking 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 Quality Care for the Uninsured Act of 1999; or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) 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. 204. ENFORCEMENT PROVISIONS.

(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 willfully 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 5 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. 205. 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. 206. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 201, 204, and 205 shall take effect on January 1, 2001. The amendments made by sections 202 and 203 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 title before January 1, 2001. Such regulations shall be issued through negotiated rulemaking.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 201) 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 the date of the enactment of this Act, 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; and

(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) PROMOTING USE OF CERTAIN ADDITIONAL ASSOCIATIONS IN PROVIDING INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2742(b)(5) of the Public Health Service Act (42 U.S.C. 300gg–42(b)(5)) is amended—

(1) by striking ''paragraph'' and inserting ''subparagraph'';

(2) by inserting ''(A)'' after ''.—''; and

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

''(B)(i) In the case of health insurance coverage that is made available in the individual market only through one or more associations described in clause (ii), the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subparagraph uniformly without regard to any health status-related factor of covered individuals and only if the individual is entitled, upon application and without furnishing evidence of insurability, to health insurance conversion coverage that meets and is subject to all the rules and regulations of the State in which application is made.

''(ii) An association described in this clause is an organization that meets the requirements for a bona fide organization described in subparagraphs (A), (B), (C), (E) and (F) of section 2791(d)(3) and, except in the case of an association that enrolls individual members who each pay their own individual membership dues, which provides that all members and dependents of members are eligible for coverage offered through the association regardless of any health status-related factor.''.

TITLE III—GREATER ACCESS AND CHOICE THROUGH HEALTHMARTS

SEC. 301. 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 a 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.

TITLE IV—COMMUNITY HEALTH ORGANIZATIONS

SEC. 401. 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. 330D. (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, 2005; 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, 2004, 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, 2005.

''(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, 2000.

''(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.''.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Pursuant to House Resolution 323, the gentleman from Virginia (Mr. BLILEY), the gentleman from Michigan (Mr. DINGELL), the gentleman from Pennsylvania (Mr. GOODLING), the gentleman from Missouri (Mr. CLAY), the gentleman from Texas (Mr. ARCHER), and the gentleman from New York (Mr. RANGEL) each will control 20 minutes.

The Chair recognizes the gentleman from Virginia (Mr. Bliley).

GENERAL LEAVE

Mr. BLILEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on this bill and all bills considered pursuant to this resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

Mr. BLILEY. Mr. Speaker, I yield myself 5 minutes.

Mr. Speaker, I rise today to support H.R. 2990, the Quality Care for the Uninsured Act. I appreciate the hard work of my colleagues, the gentleman from Missouri (Mr. TALENT) and the gentleman from Arizona (Mr. SHADEGG) on this bill. I urge all of my colleagues to support this important measure.

This bill will have a greater impact on Americans struggling to access basic health coverage than anything else we do here this week. That is because this bill is designed to address the real crisis in health care in this country, the crisis of the rising numbers of uninsured.

The problem is bad and it is getting worse. The headline in the Washington Post this past Monday highlighted the true health care crisis in America today, ''one million more in the U.S. lacked health care coverage in study of 1998.'' This is at a time when we are virtually at full employment.

The Census Bureau tells us the number of uninsured increased to over 44 million in 1998, as this chart here demonstrates. Over the last decade, we have had a long period of economic growth. Household incomes are up and everyone is trading stocks, but as this chart shows the number of uninsured grow every year.

Who are the uninsured? The majority of the 44 million uninsured come from

hard-working families. My committee held a hearing back in June to look at the problems with access to health coverage. We heard compelling testimony from Mary Horsley, a wife and mother from Cape Charles, Virginia. The Horsley family is uninsured. Mrs. Horsley told the committee about her family's struggles with illness. They cannot afford health insurance because they make too much money to qualify for Medicaid but not enough to buy insurance that will cover her husband's preexisting medical condition.

Like millions of other Americans, the Horsleys are in what I like to call the coverage gap. This chart shows us that low income workers tend to fall in this coverage gap.

Now, there are two ways this gap can be filled. One can try and fill it by expanding public programs like medicaid. Historically, this is how we have tried to address the problems of the lower-income uninsured. Using this approach, however, places millions of people in a one-size-fits-all, big government program.

There is a better way, however. We can begin to address this problem by making sure low-income workers, who do not want to go on Medicaid, have access to private health coverage like a majority of Americans have today.

This is what H.R. 2990 will do. It will expand access to private health insurance by providing tax incentives and regulatory relief.

A key feature of this bill, which I am proud to have offered, is the proposal to create HealthMarts. HealthMarts are private, voluntary health care supermarkets; employers who elect to join a HealthMart. But just like in our own health plan, the Federal Employee Health Benefit Plan, FEHBP, individual employees would make the choice of coverage from the options available in the HealthMart, not the employer.

These charts show us how HealthMarts would provide employees with new coverage options.

How can HealthMarts help the uninsured? First it would help with costs. The General Accounting Office tells us that in my home State alone, Virginia, mandated benefit laws account for 12 percent of premium costs. HealthMarts would be free to offer plans that did not include these costly mandates. Further, cost savings would be achieved by competition in the HealthMart, because the consumer can choose the plan he wants or she wants and is able to switch plans on an annual basis.

Insurers would compete for this business. This competition is surely lacking in health coverage today. There is one system where this type of choice in competition is alive and well, and it is our plan, the Federal Employee Health Benefit Plan. My colleagues and I enjoy a great treasure in our Federal health program. We have multiple plans to choose from. We are all pooled together to spread the cost of caring for the sick with the healthy and, most important, once a year we all get the chance to fire our health plan if we do not like it and hire a new one.

This choice drives quality in the health care system. This choice drives affordability in the health care system. This is a choice all Americans should have. Giving consumers the freedom to make the choice is why we are here today. We will never get to the root of the problems faced by the uninsured or the dissatisfaction some have with their current coverage until we create a true marketplace for health care.

Today, patients lack real control. They are riding shotgun in a system driven by employers and insurance companies. H.R. 2990 seeks to change this by putting patients in the driver's seat where they belong. The answers to the problems we are trying to address today do not lie in more costly mandates on health insurers.

Mr. DINGELL. Mr. Speaker, I yield myself 5 minutes.

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

Mr. DINGELL. Mr. Speaker, let us put this in the simplest terms. Health care is paid for with insurance premiums and deductibles. The payments buy a promise that health care is there when it is needed.

Is that true? Probably not. When one has a problem, one visits their doctor. Someone might have a numb feeling in their leg or a lesion or migraine headaches. The doctor examines them and decides they need a procedure or medication or a diagnostic test.

So what happens? The doctor talks to the administrative office in the HMO. They check with the insurance company. The insurance bureaucrat at the other end of the 800 telephone number says, no, we cannot pay for that procedure or treatment or medication. So the doctor gets on the phone, argues with the bureaucrat. The HMO still says no.

What does one do then? That is when Norwood-Dingell comes in. We give a person the right to see a qualified specialist. We give a person the ability to get into a clinical trial. We say women and children can see obstetricians and pediatricians or cancer specialists are available to cancer patients. We say a person can go to the nearest emergency room without prior approval or extra charges, and we give a person a fair chance to appeal an unfair or biased decision to get the treatment that is needed.

□ 1415

In short, Norwood-Dingell makes the health insurance work.

We are going to hear a lot about lawyers and employers, but let us keep a few things in mind.

If a doctor makes a wrong medical decision, that doctor can be and is held accountable. In a word, he can be sued. But if an insurance company makes a medical decision by denying someone treatment, that denial causes injury or death, the insurance company gets off scot free. Only the insurance companies and foreign diplomats escape liability. They are the only ones who get a complete shelter against wrongdoing.

A lot of people want us to believe that this debate is all about lawsuits, but that fails the simple test of common sense. When someone is sick, do they want to go to court? Do they want to see a lawyer? Do they want to have litigation? Of course not. What they want to do is to see a doctor, not a judge; and they want to get their pain and their suffering alleviated.

We are going to hear a lot of talk about helping the uninsured today. My good friend and colleague, the gentleman from Virginia (Mr. BLILEY) who I dearly love, spent a lot of time on it; but we could have written bipartisan legislation to help the uninsured. No effort in that direction was made, and that is not the bill on which we will vote today. This bill and the question before this body is about giving people health insurance. The bill that we have before us at this moment is simply about giving Members of Congress political insurance against those who know they are not being properly treated by HMOs.

Let us look at the facts. Who are the 46 million Americans without health insurance? Well, here they are. Half of them work in low-wage jobs. Many of them are people moving from welfare to work who are no longer covered by Medicaid. One-quarter of the uninsured are children. According to the General Accounting Office one-third of the uninsured pay no income taxes whatsoever. Many others pay far less than will do them any good on a tax credit. What we have to talk about here is getting the money to the people who have the need. What is needed here is a tax credit which is refundable in character. That is not before this body at this time, and the practical result of that is then that the uninsured are not going to be benefited.

The bill that we have before us is a bill which helps the wealthy and which helps the healthy.

Now let us talk about the people who are uninsured. The health insurance industry pointed out three factors that are pricing employers out of the market: modern medical technologies, rising cost of prescription medication, and longer lives for old people who need more care. This bill does nothing, nothing about any of those questions.

If this is to be a serious exercise in helping the uninsured, and I have many friends on the other side of the aisle who are sincere in that, we could have found a common ground. We have legislation around here which will really cover every American, and I think that is the way in which we should proceed. This bill does nothing except help the insurance companies and to help the well to do and to help the healthy. It creates a long downward spiral of adverse selection which is going to reduce

the number of people who are really eligible to get insurance coverage and which is going to raise the costs by leaving those people who have the least ability to pay dependent upon those services.

It is interesting to note that only one of the bills we are going to consider in this cycle of legislation was written before yesterday. Only one has been examined in broad daylight. Only one is bipartisan and has a chance of being signed into law. Only one has been endorsed by more than 300 organizations representing doctors, teachers, consumers, union members, specialists, women, doctors, and others. Only one has a chance of making life easier for the people who desperately have need.

That is Norwood-Dingell, and I would commend my colleagues to the fact that if they really want to do something about people, do not mess around with this nonsensical piece of legislation. Vote for Norwood-Dingell to get what we want.

What is this debate about today?

Let me put it in the simplest terms.

You pay for your health care with insurance premiums and deductibles. Those payments buy a promise that you can get health care when you need it.

When you think you have a problem, you visit your doctor.

You might have a numb feeling in your arm or leg, or a lesion, or migraine headaches. Your doctor examines you, and decides you need a procedure, or medication, or a diagnostic test.

So your doctor talks to the administrative staff in the office, and they check with your insurance company. The insurance bureaucrat at the other end of the 800 telephone number says, no, we won't pay for that procedure or treatment or medication. So the doctor gets on the phone and argues with the bureaucrat, and still they say no.

So what do you do then? That's what the Norwood-Dingell bill is about. We give you the right to see a qualified specialist. We give you the ability to get into a clinical trial. We say women and children can see obstetricians and pediatricians, or cancer patients oncologists. We say you can go to the nearest emergency room without prior approval or extra charges. And we give you a fair chance to appeal the decision and get the treatment you need.

In short, we make your insurance work.

We're going to hear a lot of talk about lawyers and employers in the next two days. But keep a few things in mind.

If a doctor makes the wrong medical decision, a doctor can be—and is—held accountable, the doctor can be sued—

But if an insurance company makes a medical decision by denying you treatment, and that denial causes injury or death, the insurance company gets off free. Only insurance companies and HMO's get this protection against accountability for their wrong doing.

A lot of people want you to believe this debate is all about lawsuits. But that claim fails the simple test of common sense. If you're sick, do you want to go to court—or do you want to get better? When you need treatment for an illness, do you want to see a doctor or a judge?

We're also going to hear a lot of talk about helping the uninsured today.

We could have written bipartisan legislation to help the uninsured. But that's not the bill we'll consider and vote on today. That bill isn't about giving people health insurance. That bill is designed to give Members of Congress political insurance.

Let's look at the facts. Who are the 46 million Americans without health insurance?

Half of them work in low wage jobs. Many of them are people moving from welfare to work who are no longer covered by Medicaid.

One quarter of the uninsured are children. According to the General Accounting Office, one third of the uninsured pay no income taxes. Are people who neither pay nor file taxes really going to be helped by tax deductions?

Why are these people uninsured? A spokesman for the health insurance industry pointed to three factors that are pricing employers out of the market: new medical technologies, the rising cost of prescription medication, and longer lives for older people who need more care.

The access bill H.R. 2990 does nothing to address any of those issues.

If this were a serious exercise in helping the uninsured—and I have many friends on the other side of the aisle who are sincere in that desire—we could have found common ground. We could have put together a package to help children, small businesses, and the self-employed. We could have targeted those at lower income levels, instead of showering tax deductions on the wealthy.

We could have, but we didn't. Instead we have before us a bill that helps the healthy and wealthy. It actually reduces existing consumer protections for those who today have insurance. And it dynamites an almost $50 billion hole in the deficit.

Only one of the bills we'll consider in the next two days was written before yesterday. Only one has been examined in broad daylight. Only one is bipartisan and has a chance of being signed into law. Only one has been endorsed by more than 300 organizations representing doctors, teachers, consumers, union members, specialists, women, and others. Only one has a chance of making life a little easier for the people who buy health insurance in the hope that it will pay for care when it's needed.

That bill is the one offered by my friends Mr. NORWOOD, Mr. GANSKE, Mr. BERRY, and myself. Support that bill, and reject all other bills and substitutes.

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent to control the remainder of the time in place of the gentleman from Virginia (Mr. BLILEY).

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Is there objection to the request of the gentleman from Florida?

There was no objection.

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

Mr. Speaker, I rise in support of the Quality Care for the Uninsured Act. This bill is designed to increase access to care for millions of Americans who currently lack health coverage. It includes a proposal that I crafted to expand the ability of community health centers to provide quality care to individuals in need. Community health centers are not-for-profit health care providers. By law they are established in America's medically underserved areas and must make their sources accessible to everyone regardless of individuals' ability to pay.

H.R. 2990 would expand the ability of community health centers to private affordable health care services to individuals who lack health coverage. It would authorize community health organizations to form networks of providers, to increase access to care and medically underserved areas. These networks will expand health options in communities that currently lack the necessary infrastructure to fully support the comprehensive delivery of health care services.

Specifically, Mr. Speaker, the bill will authorize a waiver of State financial requirements that may prevent managed care organizations controlled by community health centers from fully participating in the private health care market. By allowing the establishment of alternative Federal solvency standards for community health organizations, this proposal recognizes the unique circumstances facing community health centers and the communities that they serve. Community health organizations will help expand the patient base of health centers while providing a cost-effective coverage option for the small employers. These networks will be operated by local providers whose primary mission is to meet the health care needs of the communities they serve. These networks will enhance competition among commercial managed care plans because they will deliver care that is responsive to local needs. Competition will drive quality up while driving costs down.

Mr. Speaker, I was proud to cosponsor H.R. 2990, and I strongly urge Members to support its passage. The Census Bureau has underscored the urgent need for this legislation by announcing that the number of uninsured Americans rose to over 44 million last year. This legislation builds on the efforts of previous Congresses to expand health care to the uninsured.

During the 103rd Congress I joined then Congressman Roy Rowland in leading a bipartisan coalition in support of consensus health reforms. Our targeted plan included significant measures to expand health care access to the uninsured. Among its key provisions, our plan would expand the role of community centers in providing access to care in medically underserved areas. We also proposed insurance reforms to help individuals with preexisting conditions obtain coverage and to help workers keep their insurance when they changed jobs. These insurance provisions were ultimately, I underline ultimately, enacted into law during the 104th Congress, but those individuals had to wait 2 years for assistance.

Mr. Speaker, we should not repeat that mistake today. H.R. 2990 represents an important opportunity to

expand coverage to the uninsured. It is not perfect, it can go further, it can consider some of the items that the gentleman from Michigan (Mr. DINGELL) mentioned; but it would be an important opportunity to at least expand coverage, make available coverage to the uninsured. We should not make 44 million Americans wait any longer for access to the health care they need. I challenge those who support patients' rights to put people ahead of politics and join us in supporting passage of this critical measure.

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

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from California (Mr. STARK).

Mr. STARK. Mr. Speaker, I thank the ranking member for yielding this time to me, and I just want to bring to light some new information. The Joint Committee on Taxation has given us some estimates on what this wonderful access bill will do.

It will provide access perhaps to 160,000 families; that is all. At a cost of $48 billion, and try this with your shoes and socks on, that is $300,000 per family or $30,000 a year to give 160,000 families, 320,000 people, coverage. That is all it does. The benefits go to those people who are currently insured, which means the Republicans are squandering $300,000 per family for 160,000 families who are uninsured, and my colleagues want to talk about wasting money? Trust the Republicans to do it.

Mr. Speaker, the Joint Tax Committee has estimated how many people the Access bill would help.

The answer: almost no one.

The tax deduction for individuals paying for more than 50% of the cost of their health insurance will cost $31.2 billion over 10 years and result in 200,000 uninsured people getting insurance.

That's $156,000 per new insured person—$15,600 per year!

The acceleration of the 100% tax deduction for the self-employed will help 120,000 previously uninsured and cost about $3 billion over 4 years.

That's $6,250 per person per year—a cadillac cost for sure!

Just for comparison, an individual policy in the Federal Employee Health Benefit Plan costs about $2,500 to $2,800.

The Republican plan is a massive waste of money.

The Joint Tax's letter follows:

JOINT COMMITTEE ON TAXATION,
Washington, DC, October 6, 1999.

Hon. EDWARD M. KENNEDY,
U.S. Senate, Washington, DC.

DEAR SENATOR KENNEDY: This is in response to your letter of October 4, 1999, requesting revenue estimates and other information concerning several of the health care tax provisions in the conference agreement on H.R. 2488 and two of the health care tax provisions in S. 1344.

The conference agreement on H.R. 2488 contains an above-the-line deduction for health insurance expenses and long-term care insurance expenses for which the taxpayer pays at least 50 percent of the premium. The deduction would be phased in at 25 percent for taxable years beginning in 2002 through 2004, 35 percent for taxable years beginning in 2005, 65 percent for taxable years beginning in 2006, and 100 percent for taxable years beginning in 2007 and thereafter. Taxpayers enrolled in Medicare, Medicaid, Champus, VA, the Indian Health Service, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program would be ineligible for the deduction for health insurance expenses.

The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

For the purpose of preparing revenue estimates for these provisions in H.R. 2488, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2002 about 9.1 million taxpayers would claim the 25-percent deduction for health insurance expenses. About 100,000 of these 9 million taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 200,000 persons would be newly insured as a result of the 25-percent deduction for health insurance expenses.

We estimate that in calendar year 2002 about 4.7 million taxpayers would claim the 25-percent deduction for long-term care insurance expenses, and an additional 300,000 taxpayers would use cafeteria plans to pay their share of premiums for employer-sponsored long-term care insurance. About 80,000 of these 5 million taxpayers would be new purchasers of long-term care insurance.

S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

S. 1344 also contains provisions that would eliminate certain restrictions on the availability of medical savings accounts, remove the limitation on the number of taxpayers that are permitted to have medical savings accounts, reduce the minimum annual deductibles for high-deductible health plans to $1,000 for plans providing single coverage and $2,000 for plans providing family coverage, increase the medical savings account contribution limit to 100 percent of the annual deductible for the associated high-deductible health plan, limit the additional tax on distributions not used for qualified medical expenses, and allow network-based manage care plans to be high-deductible plans. These provisions would be effective for taxable years beginning after December 31, 1999.

For the purpose of preparing revenue estimates for these provisions in S. 1344, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2000, about 3.3 million taxpayers would claim the 100-percent deduction for health insurance expenses of self-employed individuals. About 60,000 of these taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 120,000 persons would be newly insured as a result of the 100-percent deduction for health insurance expenses.

We do not have an estimate of the numbers of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,

LINDY L. PAULL.

Enclosure: Table #99–3 206

ESTIMATED REVENUE EFFECTS OF VARIOUS PROVISIONS RELATING TO HEALTH CARE

[By fiscal years, in millions of dollars]

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000–04	2000–08
Health care provisions in the conference agreement for H.R. 2488:													
1. Provide an above-the-line deduction for health insurance expenses—25% in 2002 through 2004, 95% in 2005, 65% in 2006, and 100% thereafter.	tyba 12/31/01	—	—	−444	−1,379	−1,477	−1,803	−3,137	−5,878	−8,299	−8,848	−3,300	−31,264
2. Provide an above-the-line deduction for long-term care insurance expenses—25% in 2002 through 2004, 35% in 2006, 65% in 2006, and 100% thereafter.	tyba 12/31/01	—	—	−48	−328	−964	−417	−677	−1,315	−2,027	−2,146	−741	−7,324
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1].	tyba 12/31/01	—	—	−104	−151	−171	−190	−202	−204	−215	−247	−426	−1,484
Total of health care provisions in the conference agreement for H.R. 2488.		—	—	−596	−1,858	−2,012	−2,410	−4,016	−7,397	−10,541	−11,241	−4,467	−60,074
Health care provisions in S. 1344, as passed by the Senate:													
1. Immediate 100% deductibility of health insurance and long term care insurance premiums of the self-employed.	tyba 12/31/99	−245	−1,007	−1,040	−657							−2,949	−2,844
2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	−93	−281	−326	−370	−414	−458	−502	−546	−590	−634	−1,483	−4,214
Total of health care provisions in S. 1344, as passed by the Senate.		−338	−1,268	−1,866	−1,027	−414	−458	−502	−546	−590	−634	−4,432	−7,164

Note.—Details may not add to totals due to rounding.

Legend for ''Effective'' column: tyba=taxable years beginning after [1] Estimate assumes concurrent enactment of the above-the-line deducation for long-term care Insurance (item 2.) Source: Joint Committee on Taxation.

Mr. BILIRAKIS. Mr. Speaker, I yield 3 minutes to the gentleman from Tennessee (Mr. BRYANT).

Mr. BRYANT. Mr. Speaker, I thank the gentleman from Florida for yielding me time. I do rise in strong support of this bill this day. So as there will not be any confusion, I want to remind all my colleagues here that later on today and tomorrow we will be debating the bill that provides protection to those people in this country who have insurance; but, Mr. Speaker, today and right now we are talking about those 45 million men, women, and children in this country who do not have any insurance; and, therefore, patient protections that we will be talking about later mean nothing, zero, to those people without health insurance. For those 44 million people, which by the way translates into 1 out of 6 Americans, getting access to quality, affordable health care is the most important and most basic patient protection.

No other bill before this body this week addresses this crisis of the uninsured in this country. This legislation does address the problem, and it does it the right way, by providing access to affordable quality private-sector health care coverage through tax incentives and free market reforms. The Quality Care For the Uninsured Act achieves these in several ways.

First, it would expand access to the medical savings accounts. This legislation would also create two new innovative ways for people to pool together, to come together in groups to obtain more affordable health insurance. The association health plans allow small businesses and people who are self-employed to have that freedom to join together and design more affordable health plans; and the HealthMarts, which is the second one, are private organizations similar in concept to a supermarket where employers, employees, and other individuals can come to purchase health insurance.

The bill would also provide or allow local community providers to form health care networks to meet the special needs of employers and employees in medically underserved areas. These community health center networks would particularly be helpful in rural areas, certainly in areas that I represent and others in this Congress represent.

Last, but not least, this bill provides for 100 percent tax deductible premiums for the self-employed and the uninsured for health care insurance premiums and long-term health care premiums. This will be of tremendous help to the farmers that I represent.

Mr. Speaker, none of these proposals alone will completely solve this problem of underinsured and uninsured, but together they have the potential to expand access to care, opportunity to see a doctor or go to a hospital, this opportunity to a significant number of Americans without busting the budget, without creating new entitlement programs, and without expanding existing government programs.

Mr. Speaker, this legislation is a responsible approach to providing access to care for these 44 million American men, women, and children. I urge all of my colleagues to support it and help these people who have fallen through the cracks and who do not have that opportunity to get affordable good quality health care.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Georgia (Mr. NORWOOD), my good friend and a man of remarkable courage and integrity.

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

Mr. Speaker, I thought, if I could, I would take a few minutes and try to put this debate in perspective. There really are a couple of serious, serious problems in health care in America today; and since that involves each of us, each of our families, it involves each of us, each of our families, and it involves every constituent we have whether one is a Republican or Democrat. It is a very important debate, and I am so pleased that we are going to have this opportunity to stand up and discuss it, but let us try to put this in the box.

We are going to talk about two things. One of those things that must be discussed and will be discussed over the next 2 days is that we have a serious problem with so many Americans without any coverage.

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Both sides, Democrats and Republicans, recognize this is a problem. Both sides say they want to correct it, and I believe that to be the case. I have often said if we thought that was a top priority in the Congress of the United States, you need to stand up and say that is a top priority in the Congress of the United States. We are going to correct that, and we are going to fund that. We are going to take the dollars it takes to make sure that we do not have 43 million uninsured Americans.

The other part of the debate though is equally important. It is about people who actually do have insurance. I had a colleague say to me that health care reform does not do a bit of good if you do not have health care insurance. That is most assuredly true. But health care insurance does not do you a bit of good either if the benefits that the plan has offered you are being denied on a regular basis.

What we have done in this country over the last 30 years is we have turned over the health care industry of this country to the insurance industries, and they are in total charge. We preempted state laws, we are very silent at the Federal level, there is no public policy at all. The insurance industry is very much in charge.

The access bill that is before us is about the 21st century. It is about health care in the future and how we will try to help people have access to the health care. I will be perfectly honest with you, I am on my fourth or fifth bill, I forget. In the 101st Congress we had a bill, H.R. 2400. In the 105th Congress I had a bill named Parker, H.R. 1415. It had 234 cosponsors on it. This year I dropped another health care bill, H.R. 216. And all of this was about your benefits within your plan and who is in charge of health care.

But realizing early on this year that this business of access is equally important, I dropped an access bill in February very clearly stating we need to deal with the problem of 43 million Americans that are uninsured. What I was saying back in February are these are two separate subjects, though they are health care. You must keep these separate, because each solution has a different constituency. Perhaps you can pass both things, but if you blend them together very much, you can kill both things.

Mr. Speaker, let me just wrap this up and simply say we have two subjects. One is access, that is, looking into the future of health care, how we can solve some problems, and it should be debated. We are. It should be voted on, and it will be. It should be paid for though. I think if we ever get there, we will do that too.

But the other part of this is about Bob Schumacher from Macon, Georgia, whose wife is dying, and she has been denied a benefit that is in her plan. If we do not deal with this problem right now, we are going to find that further Americans are complaining about their health care, further Americans are going to be harmed, further Americans are going to be killed.

All I ask you to do is let us have both debates, let us have separate votes on this, and let us try to come to an American vote; not a Republican vote and not a Democratic vote. Let us vote as patients on this. What would you have done if it was your family?

I look forward to the debate, Mr. Speaker, over the next two days, and I am sure that if we are careful about it, the American people will enjoy it.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. GRANGER).

Ms. GRANGER. Mr. Speaker, today I am pleased to stand up and to speak out on behalf of the Quality Care for the Uninsured Act. I believe this is a commonsense solution to an all too common problem of access to health insurance.

As a mother and a small businesswoman, I understand how important health care is to each American and to every employer. The issue of health care is not just about dollars and cents or rules and regulations, or even liability. First and foremost, the issue of health care is about people and their

access to doctors. It is about knowing there is someone to call when your 3 year old wakes up with a fever. It is about knowing there is a doctor who understands the reoccurring ear infection.

Access has to be the number one goal in this entire health care issue. Today there are 44 million Americans without any health care coverage. These people are not concerned about whether they can sue their HMO, they are concerned about whether they can see a doctor. I am proud to say today may be the day we finally listen to the voices of the uninsured. The Quality Care for the Uninsured Act addresses access with HealthMarts and Association Health Plans, and also full 100 percent deductibility of health insurance.

These proposals hold the promise of health insurance for millions of Americans. By increasing the choices and options, we can decrease the number of uninsured Americans, and is that not really the most important issue? I think it is. After all, when it comes to health care, access to a doctor is far more important than access to a lawyer.

If we are really serious about expanding access to health care, we will vote for this very important proposal. I urge my colleagues to put the patients' interests ahead of special interests. Too many people are still uninsured. Today we have the chance to change that. In short, this bill will mean more access for more Americans. I encourage us all to lower our voices, to raise our sights, and to reach out for the uninsured by passing the Quality Care for the Uninsured Act.

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

Mr. GREEN of Texas. Mr. Speaker, I would like to thank my good friend and ranking member of the Committee on Commerce for yielding me time.

Mr. Speaker, I rise in reluctant opposition to H.R. 2990. Clearly, access to health care is not a Democrat or Republican issue. In fact, I have introduced legislation in the last two Congresses that would do some of the things that this bill would do. In fact, we have not even had a hearing on my bill the last two Congresses, so it is good to be able to talk about it on the floor today.

My bill would allow everyone to deduct from their taxes what their health and long term care costs would be. Unfortunately, the bill we are considering today is poorly timed and irresponsibly drafted.

The Republican leadership has gone out of their way to say they will not spend a dime of the Social Security funds until the program is fixed. Yet that seems to have lasted about a week.

Earlier this week we found out that they were dipping into Social Security for about $16 billion, and today we are proposing an agriculture bill that would dip into the Social Security trust fund to the tune of about $48 billion with H.R. 2990. So this is how it works. They also started running TV ads saying that they were going to devote 100 percent of the Social Security surplus. Hopefully when this Congress is through, we will be able to do that.

This bill promises a lot, but gives little results because it is not funded. Some of the specific things I think that is wrong with it, it expands the MSAs, a demonstration project that has failed, and we have seen that happen. Throwing more tax benefits at the MSAs will not make it become a reality and it will increase health costs for those who remain in traditional health care or insurance or managed care plans.

It misdirects Federal dollars through the tax deduction, disproportionately helps the wealthy by not expanding it to all employees and just doing self-employed predominantly. You are taking the highest income brackets, and the deductions will not help those 32 million people in the 0 to 15 percent tax bracket who will not be able to benefit from this bill.

The last concern I have is that because in Texas we have passed managed care reform and over the years had a very aggressive insurance commissioner or State Department of Insurance, this would bypass state regulation on benefits in Texas in favor of new Federal regulations, and it would disrupt state insurance markets. That is just not true in Texas, but that is in all our states. One size does not fit all.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 1 minute to the gentlewoman from Illinois (Mrs. BIGGERT).

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

Mrs. BIGGERT. Mr. Speaker, I rise in strong support of H.R. 2990, the Quality Care for the Uninsured Act. Reducing the number of uninsured Americans is one of the biggest challenges facing this Congress. My predecessor, Harris Fawell, worked tirelessly toward expanding access to care for those who are currently uninsured. Congressman Fawell's good work continues with this bill, H.R. 2990.

By combining free market reforms with health care tax provisions, this bill expands access to affordable insurance for individuals and small businesses across the country. We in Congress have a responsibility to make it easier, not more difficult, for small businesses to offer health insurance. H.R. 2990 will go a long way towards reaching this goal.

Mr. Speaker, we should not let this opportunity pass us by. I ask all of my colleagues to support this legislation.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I rise to urge a vote against this fiscally irresponsible legislation. It does not make sense to enact legislation that would cost more than $48 billion without paying for it. The authors of this bill claim that it is paid for out of the non-Social Security surplus. They have been spending this surplus once a week for the last month and a half. We started out, as this chart shows, the first of July with $14 billion in surplus, and now we are down to something less than $25 billion that we have overspent.

Here we go again. Although we are projected to begin running substantial on-budget surpluses in 2001, these are just projections. This is not real money. Enacting policies now that will result in a permanent revenue loss based on projected surpluses that may not materialize is irresponsible. Adding to the debt our children have to pay off is reckless and foolhardy.

Why would we want to rob the Social Security trust fund again? This is a tax bill that is not paid for. Let us not do this to our precious children and to their future. Let us save the Social Security trust fund.

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

Ms. DELAURO. Mr. Speaker, I rise in strong opposition to this bill. The fact is that this bill is not paid for. It is a $48 billion raid on Social Security. That is one reason to vote against it.

The so-called access bill fails to provide any access for the people who truly need it most. It includes discredited medical savings accounts that only help the wealthy and the healthy. In fact, nearly one-third of all uninsured Americans would receive no help under this bill. As has been pointed out, only 160,000 people would be the beneficiaries of this bill. A second good reason to vote against it.

The third reason to vote against the bill is that it represents a last-ditch effort to kill the Patients' Bill of Rights. The Republican leadership has announced that they will attach this sham bill to the bipartisan Patients' Bill of Rights. A strong bipartisan majority in this body supports the Dingell-Norwood bill, but we have been fighting against a small minority in the Republican leadership every step of the way.

Why do they oppose HMO reform? Because they are in league with the insurance lobby, a major campaign contributor to the Republican Party. In fact, just yesterday, on the eve of this important health care debate, the Republican leadership held a breakfast with the insurance industry, a sad testament.

We should not be surprised that the Republican leadership is thwarting the will of this House. There is nothing new here. It is what we saw earlier this year on gun safety legislation, it is what we saw on campaign finance reform, an unwillingness to allow an honest debate and the use of clever procedural tricks to defeat reform.

People in this country are dying because our health care system is broken,

and the Republican leaders' response? Meet with the insurance lobby and devise a clever way to try to kill HMO reform.

Vote against this legislation. Let us have a fair and an open debate on Patients' Bill of Rights, a bill that would put medical decision making back into the hands of doctors and patients and make HMOs accountable.

□ 1445

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from North Dakota (Mr. POMEROY).

Mr. POMEROY. Mr. Speaker, can we imagine the fireworks that would erupt on this floor if the Democrats brought forward a bill that was $45 billion in a hit to the Treasury, without a nickel in how it is paid for? That is precisely the proposal offered by the majority with this access bill, a $45 billion hit over 10 years to the Treasury, and not one nickel in terms of how those monies would be paid for.

I am for full deductibility of health insurance premiums paid by individuals, but let us show how we are going to pay for it, so we are not spending the social security trust fund to do it.

I rise for another very important reason on this bill. I am the only former insurance commissioner in Congress. I know the consumer protection role played by State insurance departments. Every day State insurance department officials are helping people get claims paid, helping them deal with insurance complaints.

This bill in a major way would preempt all of that. Association health plans, community health center networks, HealthMarts, all of these features of this access bill would take it from State insurance departments and place it into a never-never-land of a soon-to-be-created Federal bureaucracy for regulation.

This whole Patients' Bill of Rights is about getting patients protections, because they right now do not have sufficient protections with their HMOs. How ironic that the majority would come up with a proposal that literally would take those who are now protected and push them also into the unprotected categories.

Consumers should not have to turn to some Federal bureaucracy to get a claim paid. Consumers should not have to call someone in the Federal bureaucracy to get approval to get the medical procedures that they need. They should go to their State insurance department, fifty State insurance departments, all with toll-free lines located right in the State capitols.

This bill, through the association health plans, the community health center networks, and the HealthMarts, would take it all away. Keep consumer protection. Defeat the access bill.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the 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 opposition to this bill.

Mr. Speaker, I rise today to oppose this legislation that purports to provide access to health care for those who need it most—the uninsured. I know this is the month that we celebrate Halloween, but it is way too early for these gimmicks and tricks. The American people expect treats not tricks and this bill represents a trick for two reasons.

First, at a time when we are experiencing unprecedented economic growth the number of uninsured individuals has risen more than one million over the past year to 44 million Americans. This legislation that purports to help the needy does more by way of giving tax breaks to help the wealthy—that the needy would hardly benefit from this bill. According to the General Accounting Office nearly one-third of all uninsured Americans do not pay income taxes. These families would not benefit under this bill. Instead the greatest benefits under this bill would go to the 600,000 families that make almost $100,000 per year.

Secondly, this bill expands medical savings accounts—a special tax break for the healthy and wealthy that threatens to increase health insurance premiums for everyone else. This provision was added to an important health portability bill in 1996—and this provision drew a veto from President Clinton—ultimately killing the bill. Here we are again, a chance to do something meaningful to improve the quality of life and health care for those who do not have access, but yet we would attach provisions that effectively make the bill DOA (dead on arrival). The effect of merging this bill with the Norwood-Dingell bill is to kill meaningful managed care legislation.

I support improving access to health care, in my congressional district 175,000 people live at or below the poverty level. It is a district that has pockets of poverty and great need. Unfortunately, this bill does not help to alleviate the hurt and pain of the uninsured in my district. If we are serious about providing access then we need to pass a universal health care bill. A bill that allows individuals to go to the doctor when they need to go, a bill that allows them to see a specialist, a bill that allows them prescription drug coverage. That is what access is all about. This bill is a trick, a sham, and not a treat for the vast majority of Americans who need health coverage. I urge my colleagues to vote ''no'' on this gimmick laden legislation.

Mr. DINGELL. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, we have heard it already. This access package is going to cost $156,000 for a well-to-do patient. It is not going to give anything to the poor. The reason for that is that this is a tax deduction. The poor do not pay taxes.

So who is going to get, then, the money that is going to come under this proposal? Only the well-to-do. What will be the practical effect on the insurance pool? To suck out the well-to-do out of the conventional insurance pool and to set up a very special, privileged insurance pool for the well-to-do. That is what this legislation does.

In addition to that, the legislation expands SMAs. This is another proposal which benefits the well-to-do, because they do not care whether they have to buy the insurance or not, what they want to do is to get the tax deduction and tax break which benefits only those of substantial means.

The other thing that it does, it misdirects Federal tax dollars to tax deductions that help the wealthy. This is hardly a defensible expansion. Remember, we are paying $156,000 per new insurance beneficiary. The whole of this program is going to cost $31.2 billion. Guess from what part of the government accounting structure it is coming. It is coming from the social security deficit, which is now a reality at this particular time.

I think it is time we recognize that what we are here for is to craft good legislation. This is not. If Members want to craft good legislation in the field of covering new people, then the minority stands ready to help our Republican colleagues towards that end. This bill does not do that.

We came here to talk about the Patients' Bill of Rights, about protecting the rights of patients, not in obfuscating the issue by bringing forward a lot of phony tax breaks and a lot of help to fatten the rich at the expense of the poor. What we need here is attention to the real problem. Then if they want to go on in a carefully packaged and carefully programmed set of rules, regulations, and laws which will address the problems of people in terms of providing uniform coverage for all Americans, I stand ready to do it.

I remind my Republican colleagues that it was they who killed, together with the assistance of their same good friends in the insurance lobby, the President's last proposal to expand health care to all Americans. It looks like they are up to the same game today.

Mr. BILIRAKIS. Mr. Speaker, I yield the balance of my time to the gentleman from Arizona (Mr. SHADEGG).

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Arizona (Mr. SHADEGG) is recognized for 5 minutes.

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

Mr. SHADEGG. Mr. Speaker, let me begin by thanking the chairmen of the Committee on Commerce and the Subcommittee on Health, the gentleman from Virginia (Mr. BLILEY) and the gentleman from Florida (Mr. BILIRAKIS), for making this debate possible, and for their hard work.

Secondly, let me set the record straight. On two different occasions, the gentleman from Virginia (Mr. BLILEY) and the gentleman from Florida (Mr. BILIRAKIS) offered to work with the gentleman from Michigan (Mr. DINGELL) on access legislation, and their staffs made an offer to work. That offer was not taken up, so the notion that we have not attempted to work with the minority on access legislation is simply wrong.

Let me address a second argument made here, which is that these two

issues do not belong together. If Members do not believe these two issues belong together, they are not looking at what is happening in health care in America today.

If they can say, well, we should not deal with quality of care at the same time we deal with access to care, at a point in American history when we have 44 million people who are uninsured, they do not get what is going on here. If they think we should not deal with affordability at the same time we deal with quality, they do not understand that this is all about health care. If they do not think we should give people choice at the same time that we improve quality, they do not understand markets or how this system works.

We have to deal with access, affordability, and choice in order to get quality. So let me set the record straight on that point, as well.

The next issue I want to deal with is the question of pay-for. The other side says these tax relief measures, attempting to give Americans who do not have health insurance now a chance to get health insurance, are not paid for, that we cannot afford this bill. Let me tell the Members, we cannot afford not to pass this bill.

Thankfully, these people are getting care, but they are getting care in the most expensive form of all. They are getting it in emergency rooms. This bill lets every single American have a better chance to access affordable care. The statement that it does not help an entire group of Americans is flat false. It is wrong. Let me explain why.

This bill allows small businesses to pool together through HealthMarts and association health plans and to offer coverage. That includes small businesses who today cannot provide their employees any insurance, forget the tax bracket they are in. To talk about an employee the other side has talked about who does not pay a dime in income tax, but works for an employer that cannot give that employee any health care, this bill makes it possible for that employer to give that employee health care because they can pool together and offer them more affordable coverage. So, so much for the claim that it does not help anybody at all.

Then let us talk about access for the insured. This is a USA Today editorial. It appeared earlier this year. It points out that more and more Americans are losing choice. They are offered one plan and one plan only.

The minority may think that is great, a single system, take it or leave it; too bad, no choice. If it does not fit you and your family, you are stuck. Too bad. Indeed, they must think it is okay because they have offered nothing to counter that.

We have offered something. We have said, we ought to give all Americans, including those lucky enough to have coverage, more choices. Let us talk about how many people do not have choices. Seventy-nine percent of all employers in firms with less than 200 employees offer their employees one choice, only one choice. Almost 80 percent say, you get one choice. That is small business America. You are stuck with the plan you are offered.

Our bill would let those employers offer those employees not one but five or six or eight choices. Maybe Members are against choice. I did not think so. But this legislation would help those employees just like it would help the uninsured, regardless of their tax break. By the way, it helps everybody that does pay income taxes.

Let us talk about big employers. Even in firms with more than 200 employees, only 46 percent offer their employees two plans to choose from. That is, most, barely over or almost half, say you get one choice, even when you work in a fairly large company, a company with over 200 employees.

This bill is about access for the uninsured. It is about affordability for the uninsured, and it is about choice for every single American. The other side says, no, we do not want access. We do not want choice. We are not worried about affordability. It is a poison pill to simply discuss this the same day we talk about quality.

It is not a poison pill. The marriage of these two bills does not occur until after they leave the floor. That is the point in time when we ought to be dealing with a comprehensive fix for health care in America.

I urge my colleagues to vote for this bill. It is good legislation. Regardless of the obstructionist tactics of the minority, affordability, access, and choice will help health care in America. I urge my colleagues to vote for H.R. 2990, a bill which I cosponsored with the gentleman from Missouri (Mr. TALENT) and which I am proud of.

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

Mr. Speaker, we said a little while ago that this bill is obfuscating the real issue. This bill is about the uninsured. Let us look at the 44 million people who some believe are obfuscating the real issue.

Three-quarters of those people work for small businesses. One out of every six Americans is uninsured. Eleven million kids in the United States are uninsured. As I said, three-quarters of these people either own small businesses or work in small businesses or are dependents of people who own or work in small businesses.

What does it mean to be uninsured in America today? It means you face the risk of illness without the shield of health insurance. You gamble that you are not going to get sick. We have 44 million people running that gamble every day, and a lot of them lose.

Linda Welch-Green has lost. Her story was reported in the Baltimore Sun today. Three of her teeth have fallen out because she cannot afford to go to the dentist anymore. She has Bell's palsy that has paralyzed part of her face. She cannot get it treated. The reason is she works, she works full-time, and her employer offers health insurance, but it is so expensive for small employers that she cannot afford the buy-in, so she uses her money to pay for her mortgage instead of for health care for herself.

We can do something about that, Mr. Speaker, if we pass this bill. This is the only bill we are going to have a chance to consider that does anything for the uninsured, and it does a lot, the part of it that we passed out of the Committee on Education on association health plans. It is a simple thing. It allows small businesses to pool together in their trade or professional associations or farm associations, would allow farmers to do this, and when they pool together, they can buy health insurance with the same kinds of economies and efficiencies that big businesses already have.

So if you work for a restaurant, instead of being part of a six-person pool or an eight-person pool, you can be part of a pool of 20,000 or 30,000 people, because you can be part of a pool of restaurants all around the country.

We have had hearings on this bill year after year after year. Our estimate is that, at a minimum, and this is a conservative estimate, it will reduce the cost of health insurance to small businesses by 10 percent to 20 percent. That means 4 to 8 million of these people are going to be able to get insurance who do not have it.

Yes, by the way, as the gentleman from Arizona (Mr. SHADEGG) said so eloquently, maybe others who now have access to one bare-boned HMO are going to have access to a whole lot more choices.

It is about these people who are running this gamble every day. Many of them are losing. We can help them today. Let us help them. Let us not let politics get in the way of this. Let us vote for this bill today. We take up the second half of this health care reform later today or tomorrow. We can do this.

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

Mr. CLAY. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, I support access and choice for the uninsured health care consumer. However, I rise in opposition to the proposal before us today because it will not deliver on either. It fails because it promotes such flawed ideas as association health plans.

Many experts have criticized association health plans, yet Republicans continue to trumpet them. They do so at the behest of their special interest friends, and not because of any real demand from health care consumers. The dangers inherent in association health plans became apparent to me when legislation to establish them was first considered by the Committee on Education and the Workforce back in 1997.

□ 1500

The experts told us then that they had major concerns about the effect on

the insurance marketplace. The National Governors Association, the National Conference of State Legislatures, and the National Association of Insurance Commissioners advise that Association Health Plans would undermine positive State reforms already in place to help consumers and would contribute to the collapse of small group health insurance.

According to CBO, Association Health Plans would increase the risk of health plan failures and allow groups of healthier people to receive favorable premium rates while leaving groups with sick and elderly enrollees to pay higher ones.

The American Academy of Actuaries advise that Association Health Plans could increase solvency risks and create regulatory confusion. The Urban Institutes Research determined that Association Health Plans would not reduce the number of the uninsured because nonparticipating firms are likely to drop their health insurance coverage rather than pay the higher rates that would result from a deteriorating risk pool.

I urge my colleagues to reject these dangerous remedies and vote no on H.R. 2990.

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

Mr. TALENT. Mr. Speaker, I yield myself 30 seconds to address two points.

We have very strong reserve requirements in this bill. There is no solvency problem, no reason why these associations cannot sponsor plans the same way that big companies do.

The second thing is that the bill requires that employers must offer, must carry, they must offer this coverage to every employee they have on the payroll, even if they have a history of illness. This will result in sick people going into Association Health Plans because they are going to get better coverage there.

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

Mr. BOEHNER. Mr. Speaker, when we look at today's health care system, there are two problems that most all of us can agree on, that we need more accountable in managed care, which virtually every Member of this Chamber is supportive of, and we that have 44 million people who have no insurance whatsoever.

So as we proceed in this debate, it is clear to me that we have three principles that we have to follow. How do we make sure that we get more accountability in managed care.

Secondly, how do we make sure that health care insurance is affordable for all Americans to ensure that all Americans have greater access. Accountability, affordability, accessibility.

In my view, we cannot deal with one of these issues without dealing with all of them. We cannot deal with one principle and ignore one. That is why this rule today and this debate that we are having is about accessibility today, and we will deal with accountability tomorrow.

When we look at the uninsured, as the gentleman from St. Louis, Missouri (Mr. TALENT) pointed out, they work for small businesses. They want to buy insurance, but they cannot afford to do it.

When one looks at what we are going to do tomorrow, we are going to raise the cost of insurance. As we add more accountability for insurers, employers, and others, we are going to raise the cost of insurance. That is what the debate earlier was about. We wanted to offset the cost of it.

As we raise it, we are going to push more people into the ranks of the uninsured. That is because there is a clear link between the cost of health care and people's access to it.

So we have got to move this bill, this access bill today, because whether one has insurance or not, one wants to be protected. We ought to help all patients in America today whether one has insurance or not.

I think that the bill that we have today guaranteeing greater access to health care for the uninsured is the first major step that we take. Then tomorrow we will deal with more accountability.

Mr. CLAY. Mr. Speaker, I yield 1 minute to the gentlewoman from Ohio (Mrs. JONES).

(Mrs. JONES of Ohio asked and was given permission to revise and extend her remarks.)

Mrs. JONES of Ohio. Mr. Speaker, we all know that Halloween is fast approaching. The question is trick or treat. H.R. 2990 is, in effect, a trick or treat measure.

We offer a treat with Norwood-Dingell, the Patients' Bill of Rights. However, Americans are being tricked by H.R. 2990.

The trick: getting health care in America. The treat: goes only to the wealthy. The trick: pooling and separating of persons with greater health risks from those with less, leaving many people uninsured. The trick: MSAs, Medical Savings Accounts, they are MIA, missing in action. No insurance company has yet to offer this coverage to senior citizens. The treat: health care access for small business. I sit on the Committee on Small Business. I know what they need.

The trick is that these Association Health Plans would not be subject to State regulation and cannot be sued in court just like the HMOs. Just like Halloween, H.R. 2990 is a hollow effort. Let us deflate this pumpkin now.

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

Mr. GANSKE. Mr. Speaker, I have spoken on the floor of the House many times on the issue of access. I have grave concerns about one of the provisions in this bill as it relates to Association Health Plans. The times that I have spoken before on the House floor, I have entered into the CONGRESSIONAL RECORD these letters which I am going to cite. The National Governors Association, National Conference of State Legislatures, and National Association of Insurance Commissioners have expressed reservations about Association Health Plans.

Here is a memo from the HIAA. It strikes my colleagues as a little ironic that I am citing this. I happen to think they are right on this, because insurers like Blue Cross Blue Shield and others are the insurers of last resort. They know about the risk pool in the United States.

They say, ''We have grave concerns about the calls for Association Health Plans and HealthMarts, because they would hurt many small employers who provide coverage to their employees; and that could in turn cause many of those employers to drop their coverage because it would be too costly.'' That would be exactly the opposite purpose of what we want to achieve in this bill.

Here we have a memo from Blue Cross Blue Shield. ''Association Health Plans, the unraveling of State insurance reforms.'' Same source, ''Association Health Plan, national survey finds that small businesses reject Association Health Plan legislation.'' Blue Cross Blue Shield, ''Association Health Plan legislation would increase administrative costs for small businesses.''

Association Health Plan study shows that a claim that coverage would increase is fundamentally flawed.

Here is a Blue Cross Blue Shield study, ''Association Health Plan legislation would reduce insurance coverage.'' Another Blue Cross Blue Shield study, ''Association Health Plan legislation would require billions in Federal regulatory spending.''

Then I have a letter that is from a number of organizations that say, key concerns about Association Health Plans are that it would increase the cost of insurance rather than decrease it, that it would leave a sicker pool for those States and thereby actually result in the exact opposite of our access legislation.

Mr. Speaker, this is a poor provision, and we should oppose it.

Mr. Speaker, I include for the RECORD the letter I referred to as follows:

JUNE 24, 1999.

DEAR REPRESENTATIVE: As representatives of consumers, seniors, labor, the religious community, and people with disabilities and chronic illnesses, we are writing to urge you to oppose H.R. 2047, the ''Small Business Access and Choice for Entrepreneurs Act of 1999.'' This bill would move our health care system in the wrong direction. As long as Congress continues on the path of incremental health reform, we believe that such reforms must meet this litmus test: does the bill make health care more affordable for American families, without creating harmful side effects that offset its benefits? We believe that Association Health Plans (AHP's), as defined in this bill, will do more harm than good to our health care system.

Our key concerns about the bill are:

''Affordable'' health coverage through skimpy benefits. The bill allows AHP's to design their benefit options, exempting AHP's

from state benefit mandates that apply to other insurance plans (except laws that prohibit an exclusion of a specific disease). This means that AHP's will be free to create barebones policies with skimpy benefits. The premium may well be low and ''affordable'' but when policyholders get seriously sick, or when they seek cancer screening or preventive care that would have been covered, they are likely to find their out-of-pocket costs to be very high.

Fragmentation of health risk pool. AHP's have the potential to further fragment the risk pool. Because AHP's would be exempt from state benefit standards, they would attract healthier, low-cost members. There is a grave danger that associations will form in part to offer low cost coverage to people with low health risks or avoid high cost areas. The net effect is to undermine state regulatory efforts to spread risks broadly.

Existing AHP's exempt from state premium taxes. The bill allows states to collect a ''contribution tax'' only on plans started after enactment of the Act. This creates an unfair loophole for existing associations; unlike other health plans they will be exempt from premium taxes that are used to cover health care costs for the uninsured and certain high-cost individuals.

Exemption from state consumer protection regulation. In addition to being exempt from state benefit mandates, AHP's could be exempt from state consumer protection regulation, like other self-insured health plans. Creating a new loophole from regulation is a step in the wrong direction for our health care system.

We agree that small businesses—as well as large businesses, individuals, and families—should all have access to affordable health care coverage. But we believe that to achieve this goal, we need to set rules so that marketplace competition benefits consumers, not health plans (or associations) that cherry pick the healthy. We need standard, comprehensive benefits. We need market reforms that spread the cost between the healthy and the sick. We need sizable subsidies to bring premiums in reach of moderate-income families. Association Health Plans do not move the health care system in the right direction.

Sincerely,

American Counseling Association, American Federation of State, County, and Municipal Employees, Bazelon Center for Mental Health Law, Brain Injury Association, Center on Disability and Health, Committee on Children, Communication Workers of America, Consumer Coalition for Quality Health Care, Consumers Union, Eldercare America, Inc.

Families USA, Friends Committee on National Legislation, General Board of Church and Society of The United Methodist Church, National Association of Developmental Disabilities Councils, National Association of People with AIDS, National Association of School Psychologists, National Association of Social Workers, National Council of Senior Citizens, National Health Law Program, National Mental Health Association, National Osteoporosis Foundation.

National Partnership for Women & Families, National Patient Advocate Foundation, National Senior Citizens Law Center, National Women's Health Network, Neighbor to Neighbor, Network: A National Catholic Social Justice Lobby, Public Citizen, Service Employees International Union, The Arc of the United States, UNITE, Union of Needletrades, Industrial & Textile Employees, United Church of Christ, Office of Church & Society, United Food and Commercial Workers International Union, Universal Health Care Action Network (UHCAN).

Mr. TALENT. Mr. Speaker, I yield myself 1 minute to respond.

The gentleman is quite correct, the insurance companies do not like this legislation and neither do the insurance regulators, because it will result in small businesses being able to participate in associations which will have at least some self-funded plans.

The insurance companies do not like that because they lose business. The insurance regulators do not like that because they lose business. They do not get to regulate the self-funded plans.

As for this costing small businesses more money, tell that to the small funeral home in North Carolina with less than 10 employees that was hit with a 73 percent increase this year by Blue Cross Blue Shield because it is on the small group market.

Tell that to the members of the Western Retail Implement and Hardware Association which was hit with a 65 percent increase this year because it is on the small group market. Tell that to the small businesses around this country that are experiencing on average a 20 percent increase in health costs.

No, the reason all the small business groups support this, Mr. Speaker, is because it is going to reduce their costs and decrease the number of uninsured.

Mr. Speaker, I am very happy to yield 3 minutes to the gentleman from California (Mr. DOOLEY), my friend and cosponsor of the Association Health Plan bill.

Mr. DOOLEY of California. Mr. Speaker, I rise in support to draw the attention of my colleagues to a provision in this bill that would dramatically expand access to affordable health care for small businesses and working families. The bill allows small businesses and self-employed individuals to purchase health insurance for themselves and the workers through Associated Health Plans.

We all saw on the news last week the ranks of those without insurance grew by 1 million last year, up to 44.3 million. It also was not lost on us that, of that number, 60 percent of those individuals are working for a small business.

I support this legislation because it would expand access to health insurance to the working poor of our country. My district in the Central Valley of California has one of the lowest private insurance coverage rates in the State, and the problem is getting worse. It is also one of the lowest income districts in the country. These low-income families have few options for gaining health insurance.

But an excellent solution to this problem has already emerged in the form of an Associated Health Plan that is already providing coverage to thousands of farmers, farm workers, and their families.

In my district, where agriculture represents the heart of our economy, Association Health Plans have made a significant impact and can make an even stronger impact by providing health insurance to more seasonal and migrant farm workers.

I would like to share with my colleagues just one story. The Lopez family from Visalia, California, in my district, has firsthand knowledge on how Association Health Plans can provide top quality care. Amalia Lopez works at a citrus packing house in Visalia and receives her health insurance through an Association Health Plan through Western Growers Association. Her daughter Lizette was diagnosed at age 10 with a heart ailment; and it became apparent, unless she had a heart transplant, she would die.

In June of last year, Lizette was informed that a donor had been found in Western Growers insurance plan, helicoptered to the UCLA Medical Center for an operation. The operation was a success, and, today, Lizette is back in school and living the life of a normal teenager.

The hospital bill for Lizette's operation was $270,000. But the Association Health Plan covered the vast majority of the cost and Lizette's family only had to pay $5,000.

Lizette's story demonstrates that Association Health Plans work in delivering affordable health care to working families. They provide a compelling and cost effective means of providing affordable quality health insurance to a greater number of people.

The issue for the Lopez family and thousands of other low-income families is not a choice between different insurance plans, it really is a choice oftentimes whether they will have health insurance through an Association Health Plan or no health insurance at all.

Let us not deny low-income families an opportunity to have quality health insurance that can be provided through an Association Health Plan.

Mr. CLAY. Mr. Speaker, I yield myself 10 seconds.

Mr. Speaker, it is noteworthy that the gentleman from Missouri (Mr. TALENT) cited that insurance commissioners and insurance companies oppose the Associated Health Plans. Also noteworthy, he did not cite the 31 Republican governors that also oppose it.

Mr. Speaker, I yield 2 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I thank the gentleman from Missouri for yielding me this time.

Mr. Speaker, the Republican leadership has a knack for putting an attractive name on terrible bills. They are doing this today with H.R. 2990, what is called the Quality Care For The Uninsured Act.

H.R. 2990 provides no increased access to health care for the uninsured; and, yet, it would take up to $43 billion away from important programs that do help the American people.

This bill is a sham. We do not need it to make health insurance tax deductibility for the self-employed. That will happen even without this bill.

Among other deceptive things that H.R. 2990 would provide are Medical Savings Accounts. We told our colleagues this was a bad idea when it was

forced down our throat 2 years ago. Even the insurance industry has not used them. MSAs are a proven failure, and we do not need to be voting for them today.

This bill would also provide tax deductions for long-term care. Who will that help? Only those who pay taxes, those who, after living expenses, have money left over to pay for it, the usual people the Republican leadership looks out for, the rich.

Mr. Speaker, we should care about the 44 million uninsured in this country. They are mostly women, people of color, and the poor. I am committed to working with my colleagues on both sides of the aisle and groups around this country to make sure that we do achieve universal access and universal coverage.

But this bill, H.R. 2990, does nothing, absolutely nothing to provide any help to these people who are largely poor to purchase any coverage.

□ 1515

The only bill that will give back access to health care for those from whom managed care has taken it is H.R. 2723, Norwood-Dingell bill. Let us pass that bill to provide real access to quality care for the insured. That is the first step. Then let us work together to give real access to health care for the 44 million who currently have none. Vote ''no'' on H.R. 2990.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. ANDREWS).

Mr. ANDREWS. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise in opposition to this bill.

Mr. Speaker, this bill provides taxpayer subsidized access to people who largely do not need it, who already have it, and does virtually nothing for those who have nothing.

We heard some talk on the floor earlier about the typical uninsured person, and that is the person I want to focus on for a few minutes this afternoon. She is usually a working person. She makes $20,000 or $21,000 a year. She has children, and she is working 40 hours a week.

I want us to examine how little this bill does for that person. The first thing she is supposed to do under this bill is, if she is self-employed, is to have a sped-up deduction from her income tax return, which is worth the princely sum of $300 a year, when fully phased in, toward her $6,000 that she would have to pay in premiums or more. That is nothing more than superficial help for someone.

The next thing she is supposed to hope for is that her employer, if she is employed by someone else, will join an association health plan. The most optimistic projections I have ever heard about these things say they might lower the cost to small business by 15 or 20 percent. Now, that is nothing to sneer at. That is nothing to sneer at, but she has to keep her fingers crossed that maybe her employer will do such a thing and she will get lucky.

Of course, once she gets into such a plan, all the protections of State law, the mandatory stay if she has a C-section, the mandatory coverage for breast or cervical cancer, the mandatory coverage for immunization for her kids are not subject to these plans. So she can wind up with a health insurance plan that is not worth the paper it is written on.

Finally, this bill gives her the tremendous opportunity to contribute to her medical savings account. After she has paid her rent and her utility bills and her groceries and her auto insurance and her car payment and her child care and all the other things she has to do, this enormous amount of money that she has left over she can now put into an MSA.

This is a cruel hoax. It should be defeated because it does not provide access.

Mr. TALENT. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Speaker, as we begin the floor debate today on patient protections, it is important that we do not forget those 44 million uninsured Americans who have no protections at all. More than 60 percent of the uninsured have one thing in common; they are either self-employed or their family is employed by a small business that cannot afford to provide health benefits.

As a former small business owner, I understand firsthand that small businesses have difficulties in providing health care to their employees. Conventional health insurance and administrative costs are just too expensive for small businesses. In 1997, a typical small business owner paid $4,342 per employee for a family plan, yet a Fortune 500 company paid an average of $3,521.

Association health plans would empower small business owners with the purchasing power of a large business. In fact, AHPs would reduce health care costs for small businesses by 10 percent.

Providing health care for small business employers ought not to be a choice between feeding their own families and taking care of their employees. The small business owners of this Nation want and need to do both. AHPs will help 8 million small business employees obtain coverage. Small businesses need equal fitting in the health insurance market. That is protection we cannot afford to pass up.

Let us open up health care for all working people. I strongly support this bill, and I urge my colleagues to vote in support of it.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentlewoman from Michigan (Ms. KILPATRICK).

(Ms. KILPATRICK asked and was given permission to revise and extend her remarks.)

Ms. KILPATRICK. Mr. Speaker, I thank the gentleman from Missouri (Mr. CLAY) for his fine leadership.

One of the most important issues we will face in this 106th Congress is health care. Will Americans in the richest country in the world have available to them the health care they need for themselves and their families?

Access. Will they have the access to get the health care that they need? I am afraid, my colleagues, the bill before us today does not address that issue. Our own Government Accounting Office has said to us that the poorest of the poor who are uninsured today, with this access bill before us, still will not have access.

Is it the right thing to do? I think not. First of all, the bill is for the wealthiest and the healthiest. Yes, we want everyone to have insurance. Yes, we want those small business owners to be able to have insurance for themselves and their employees. But we also want the others who are uninsured to have insurance, too.

All week long we have been hearing that over 40 million Americans do not have health insurance, that one out of six do not have health insurance, that 11 million children or more do not have health insurance. Will this bill address those people? In large part, it will not.

It is unfortunate as we debate this subject today, with this most important issue that our country faces, that this bill continues to leave too many people out. The bill is not offset.

We, in our other proposal, which is a bipartisan proposal I might add, and would cost $7 billion over the next 5 years, wanted to have offsets for it. Our leadership, the Republican leadership, said no. This bill will cost $40-plus billion. It is not paid for. It is not offset. And we think that is unfair and unconscionable.

It does not improve the affordability of health care if an individual does not have the up-front money. Many families and many children who live in those families do not have that. It does not help the poorest of the poor in America. When will they have access?

It digs into our Social Security Trust Fund in that it will take out from the Treasury before we put into it. It is not fair.

Mr. Speaker, I urge my colleagues, let us not adopt this. Let us get back to work on a real bipartisan solution that actually accesses those things that people need to carry on their daily lives. It is a bad idea; it is a bad bill; and I urge my colleagues to vote ''no.''

Mr. TALENT. Mr. Speaker, I yield 3 minutes to the gentleman from Kentucky (Mr. FLETCHER).

Mr. FLETCHER. Mr. Speaker, I certainly appreciate the gentleman from Missouri (Mr. TALENT) and the gentleman from Arizona (Mr. SHADEGG) for the work they have done on this bill to make sure that we make health care more affordable and more accessible.

Let me first start in saying, what does it mean to be uninsured in this country? I will share with my colleagues, and especially those on this side of the aisle that oppose this, what it really means.

A patient named Mary came to me a few years ago. She had no insurance. She was not the poorest of poor, because the poorest of poor have Medicaid. She was working, but she did not have insurance. She came to me and, upon exam, it was very obvious that she had a very large tumor. Cancer, metastatic cancer, that probably could have been prevented had she had health care and had the kind of preventive care that patients that will benefit from this legislation will have.

Now, many will say this is not a perfect solution. I agree with that. But what it means to not have health care means an individual does not have access to getting the kind of preventive care that will prevent the kind of diseases that will take an individual's life too soon.

In Kentucky, what is happening? We have had health care reform. Now, if an individual is on the individual market, they only have two choices of insurance. And small businesses only have a few. This plan with associated health plans and health marts gives the opportunity for individuals to have health care, as small businesses can help reduce their costs from 10 to 15 percent and be able to offer a spectrum of choice that will enable them to get the kind of health care and the preventive care that they need.

Some folks say, well, we should not link these two. I am kind of disappointed they were not linked to begin with because they are inseparable. The whole debate about patient protection is about how the money, cost of reimbursal, affects access. Because if an insurance company says they are not going to pay for something, they do not prevent an individual from having treatment; but they limit the access because the patient cannot afford it.

Right now we have limited access because folks cannot afford health insurance, because small businesses cannot offer it, because we do not have legislation that encourages small businesses to offer it. This will allow the tax deductions for individuals to allow small companies to come together.

And now insurance companies do not like it. Why? Because they will have to contract and negotiate with a group of individuals much larger than just a small company. I have been a small business owner. I know what it is like to buy insurance. I have seen the costs escalate every year, and I think this will help small businesses.

I ask those folks on the left that oppose this to look at themselves in the mirror and look at patients like Mary, who I am talking about, and ask themselves whether this will help her get insurance. I hope my colleagues can look at themselves in the mirror and say, this is not perfect, but at least it is a step in the right direction. My intent in coming to Congress was to make sure that we eventually get every American covered with health insurance. This is a step.

Some would like a government-run, single-payer system; others like a market-based system. I think a market-based system with choice is the way to go. This does that. I encourage my colleagues to vote for this measure.

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

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

Mr. Speaker, some will say this is about access for the more than 44 million Americans that are now known to be without health care. In fact, we now know, since 1998, that more than 1.3 million new persons that are uninsured.

But let us examine if this is really about access for all of those people or for the majority of those people. Certainly coming from rural North Carolina, I can tell my colleagues that rural North Carolina does not have as many insured people with HMOs as they would have in urban areas. So access is important. Uninsured people are very important.

But when we consider that this tax break is designed for those who have been substantially paying into the revenue, we know that that eliminates immediately a majority of the children who are uninsured who may have working parents who are not on Medicaid. They make too much for Medicaid but are not insured. We have to understand that these individuals would have to pay a substantial amount to make any sense. If indeed they had the $4,500 or the $5,000 to pay for the premium, perhaps they would get $700 as a break.

Help me understand how those 33 million people can call this access. Indeed, this is insufficient and should not be labeled as access. The Norwood-Dingell bill is about access. It is about access for those who have insurance to have better access, to ensure that their care is based on medical necessity, that they will not be denied based on an insurance promise that we will not allow you to be covered.

Indeed, this is a fraud. This is inadequate. We should be ashamed of ourselves thinking we are addressing the needs of the American people by calling this access. Defeat this bill and, indeed, support the Norwood-Dingell bill.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Mrs. THURMAN).

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

One year ago, I actually introduced a piece of legislation because of an article that was in the St. Pete Times about a group of employees whose company actually was on the verge of bankruptcy. They allegedly pocketed their employees' health care premiums. The health insurer, hoping that the employer would catch up on overdue premiums, agreed to work with the employer to resolve the unpaid debt.

Meanwhile, the unsuspecting employees continued to receive authorized health care coverage. When the company ultimately filed for bankruptcy, the health insurer retroactively terminated the employees' health plan. One woman in this article ended up having to be stuck with $20,000 worth of medical bills.

As a result, the cost of any health visit or procedure conducted the preceding 3 months became the sole responsibility of each employee. In addition, because they did not meet the 63-day standard under HIPAA, because it went 70, they could not even get any kind of insurance.

□ 1530

I think it is unconscionable. As we introduced this legislation, we found out that there were several other areas around this country that these same things happen. So on Monday I went to the Committee on Rules because I, too, am concerned about access and I am really concerned about access for people who had it and lost it because they do not have the opportunity to contract with this company but the employee does. The insurance commissioner in Florida said, in fact, they were in their rights because the contract was with the employer.

So we went in and we said, okay, look. They ought to prohibit retroactive termination of health insurance by requiring that the insurance company provide 30 days' notice of pending termination of coverage.

In addition, we required that such employees be extended HIPAA protections for obtaining alternative coverage. I do not want to hear about access. This was not included and this was one that cost nothing.

Mr. TALENT. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. CHABOT).

Mr. CHABOT. Mr. Speaker, as we consider health care legislation in Congress today, it is essential that we find ways to make health care more affordable for American families.

There are 44 million uninsured people in this country; and this number, unfortunately, is growing steadily. Comprehensive health insurance is rapidly becoming too expensive for the average working family, and many small businesses are unable to provide costly group plans. We need to help the millions of Americans that do not have health insurance, as well as those who are struggling to afford quality care.

The Quality Care for the Uninsured Act will do just that by allowing taxpayers to deduct their health insurance premiums and giving small businesses and associations the freedom to provide their employees more comprehensive and flexible health care. Mr. Speaker, this proposal is a positive step forward.

Earlier this year I introduced similar legislation that received bipartisan support. I would ask both sides of the aisle to support this.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Speaker, I agree that small businesses need help for their employees. As a matter of fact, all consumers of health care need help. The 44 million uninsured in this country need help. Patients need access to primary care and to physicians.

What this country needs is a national health insurance, a national health policy that takes care of the needs of all the people. But what we need right now is to reform managed care. And the only bill that provides any real help for managed care reform, for real access for physician-patient communication, the only bill that moves us seriously in the direction of taking care of the immediate needs of millions of people in this country is the bipartisan Dingell-Norwood bill.

I would urge that all other items before us, while they may contain meaningful elements, really do not do the job. The only way to do the real job is to vote for the Dingell-Norwood bipartisan bill.

Mr. CLAY. Mr. Speaker, I yield 1½ minutes to the 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 know that the intentions of the gentleman were good with respect to the staggering numbers of uninsured Americans.

Forty-four million Americans lack access to basic health care, and 44 million Americans live in fear of getting sick. But what we must realize is that we must not give them a bucket of water with a leak in it. And right now that is what this legislation does. That is why we should stick to passing the Dingell-Norwood health care reform, a straight-up vote on giving the American people what they want.

I have a letter here, Mr. Speaker, that I would like to submit into the RECORD from a nurse and three doctors who said, ''We are mad as hell, and we are not going to take it anymore,'' Dr. Self, Dr. Zaremski, and Nurse Self. And the reason is because they were trying to express their beliefs on behalf of the patients and they lost their positions in the medical profession.

(September 29, 1999)

AN ''OPEN LETTER'' TO THE HONORABLE MEMBERS OF THE UNITED STATES HOUSE OF REPRESENTATIVES REGARDING MANAGED CARE LEGISLATION

(By Thomas W. Self, MD, FAAP, Linda P. Self, RN, BSN, Miles J. Zaremski, JD, FCLM)

September 29, 1999.

DEAR HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES: We hope that our remarks that follow will be able to be part of the floor debate that will occur on managed care legislation, scheduled for early next month. While we have endeavored to communicate with several of you, either by letter, phone or by in-person conferences with you or your staffs, we feel our individual, yet collective, wisdom on the underpinnings of this legislation before you is critical and important. Two of us have a unique experience not shared by other health care providers in our country. The other has considerable expertise based on experience and writings on managed care liability, what our courts have done with ERISA preemption, and what is likely to be done in the future by our judicial system. Two final introductory remarks. First, there is so much that needs to be said that brevity in our remarks could not be achieved. Second, while this letter comes from the three of us, we refer to each of us in the third person.

THOMAS W. SELF, *MD, FAAP.*
LINDA P. SELF, *RN, BSN.*
MILES J. ZAREMSKI, *JD, FCLM.*

Our plea comes not as Democrats, Republicans or members of other political parties. Our plea comes to you as a physician, nurse and lawyer, representatives of those at the crossroads of medicine, health care and law. Our plea comes to you also as people who are deeply and passionately concerned about the quality and delivery of health care for America's patients, all patients, and the legal and legislative efforts to do the right thing—insure fairness and accountability for parties and by those delivering health care.

To quote a famous line from a motion picture of some years back, the battle cry of patients is, ''We are mad as hell and we are not going to take it anymore!'' Patients and providers alike should not be subject to the grave inequities foisted upon them by what managed care has done to the delivery of health care. Linda and Tom Self are fitting and, perhaps, unfortunately, unique examples of what has to occur before managed care moguls will listen.

As a San Diego doctor trained at Yale and UCLA, who ran afoul of managed care and who was actually fired for spending ''too much time'' with his patients, Dr. Self is unique among health care providers in that he fought back against the medical group that fired him and won a three year ''battle'' that culminated in a three month jury trial. His victory is the first of its kind in the nation, and was profiled by ABC's ''20/20'', on August 6, 1999.

His experience, where managed care profit motives infiltrated and contaminated the professional ethics of his medical group, shows clearly the murky and often brutal influences wielded by HMOs which have only profit, not quality of care, as their goal. In this scenario, patients become ''cost units'' and doctor is pitted against doctor, undermining the very foundation of medicine and throwing to the winds the Hippocratic axiom, ''first of all do no harm.''

With the art and science of medicine controlled by managed care forces, it is not surprising that the number of patient casualties continue to soar. The ability of a clerk with no medical training, in the employ of a payor thousands of miles away, to overrule medical decisions of a trained physician is allowed in no other profession, but is the standard of practice under managed care! Furthermore, this type of employee and also the managed care entity which acts as the puppeteer behind the clerk are completely immune from any legal accountability when their faulty medical decisions cause patient harm. That this situation is allowed to continue is also peculiar only to the medical profession. This is unfair and inequitable!

As an experienced diagnostician with the reputation of being thorough and careful, Dr. Self was criticized under managed care dictates as a physician who ordered too many costly tests and as a ''provider'' who ''still doesn't understand how managed care works.'' Sadly, this situation continues nationwide, as more and more experienced doctors are unjustly censored, dropped from managed care plans or terminated from medical groups anxious to conform to managed care policies, leaving their needy patients feeling confused, frightened and abandoned.

This pillage and waste of medical resources (under the yoke of managed care which destroys the very quality and continuity so necessary for a positive outcome from medical treatment) is running rampant in America. Dr. Self and his wife have put their lives and their careers on the line to combat the wrongs caused by the health care delivery system called managed care. Now, representing, in microcosm, all health care providers, they turn to you as lawmakers, representing all past, present and future patients, to stop the horror and carnage by health plans by voting for the Norwood-Dingell bill, H.R. 2723, and restoring quality, decency and humanity to health care for the American people.

Linda Self, a registered nurse, is, like her husband, a healer. Always active in charitable activities, she returned to nursing full time four years ago to work with her husband when he lost his job. After being away from nursing for many years, she realized that her compassion and love for the art of healing was now even stronger, especially after raising two children, one of whom had a serious illness. Devoted to caring for children with chronic diseases and giving support to their families, she was shocked and unprepared for the massive de-emphasis on patient care that had been fostered by health plans. Linda realized that her commitment to people had not changed nor had the needs of such children—what had changed, and changed for the worse, was the indifference to patient suffering held by the managed care system. She realized that in order to care for sick patients and their families in the 90's, there is, and was going to be, a constant controversy with the managed care bureaucracy involving patient referrals, treatment authorizations and, above all, the daily need to appeal treatment decisions lost, delayed or denied by their patients' health plans.

As if also in microcosm to what other private medical practitioners face, this office ''busy work,'' in addition to the requirements of providing necessary medical support to sick patients, has created enormous frustrations among health care providers as well as increasing the costs of running a practice. Conversely, reimbursements from health plans have steadily diminished, regardless of the severity of the patient's illness or the increased amount of physician and nursing time expended.

Additionally, in her dual role as nurse and office administrator, Linda works daily to insure that patients receive the appropriate medical care they need and deserve without suffering the indignity and humiliation of having their health plans ignore, delay, or deny health care that is not only medically necessary, but for which the patient has already paid insurance premiums. This endless paper shuffle mandated by managed care without its cost cutting mentality further decreases the amount of time that a nurse can devote to patient care. This dilemma has driven competent and caring paraprofessionals from the medical field in droves, thereby further weakening the overall quality of medical care needed by patients nationwide. The resulting upswing in poorly trained, undedicated office personnel hired to replace the nursing flight has created a hemorrhage in medical care delivery which, if not stopped, will hasten the demise of American medicine as far as any vestige of quality of care which still remains.

Patients must not be considered commodities to be bartered by health plans. Payors must be held fully and judicially accountable wherever their pressures on physicians to curtail tests, delay or deny treatment plans,

or by clogging the wheels of medicine with mountains of paperwork cause patient harm. Therefore, Linda Self, speaking as a mother, a patient, and a nurse brings her experiences to the House floor and adds her plea to those of Dr. Self and Mr. Zaremski to bring dignity and salvation to the practice of medicine.

Those in the House, listen, as we have done for years, to the voices of the grass roots populace when they cry out for help and relief from a medical system that harms, not heals. Read, if you will, the numerous e-mails and other written communications from viewers of the ABC ''20/20'' program on Dr. Self and other well wishes after he and his wife's historic jury verdict, which we have included as a attachment to this letter. A sampling of quotations from these communications (emphasis added) follows:

''As an R.N. I have had similar experiences as Dr. Self concerning HMO's. He is the type of doctor HMO's do not want, since he actually takes enough time for each patient, and does the right thing. A warning to all patients: do not choose an HMO if you have a chronic or rare illness! They will hasten your demise; they are Goliath and you are David. . . . Until patients become better-informed and less passive about their health care, and until doctors start standing up, like Dr. Self, HMO's will continue to run over the patients they are supposed to serve.''—Sheryl W. McIntosh.

''Your August 6 piece on Dr. Self who was fired for ignoring his group's bottom line and putting his patient's needs first was excellent. This is happening more frequently than people realize. Only when people have access to information like you provided—or when they get sick and learn firsthand—do they realize how corporate managed care has affected American lives. I hope you will talk to other medical caregivers and deal with other facets of this complicated problem.''—Francis Conn.

''This might be just the tip of the iceberg. Our health care should not be treated as a commodity, i.e., something to make money on at your or my expense. Neither should it be a political football where the vote goes to the place with the most political donations . . .''—James A. Eha, M.D.

''. . . At first HMOs were VERY good but every single year that passes it get volumes worse. Now, it is so hard to get a referral, a prescription, a test or an office visit. . . . My husband has to take off work because you have to take the appointment they give you. . . . They make it nearly impossible to get care. They have those drug lists that they are always changing so the doctors are changing your meds all the time making you very sick. They do not allow doctors to do their jobs . . .''—Diann Wolf.

''An identical story happened . . . with my brother who is a family practitioner. . . . He dealt mostly with AIDS patients and the HMO found that to be too costly. He and his fellow practitioners in his office decided to leave the medical practice and regroup mentally to figure what to do. They had spent many months without pay at all due to the methods of saving costs by the HMO. . . . and just so the HMO's could make some money, good doctors are leaving the profession.''—Michele Drumond.

''. . . For the past 11 years I have cared for people in long term care. . . . just imagine the lack of incentive there is for good care of the elderly or disabled. Many newer meds are not covered as they are not cost effective . . . patient loads rise but staffing does not, rules and regulations of documentation rise, staff does not nor does equitable pay. The diagnosis to dollar mentality is ripping the caring soul and commitment out of medicine. Everyday I ask God to give me both compassion and wisdom in my job, but my soul feels that the battle of excellence in care and cost will always be won by cost. I feel called to this job, and just have to do what I do the best that I can, but NEVER would I want any of my four children involved in direct patient care. the physical, emotional and psychological load is becoming too great!! I strongly believe we will see life expectance decline . . .''—Barbara Harland, RN.

''. . . I work for a doctor's office . . . I do all referrals, authorizations and surgery precerts for our patients. It has become a nightmare to approve any surgeries without going thru the third degree for patients. They can't begin to realize what we in the ''field'' go thru to get these things approved . . .''—Susie Wallace.

''''There are men too gentle to live among wolves' to a gentle and courageous man & woman [Tom and Linda Self].''—Brian Monahan.

''. . . It is a great irony that, after a generation of tremendous growth of our knowledge and our ability to care for patients and diseases in a manner far better than we ever could before, greedy companies are seeking to limit our doing so. . . .''—Herbert J. Kauffman, M.D.

''. . . I deeply respect what you've accomplished and appreciate the way in which your victory benefits patients and those of us who choose to treat patients according to sound clinical decision-making versus adherence to the masters and dictates of those more concerned with profit than quality patient care . . .''—Robert Alexander Simon, Ph.D.

''. . . Seven years ago I was hired as a homecare Social Worker. . . . Then, managed care entered the scene—frequently denying approval for a social-worker's services. Since urgent social worker intervention was often necessary with our patients, there were many times that I was dispatched to the patient's home to provide emergency services . . . only to later receive a ''denial of payment'' from the managed care company . . . [Hospital] required me to find any excuse possible to visit those patients whose insurance would pay, and would cram as many patients as possible every day into my schedule. It was all so very, very wrong. For months this unethical practice tore me apart—and eventually made me very ill. I quit my job. . . . I had been forced to compromise my ethics in order for [Hospital] to maximize their profits. I applaud your courage, and I just wanted you to know that I am proud to be the parent of one of your patients.''—Ruth Bronske.

''You stood tall for yourself and set a perfect example for the rest of us. I am so pleased.''—George Jackson, M.D.

''. . . Congratulations on winning your lawsuit! Truth always comes out triumphant. Hopefully the HMOs . . . of the world will put the patients' interest first and the bottom line at the bottom as it should be from now on. . . .''—Faith H. Kung, M.D.

''. . . Dr. Self stuck his neck out and he lost his job, but he stood up for what he believed in and hopefully other doctors will do the same. He should be commended for what he did. I hope . . . that if something really bad ever happens to me and I need tests run or extensive surgery done, the doctor better not look at what kind of insurance I have rather than giving me the best medical attention I need that could save my life . . .''—Kim Lewis.

''. . . I have quit the medical field in the past month because medicine is no longer about patient care and needs. It is only about how much money can be made off of them. Thank you for letting me see it is not just the employee that is affected!''—Linda Copp.

As a legislator, you can therefore appreciate first hand, the anger, frustration, and hopelessness expressed by your constituents such as what we have quoted above. Then, recall the quote by Margaret Mead, ''Never doubt that a small group of dedicated people can change the world. Indeed, it is the only thing that ever has.'' The ''rank and file'', the grass roots populace is, we think, what Ms. Mead had in mind when it comes to health care in our country.

The third major thrust of our letter pertains to the three of us having seen and heard the disingenuous expressions of opponents of what patients really need and which is embodied in the Norwood-Dingell bill. First, we have heard that lifting the ERISA preemption will cause employers to terminate health plans for their employees, that lifting this so-called shield will cause premiums to increase and that trial lawyers will gain an avenue to sue. To all of this, and with all the passion we can muster, we say, ''absolutely not!''

First, ERISA, enacted in 1974, had nothing to do with shielding managed care plans from accountability for their medical decision-making process. There has never been anything in the legislative history on ERISA having to do with this subject. The American Bar Association, not known at all for representing trial attorneys, voted last February 302–36 to lift the ERISA shield.

Next, allowing for accountability by health plans to patients, as contained in H.R. 2723, provides for real equity in distributing responsibility to all those persons and entities involved in the medical decision-making process. This does not mean increased or additional litigation! The liability exposure to managed care entities that would exist with removal of the ERISA preemption shield will force these entities to insure improvement in patient care, by, for example, not allowing clerks to override physician treatment decisions, providing a review process to all treatment denial determinations, etc. As a result, the number of bad-outcomes leading to litigation will likely decrease, leading to less litigation. And where bad-outcomes do occur, allowing direct suits against health plans will not create more lawsuits, but will rather lead to roughly the same number of lawsuits—with one additional defendant. This one additional defendant will better allow a trier of fact to equitably distribute liability to the persons and entities responsible for the harm. In the end, there are fewer bad-outcomes, less litigation and better equity in the distribution of fault.

Alsi, realize that H.R. 2723 provides for accountability and responsibility of health plans according to state laws. State courts are where this area of responsibility and accountability for health plans should reside. For example, if your state has ''caps'' on the amount of money that an injured person could receive, such as in California, then those caps would equally apply to exposures faced by health plans.

And if the Texas state statute on holding HMOs responsible is any example, fears of increased litigation are totally without any basis in fact. In the three years since that state's law was enacted, there have been less than a handful of cases filed against health plans in that state. Also, in joining with Georgia legislators, the California[1] state assembly of 80 members (overwhelmingly) passed legislation recently providing that HMOs can be held accountable for their medical decision-making. On September 27, 1999, Governor Grey Davis signed into law this legislation, and, in so doing, stated, ''It's

[1] California is said to be the ''birthplace'' of managed care.

time to make the health of the patient the bottom line in California HMOs.''

In conclusion, we implore each and every one of you to do the right thing. Vote your conscience by voting for the rights of each and every American who has been, or will be, a patient in our health care delivery system. Remember that a person's health is unlike anything that can be bought, traded, negotiated or sold. Don't hold hostage human sickness and injury to a ''bottom line'' mentality. Keep in mind the words of a colleague in medicine who wrote Dr. Self after his jury verdict, ''The rewards of being a doctor are largely measured in identifying what is best for the patient and then having to do what one believes is correct and best for the patient.'' Again, we reiterate the quotation by Mead: ''Never doubt that a small group of dedicated people can change the world. Indeed, it is the only thing that ever has.'' In passing H.R. 2723, each one of you will heed her message, and, accordingly, insure that the tendrils of greed and disregard for legal accountability in managed care will no longer be able to find fertile soil in which to take root and grow.

Thank you.

Sincerely,

THOMAS W. SELF, *MD, FAAP.*
LINDA P. SELF, *RN, BSN.*
MILES J. ZAREMSKI, *JD, FCLM.*

This particular legislation gives tax benefits to the uninsured, but nearly two-thirds of the uninsured population are in the 15 percent tax bracket, which means they only receive a 15 percent relief. We are talking about poor people, working people, Mr. Speaker, who cannot afford any sort of excess funds to buy the insurance and then others are already on Medicaid. This is an important issue to ensure that those who are uninsured get health coverage.

But, Mr. Speaker, we need deliberation. We need hearings. We need the opportunity to do the right thing. Let us just vote for the Norwood-Dingell reform bill.

Self-employed taxpayers may deduct payments for health insurance. The deduction cannot exceed the net profit and any other earned income from the business under which the plan is established. It is not available for any month in which the taxpayer or the taxpayer's spouse is eligible to participate in a subsidized employment-based health plan.

These restrictions prevent taxpayers with little net income from their business, which is not uncommon in a new business, or in a part-time business that grows out of a hobby, from deducting much if any of their insurance payments.

What about the 12.5 million people who do not pay income taxes? What about the 12.5 million who work on low wage jobs, those who do not make enough for health coverage?

In 1996, close to 33 percent of the U.S. residents were living in poverty or near poverty. Twenty percent of all households had incomes below $14,768 per year. Among the near poor, those who work on low wage jobs, 35 percent of all men and 29 percent of all women are uninsured. Whites account for close to 27 percent, African Americans account for 55 percent, Hispanics account for 60 percent and Asian Americans account for 31 percent of the uninsured.

What about the woman who called my office last week who had cancer and congestive heart failure? She was dropped from her insurance when she became a widow. She was worried about the high cost of her prescriptions that she is unable to afford. She was worried because she receives samples from her doctor and she wonders how long his good will can last.

What about the Hispanic family with several children? Although both parents work, they do not make enough to afford health coverage. One of the children has developed a serious illness and needs to be hospitalized. The child cannot survive without the operation and the parents cannot afford to pay for it.

What about the woman who just discovered a lump in her breast. She is nervous because of the lump, but she is more nervous because she has no health insurance. She cannot go to a doctor for screening and she cannot afford a mammogram.

What about the man who went to the emergency room because he became ill and discovered that he had diabetes? In addition to the bills he accumulated because of his hospital stay, he also has to pay for insulin and other supplies to manage his condition.

These are the people that need our help. These stories only represent a few of the people that need access to health insurance.

Like many of my colleagues, I received many letters from businesses in support of this bill. I am sensitive to the needs and concerns of small businesses. I understand the various costs associated with running a small business and I respect the entrepreneurs that want to provide health insurance to their employees.

Many of these employers want to do the right thing. However, this bill does not benefit the small business owner, nor does it benefit the employees. This bill will only benefit the insurance companies and wealthier Americans.

I urge my colleagues to vote against this bill. We need to go back to the drafting table to come up with a better plan for these 44 million Americans. Let's offer some real reform for those working families and their children.

Mr. CLAY. Mr. Speaker, I yield the balance of my time to the gentleman from Tennessee (Mr. FORD).

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Tennessee (Mr. FORD) is recognized for 1 minute and 20 seconds.

Mr. FORD. Mr. Speaker, although I applaud the Republican realization that improving access to health care is vital to all Americans, I must oppose the bill.

The Census Bureau, as we all know, has reported that more than one million people last year, and now the number is up to 44 million people, are without health insurance. In my State of Tennessee, close to three-quarters of a million people are without health insurance. That amounts to about 15 percent of the State's population.

As a healthy 29-year-old male with a comfortable income, I would be eager to set up a medical savings account, which is one of the features of this proposal put on the floor today. However, this would help far too few of my constituents. It would hurt the poorest working people who have plans with the smallest deductibles. Eleven million children nationwide are without the basic care afforded to prison inmates in America. The most disproportionate groups of Americans uninsured were women and the working poor.

The Republican access bill does nothing to alleviate the problems of the working poor and children have in gaining health insurance. The main provision of the access bill is an expansion of medical savings accounts. This assumes that those without health care have enough money to save or are healthy enough to wait for interest to accrue.

The access bill also contains two other troubling provisions, the Associated Health Plans and HealthMarts. Each would allow insurance companies to bypass State laws and regulations, allowing plans to select the young and the healthy from the State-regulated markets. This would drive up the premiums for the sick and the old.

This $48 billion, which my dear friend says this will cost, again represents another raid on the Social Security Trust Fund. The $792 billion tax scheme they are attempting to pass cannot be paid for without dipping into the trust fund, and neither can this.

Mr. TALENT. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, this is about people who do not have health insurance. Let us remember who they are. Three-quarters of them work for small businesses or they are dependents of people who work for small businesses or they own small businesses. They are our friends. They are our neighbors. They are people who have been down-sized by big companies and who have had to go to work as consultants. They are people who have retired from companies who are not old enough yet for Medicare. They are people who have histories of illnesses, and they cannot get insurance on the individual market unless they want to pay $1,000 or $1,200 a month.

I bet everyone in this room is somebody like that or knows somebody like that. We know who the uninsured are. And we can help them. We can help all those people who are working for small businesses that cannot afford to provide them with health insurance or cannot afford to provide it at a cost that they can afford, and we can do it with Association Health Plans that allow small businesses to pool together just the way big businesses do and buy health insurance for groups of thousands and thousands of people across this country, with all the efficiencies that that means, without the insurance companies' marketing costs and the profit margin and with the efficiencies of a big pool.

We have studied this bill a number of years. We passed it in the House last year. We can make a difference for people who desperately need to have us make a difference for them.

What are the reasons given for not doing this? It costs too much. Well, the Associated Health Plans do not cost the Government anything. The rest of

the bill costs $8 billion over the future 5 years. We paid $20 billion in agricultural relief over the last 2 years. I supported that. I thought that was important.

Everybody in this House, the White House, and most of the people here want to pass a tax cut of at least a couple hundred billion dollars. So we cannot spend $8 billion helping the uninsured? We cannot afford not to help these people who are sick.

The Association Health Plans are not safe. The reserves are not high enough. We met every objection of the American Academy of Actuaries. These are going to be fully regulated by the Department of Labor or by the States if they want to. The insurance companies do not like it. No, the insurance companies do not like Association Health Plans. We will have to live with that. It increases costs to small businesses and farmers.

Tell that to the coalition of 90 small business people and farmers who support this bill because they know it will reduce their costs and enable them to make health insurance available.

It is only for the healthy. Mr. Speaker, it is precisely the ill people who want to get in big groups. That is why they like to work for big businesses. They are the ones who will be benefited by Association Health Plans.

And then the one I cannot understand more than any of the others: it is only for the rich. Only the rich people are going to benefit from this.

Well, tell that to Lasette Lopez, who my friend from California talked about. Her mom is a migrant worker. She got a heart transplant and she is alive because of a State Association Health Plan. I do not think she is rich. Tell that to Linda Welch-Green, a report in the Baltimore Sun today, who works as a cashier at a garage. She would be able to get her health insurance under this and get her Bell's Palsy taken care of. She is not rich.

Let us forget about those tired old arguments, the old class envy thing that gets brought out every time we try to do something good for America. Let us help these people. This is the only opportunity we are going to have to do that. It is a real opportunity. We have studied it long enough. We passed it last year. Let us pass it now and send it over to the Senate and insist that they do something for our friends and our neighbors who do not have health insurance and face the risk of illness every day without it.

Mr. STARK. Mr. Speaker, I yield myself 3 minutes.

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

Mr. STARK. Mr. Speaker, I do want to remind my colleagues that this bill is the penultimate waste of taxpayers' money.

The Joint Committee on Internal Revenue Taxes, a committee run by the Republican majority on the Committee on Ways and Means to estimate the cost and benefits of tax bills, has estimated that there will be a grand total of 160,000 uninsured individuals who could possibly benefit from this bill, 160,000 people, I say to the gentleman from Missouri (Mr. TALENT), at a cost of $48 billion over 10 years.

Mr. Speaker, would the gentleman from Missouri (Mr. TALENT) like to respond to a question?

Why does he think it is so important to spend $48 billion to help 160,000 people? Because that is all this bill does.

Mr. TALENT. Mr. Speaker, will the gentleman yield?

Mr. STARK. I yield to the gentleman from Missouri.

Mr. TALENT. Mr. Speaker, there are 44 million people who are uninsured.

Mr. STARK. Mr. Speaker, reclaiming my time, but according to the Joint Tax Committee, only 160,000 people who are uninsured will receive any benefit.

Mr. TALENT. Mr. Speaker, if the gentleman will continue to yield, the Association Health Plan provision in the bill about which I just spoke will, conservatively speaking, provide health insurance to 48 million people who currently do not have it.

I would say to the gentleman, if there is a chance that this bill can provide help for these people, it is a chance that we ought to take. I would ask the gentleman why is he not willing to do that on behalf of these people.

Mr. STARK. Mr. Speaker, I am not willing to waste $30,000 a year per family to pay for it because the insurance is not worth that much. This is squandering the taxpayers' money. I will repeat what the Joint Committee on Taxes has said.

□ 1545

That the total people benefiting from this bill, while there will be 12,400,000, all of them already have insurance. There are only 160,000 people who are eligible who are uninsured.

So we are spending, I just want to repeat, we are spending $48 billion to help 160,000 people. They may each insure two people so to give my colleagues credit, I will say it is 320,000 people. That is a cost of $15,000 a head, $30,000 a family, for 10 years. My colleagues could buy them a hospital and a doctor for that kind of money.

The Republicans just do not know what they are doing. They are squandering the taxpayers' money.

I just want to remind everybody, $48 billion to help, according to the Committee on Ways and Means, Republicans-controlled Joint Committee on Taxation, there are only 160,000 people who are uninsured who qualify. That is ridiculous.

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

Mr. Speaker, as the House prepares now to consider legislation on liability and lawsuits, it is important that we consider that there are 44 million Americans who lack even the basic coverage of today's health plans.

What we do in this health access bill will keep many of them from falling into the uninsured. It will, furthermore, qualify more and more people who work, who are self-employed to be able to have access to plans. It will level the playing field within the Tax Code for everyone.

The gentleman from California has just said we are squandering the taxpayers' money. Far more billions of dollars are going out for the deductibility of employers who are providing health insurance today. They get a tax deduction. Why should only the employer get a tax deduction? Why should not the self-employed get an equal tax deduction? And why should those who pay their own premiums, without the benefit of an employer's program, not also get a deduction?

This is equity within the system, as well as making insurance more affordable for all of those people.

This bill also is not just about that type of insurance. It is about long-term care, which is a medical concern of a different sort for more and more millions of Americans, and greater access to long-term care, helping those people who are taking care of the elderly in their own home by giving them an extra tax exemption.

Now, the gentleman from California says that is squandering the taxpayers' dollars. I dare say to those families who are taking care of the elderly in their homes, that to get a little bit of tax relief is certainly not squandering the dollars that are coming in to Washington.

The 44 million people will increase that are uninsured unless we address the barriers to access. This bill is a first step to do that. It is not the ultimate answer, but these barriers are preventing Americans from getting affordable care at a rate of nearly 1 million a year; and, frankly, all the lawsuits in the world will not add anything to help a worker struggling to buy health insurance for his or her family or struggling to maintain their elderly in their own home.

The best patient protection of all is health insurance, and our plan is the only one before the Congress that helps families get the coverage and the care that they need.

Our plan is based on three fundamental principles: Affordability, accessibility, and individual choice. A major source of America's frustration with HMOs is a lack of control, which both patients and doctors feel. Patients want to be able to pick up the phone and get an appointment to see their own doctor. Doctors want more time with their patients and to treat them as they see fit.

Answers to these frustrations, however, are found when we empower people, not lawyers. Our plan helps make health care available and affordable for every generation. Baby-boomers caring for elderly family members at home will get help from our tax breaks, as I mentioned. We even help them plan for

their future and the long-term care that they may need through deductions for the purchase of long-term care health insurance.

A new family will also get help with its health insurance costs, costs that have outpaced average household income last year by nearly two-to-one. And small businesses, which create 95 percent of new jobs, will benefit with accelerated deductions for the self-employed, so start-up companies can offer competitive benefits to attract and retain the best workers.

Finally, nothing embodies the vision of choice and accessibility more than medical savings accounts. Expanding MSAs will give consumers more control over their health care dollars, offering them the freedom to consult any doctor they choose to lower their deductibles or premiums and to save any unused funds for future health care expenses. With MSAs' patients and not insurance companies, not a third party payer, controls the choices. There are no gatekeepers, and there are no middlemen.

More Americans are using medical savings accounts because they put patients back in charge and not insurance companies. In fact, 28 percent more Americans opened MSAs last year. That means that thousands of Americans who previously had no health insurance are now covered because of MSAs, and that is our top priority.

By the way, this is $9 billion of revenues over 5 years, not the $50 billion that we have heard over and over again from the other side. After all, the House budgets only for 5 years, and they have been prepaid by the American people in the form of a projected surplus that will be close to $300 billion over the next 5 years; $8 billion out of $300 billion, and that is all according to the Congressional Budget Office.

Are Democrats now saying that they are not for any tax relief whatsoever, even to help low- and middle-income Americans get health insurance? Are they opposed to giving some relief for those caring for their elderly relatives at home?

I would remind my colleagues what Senator BOB KERRY, a Democrat, said, and I quote, to suggest that we cannot afford to cut taxes when we are running a $3 trillion surplus is ludicrous, unquote.

In closing, let us not lose sight of the real health care problem facing Americans and their families today: Lack of the most basic patient protection of all through health insurance. And while accountability in health care is an important aspect of the managed care debate, there are 44 million reasons why Republicans are broadening the focus to include affordability, accessibility and individual choice. Americans want more ambulances, not more ambulance chasers, and they want to spend more time in front of their doctors and not in front of a judge.

This bill is the right kind of health care reform, and I urge a ''yes'' vote.

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

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

Mr. Speaker, I wonder if the gentleman from Texas (Mr. ARCHER) would indulge me and respond to a question. I had stated that over 10 years this bill would cost, just for the tax deduction, $31 billion.

The gentleman is quite correct, for 5 years it would cost less, but in the outyears the cost goes up.

Is it not correct that there would only be 200,000 uninsured people, or 100,000 insured individuals, policyholders, who would benefit from the tax, according to our own Joint Committee on Taxation?

Mr. ARCHER. Mr. Speaker, will the gentleman yield?

Mr. STARK. I yield to the gentleman from Texas.

Mr. ARCHER. Mr. Speaker, the gentleman appears to be quoting the Joint Committee on Taxation for his numbers, and I have requested the Joint Committee on Taxation to give me the basis of that, and they say they have no knowledge of that. So there is some misunderstanding relative to those figures.

Mr. STARK. I will be glad to share with the gentleman those figures, and perhaps we can discuss it later.

Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. RANGEL), the ranking member of the Committee on Ways and Means.

Mr. RANGEL. Mr. Speaker, I think the whole country now knows the substance of the bipartisan bill, the Norwood-Dingell patients' rights bill. I think all over, people are saying that the patients' rights should be determined by physicians and when that does not occur and when there is liability that they should have the right to sue.

I think that there are enough people on the other side of the aisle that have decided that this was the right, this was the decent, and this was the moral thing to do.

I think that both the majority and minority have come to believe that now the majority of the Members of the House were going to vote on the Norwood-Dingell Patients' Bill of Rights, and every editorial indicated it would pass and the President would sign it into law.

We wondered what little tricks anyone could come up with; what could they possibly do and what could they pull out of this hat of tricks that they manage to come up with from time to time? They could spread EITC further and not give the poor folks what they are entitled to when they work every day. They could look for the thirteenth and the fourteenth month. They could start determining that everything that came up they could not pay for was an emergency. But we never, never, never thought that they would just pull out of the hat a tax bill that never came out of the tax-writing committee.

I say a tax bill that never came out of the tax-writing committee because I am led to believe that the provisions that are in this health access bill came out of the conference the Joint Committee on Taxation had, that is the Republicans had, and that no Democrats were involved in it, except to vote against it.

So why would they take a bipartisan bill that Republicans have worked hard on and try to attach this poison pill to it, knowing that it is not paid for? It can be said that it is $9 billion, it is $12 billion; it can be said that it is not $40 billion or $50 billion, but if the President has promised that if it is not paid for he is going to veto it, then I guess the only answer to the senseless, committeeless bills that have come out to the floor from either the Committee on Appropriations or the Committee on Rules is that the majority has decided that it really does not intend to legislate at all. What it intends to do is to send out political statements so that the President of the United States can fulfill his commitment to the American people and to veto those bills that are not funded.

It is not fair. It is not fair to do this for a bill that my colleagues know we have the votes to pass in the House of Representatives.

Mr. ARCHER. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. SAM JOHNSON).

Mr. SAM JOHNSON of Texas. Mr. Speaker, again I find myself on the floor in another debate about freedom, the basic principle of democracy. To debate over freedom means to choose the quality health care that one wants.

This bill permits all individuals access to health care by expanding medical savings accounts. Medical savings accounts allow all Americans to have the freedom to choose their own doctor and decide, with their doctor, what sort of medical care they need.

My colleagues will notice that medical savings accounts have been expanded by more than 28 percent last year. We need to allow them to choose. The best way to provide health care to every American is not to add government regulations but to lift the regulations that prevent people from getting quality care.

I believe the path to good medicine and health care should pass through the doctor's office, not the lawyer's office.

I think that it is important for us to help people learn new innovations, and this bill also contains a medical innovation tax credit which helps our teaching hospitals and research facilities continue their fight to find cures for deadly diseases such as cancer.

The American people have said they want control over their own health care. The answer to this problem is to give every American the freedom and control to choose their own doctor and medical savings accounts, and this legislation will do just that.

□ 1600

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

Mr. CARDIN. Mr. Speaker, let me thank my friend from California for yielding me this time.

Mr. Speaker, every Member here is concerned about the rising number of uninsured Americans, now more than 43 million; and we recognize that steps must be taken to address this problem. But H.R. 2990 is not the answer. This bill does very little to reduce the number of uninsured. Instead, its sponsors are proposing a new set of tax breaks that would help those that are least likely to be currently uninsured, as my friend from California pointed out.

It also contains many provisions that will hurt us in covering people with insurance. The Health Association Plans that the sponsors brag about, there is a reason why the National Governors' Association and the National Conference of State Legislators are opposed to it, for it preempts these plans from State reform. Under the guise of helping small business be able to find health insurance, instead what we are doing is preempting State reform.

And I could tell my colleagues in my own State of Maryland we have a small market reform; it is working. Small employers can find affordable health insurance. If we pass this provision, we have destroyed the Maryland small market reform, and we are going to have less people insured by small employers in our State if that provision becomes law.

But let me tell my colleagues the real reason, the most important reason, why we should oppose this effort. If we want to pass a patients' protection bill in this Congress, if we want to provide help to our constituents from the practices of HMOs, then we need to defeat this bill. The unfair rule that we are operating under marries this proposal with the Patients' Bill of Rights, and if this becomes part of the Patients' Bill of Rights, it is much less likely that we are going to enact a Patients' Bill of Rights in this Congress. That is why this rule was passed in the way it was, and that is why this bill is on the floor today.

Mr. Speaker, if we are serious about expanding access, let us work together to do it. This bill will not do it. I urge my colleagues to reject it.

Mr. CRANE. Mr. Speaker, I yield 1½ minutes to our distinguished colleague from Arizona (Mr. HAYWORTH).

Mr. HAYWORTH. Mr. Speaker, I thank my friend from Illinois for yielding the time, and I thank my friends on the left for offering a clear choice today, because really this comes down to a simple question: Who do you trust in terms of health care?

One of the reasons I left private life and ran for public office is because those on the left favored big government to run health care, take power out of the hands of patients, put that power in the hands of Washington bureaucrats, and that is being reaffirmed, Mr. Speaker, even while those on the left offer their incisive legislative analyses of why there is a poison pill attached to this.

Mr. Speaker, how on earth can putting power in the hands of patients to choose the doctors they want through medical savings accounts, how on earth can that freedom be regarded as a poison pill?

I rise in strong support of this legislation, mindful of the fact that nearly one-quarter of the population of Arizona is uninsured, and I wish my friends in the minority would come with me to Show-Low, Arizona, to hear the people of that town say give us medical savings accounts, give us the ability to choose health care for ourselves, we need that help; and I wish they could hear the pleas in the town hall meetings I attend where the self-employed say give us 100 percent deductibility on health insurance, the same provisions the big boys have.

That is what this legislation does, and association plans, it is interesting to hear my friend from Maryland, they cannot have it both ways.

Mr. Speaker, if my colleagues want to federalize health care in one arena and then criticize accessibility to insurance through Association Health Plans, there is something there that cannot be reconciled.

Stand for the people, stand for freedom, stand in favor of this legislation.

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

I suspect, Mr. Speaker, that the gentleman from Arizona, like myself, gets his health insurance from the Federal Government, and I do not hear him complaining about that.

Further, Mr. Speaker, I would just like to remind my colleagues that at a cost for these 200,000 uninsured people of 15,000 a year, the Speaker would have to have a breakfast to raise money from lobbyists several times to be able to get enough money to pay for the cost of this health plan.

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

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

Mr. LEVIN. Mr. Speaker, this so-called access bill is in truth a smokescreen, so flimsy that it is easy to see through. Its main effect would be to sink Dingell-Norwood, not help the uninsured. It is about access of the majority to special interests and their access to the majority far more than it is about access of 45 million uninsured to health insurance.

Mr. Speaker, that is clear because, number one, according to the analysis of the joint task committee, and I am sorry the chairman of the committee is not on the floor; here is the letter dated October 6 from the Joint Committee on Taxation that is under the control of the majority. It says that this bill would help 160,000 taxpayers, only 1 percent of the uninsured. Ninety-nine percent of the uninsured would be left high and dry while giving a tax benefit to those already insured, and the higher one's income, the more would be the tax benefit.

Number two, it is not paid for, and it is going nowhere.

Three, the majority have refused to allow the minority to present an amendment to pay for the cost of Dingell-Norwood. They say they are doing that because the amendment would not be germane. What is not germane is the inability and unwillingness, not the inability, but the unwillingness, of the majority to make this amendment germane. The majority claimed there was no consideration in committee of the Democratic paid-for proposal, but all but two parts of it were in the Republican tax bill that passed this House, and the other two were in a proposal presented in the Committee on Ways and Means by Democrats.

The best answer is a large vote for Dingell-Norwood and place the Republican leadership in a quandary as to what to do next to thwart the will of the American people. Let us give a resounding vote to Dingell-Norwood.

Mr. CRANE. Mr. Speaker, I yield 1½ minutes to our distinguished colleague from Washington (Ms. DUNN).

Ms. DUNN. Mr. Speaker, I rise today in support of the Quality Care for the Uninsured Act, a bill that will address the most critical issue facing our Nation's health care system today, that is, the issue of access. The total number of uninsured Americans in the United States today is 44 million people, 706,000 people in my home State of Washington. As we proceed with this debate, we must remember that maintaining the world's finest health care system is a balancing act. How do we sustain the quality of health care that most Americans enjoy and still extend the benefits of that system to those who lack coverage?

The first principle we must accept is that the marketplace, not the Government, must be the focus of our support efforts. Our health care system is the envy of the world, and American businesses, hospitals and researchers are on the forefront of medical innovations that are bringing a better quality of life to the people of the United States.

In my home State of Washington hundreds of companies are researching new ways to combat illnesses through biotechnology, through new medical devices, and through automated testing. Many of these treatments will be the foundation of a new health care system, one that increasingly relies on groundbreaking technology to replace traditional treatment methods. We must not overly burden this system with new costs that will lead to more uninsured Americans or redirection of precious resources away from investing in critical new technologies. Helping people purchase private-sector insurance is the most important first step we can take to improve our system.

Mr. Speaker, the American people need access to coverage that keeps

them healthy more than they need mandates to government. Please support this bill.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Washington (Mr. MCDERMOTT).

Mr. MCDERMOTT. Mr. Speaker, on the way in here I met a reporter from one of the major newspapers that said what is going on up on the floor? Why are they adding that access stuff to the perfectly good bill that the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) put together? I said, well, they are just trying to avoid for one more time addressing the issue of the uninsured in this country.

This bill will do absolutely nothing. Less than 1 percent are affected at all. If my colleagues were serious about the tax break, they would make it a refundable tax break. The gentleman from California (Mr. ROGAN) and I put in a bill that said give a 30 percent refundable tax break, but they did not do that because they did not want to help the people on the bottom.

In the census data they talk about, they talk about people who make less than $25,000 in this country. One out of four is uninsured, and this bill does nothing for those people. So they simply are not serious about access.

Now I believe that the reason this is out here is because the polling must be real bad. They took all that credit for beating the President who wanted to give affordable health care that could never be taken away. They said we killed it; we are going to let the private sector take care of it. Well, Mr. Speaker, the private sector has now put them in the position where it is not 35 million who do not have insurance; it is 44 million who do not have insurance. That is why we have Medicare, my colleagues.

Forty-nine percent of seniors had health insurance in 1963. Today 99 percent of the people have it. They got it because we had a government program run through the private sector, private doctors, private hospitals, and what this bill will do; and I kind of hope it passes because I know it will fail because what they are doing is cutting up the insurance pool, and it is ultimately going to fail, and we are going to have more people uninsured.

The gentlewoman from Washington (Ms. DUNN) talks about it helping her State. There is no individual insurance available in the State of Washington. So if someone tries to buy it, they cannot buy it. We can have all the tax deductions in the world, and we will not get a single dime.

Vote no on this.

Mr. CRANE. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. FOLEY).

Mr. FOLEY. Mr. Speaker, I rise in strong support of this package, and I will say some of the conversation from the other side of the aisle is suggesting if it is not my idea, it is not a good idea.

I happen to be a cosponsor of Norwood-Dingell, and I support this package. I have worked with the great Governor Lawton Chiles in Florida, and we came up with similar proposals when I was in the legislature. We talked about expanding access. There is a problem of uninsurability, there is a problem with fewer people becoming enrolled, and there is a crisis of cost shifting. Hospitals, uninsured, all these programs are helping to raise premiums because fewer are insured.

My colleagues, we can do both today. We can pass good health care legislation as prescribed by Norwood-Dingell, but we can also talk realistically about some tax cuts to make insurance more affordable.

Now the President goes out and campaigns on giving tax deductions for elder care, and from the other side of the aisle we hear applause. But if it is a Republican idea, it is stupid, it is bankrupting the system, it is too expensive.

My colleagues, let us stop the rhetoric. Let us help average Americans. Let us get out of this chamber, this echo chamber of hostility, and pass some real legislation. We do have a chance to do both today. Do not shirk from the responsibility and the opportunity.

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

Mr. Speaker, I am pleased to help 160,000 Americans to the tune of $48 billion. That is real help to the average taxpayer.

Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. LEWIS).

Mr. LEWIS of Georgia. Mr. Speaker, I rise today with great concern. I am deeply concerned that millions of Americans are without health care. I am concerned that parents cannot afford to take their sick children to see a doctor. Too many of us are more worried about insurance companies than patients' care. We are more concerned with managing liability than caring for those who are sick and weak.

This is not just, this is not right, this is not fair. Access to health care is a right.

Mr. Speaker, we need to pass a meaningful Patients' Bill of Rights. We need a bill that will hold insurance companies responsible. We need a bill that will give patients the right to sue in State courts.

□ 1615

We need to do what is right. Let us not jeopardize this remarkable opportunity we have worked so hard and so long to build. My colleagues, the people of America are counting on all of us.

Mr. Speaker, let us work together to pass one of the most important health care bills in our lifetime. Now is the time, not next year, not next month or next week, but now is the time to pass a Patients' Bill of Rights, without poison pills.

Let us do what is right. Do it for the American people. Do it for the 40 million without any health insurance, without health care. Pass this bill for the people. Pass the Dingell-Norwood bill.

Mr. CRANE. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, my State of Illinois saw its ranks of uninsured increase from 12.4 percent in 1997 to 15 percent in 1998. That is disheartening and unacceptable, and we want to see what this Congress can do to address the problem. We have before us today H.R. 2990, the quality care for the uninsured, which is intended to reduce the ranks of the uninsured.

Much to the disappointment of some of our colleagues on the other side of the aisle, it is not drafted to create a Federal takeover of our health care system. Rather, it is intended to help hard-working uninsured Americans afford health insurance for their families and it will solve the problem, at least better than it is being addressed today.

Will it do all? Probably not. But let us give it a chance. This bill contains provisions that our small business community tells us will go a long way in bringing more Americans under the protection of health insurance so they do not have to fear financial ruin as a result of a medical crisis.

I urge my colleagues to support H.R. 2990 and help the 44 million Americans who have been ignored for too long.

Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Ohio (Mr. PORTMAN).

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

Mr. Speaker, I rise in strong support of the health access bill before us today. It is interesting, the Norwood-Dingell bill is not before us. We are talking about another piece of legislation that is directly focused on trying to cover more of the uninsured.

Just two days ago the Census Bureau told us that 44.3 million Americans now do not have health insurance in the years 1998 and 1999. That means there are about 1 million more uninsured since 1997.

That is disheartening, that in this time of relative prosperity we do have about 16 percent of our population without insured access to health care. That is what this bill is all about.

About 161 million Americans get their health care coverage through their employers, and, of course, many of those are small employers. We all know small business, self-employed people, typically operate on very tight margins, making health insurance very difficult for them to afford. And as we debate the managed care issues before us today, we have to be sure we are not increasing the ranks of the uninsured, by increasing the potential for liability, by increasing the Federal mandates, by increasing the costs and burdens of health care.

The essential provisions of this health care access bill will go a long way towards seeing that not fewer, but more Americans receive insured access

to health care. That is why this is so important.

It has a lot of good provisions on the tax side. Taxpayers who pay more than 50 percent of the costs of their premiums that the employers are not picking up will now be able to deduct 100 percent of that premium cost they incur that is.

This is a good idea. Over 7 million people now need long term care insurance. We now think that by 2050 that number is going to be about 20 million Americans. This bill addresses this problem by providing individuals who purchase long-term insurance with 100 percent deduction.

Mr. Speaker, there are so many other good things in here that will focus on the issue of trying to get more access, including medical savings accounts, new drugs to find cures for diseases. This is the right prescription to making our health system work better.

Mr. STARK. Mr. Speaker, I am pleased to yield 1½ minutes to the gentleman from California (Mr. BECERRA).

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

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

Mr. Speaker, over 44 million Americans do not have health insurance, yet this bill that we have before us by the majority wants to spend $48 billion to cover 160,000 of those 44 million Americans who do not have health insurance. It is also a bill that leaves the uninsured out in the cold, not just because it does not cover enough of them, it is because most of these tax breaks go for those who pay income taxes in large portions. So who is left out? Most of those 44 million Americans who are working poor, and, therefore, do not pay the substantial number of income taxes to get all of those tax breaks.

Who will benefit? The 160,000 people who benefit are those who are higher income individuals who can shop around and buy insurance already. It is an abusive way to try to spend money. It is an abusive way to try to give coverage. There are better ways to do it.

Perhaps the worst thing about this bill is it is fiscally irresponsible. $48 billion, not paid for, and, worse than that, somehow the math does not add up. The majority here is talking about doing an $800 billion tax cut. It is already overspending its appropriations bills for next year's budget by about $30 billion, and now we are going to pile on top of that $48 billion.

Explain to the American people where you get the money. You can only spend a dollar one time. You are trying to tell the American people you have a shell game going on and you can spend it lots of times.

Let us not pass this bill. Let us get real reform, and tomorrow let us get to the real work at hand, and that is to provide the American people with the rights that they demand. When they go to a hospital, they want to know that they have the best information, the best doctors, to get the best care, and if they do not get it, they deserve to go after whoever was responsible for not giving it to them.

Let us do the right thing. Let us get beyond this, defeat this, and get to getting to the Patients' Bill of Rights.

Mr. CRANE. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Speaker, I rise in strong support of this legislation to provide access to health insurance by the uninsured. The number of uninsured people has risen dramatically, a very troubling fact, given the economy, the low unemployment and poverty rates. Health insurance is a critical component of personal financial fitness and we should be doing all we can to help people afford health insurance. You can be for patients rights and for coverage of uninsured Americans.

This legislation provides tax deductions for people who pay 50 percent of the cost of health insurance and long-term care insurance. The GAO has said this will expand coverage to 40 million Americans, 25 million of whom are uninsured. Does it matter whether you help 25 million of the 43 million uninsured? You bet it does. And by making insurance more affordable, you can help them get into the health care system we all value and depend on.

We spend $100 billion in tax breaks for people who have employer-provided insurance, regardless of their income, so why should we not treat those who pay their own premiums exactly the same way? It is a matter of fairness, it is a matter of access to critical benefits, health insurance.

In addition, this bill expands availability to MSAs. I have visited a company in my district, a manufacturing company. These are working people, and they have chosen MSAs. They have a choice and they choose MSAs. Why? Because they can spend MSA dollars on dental benefits, vision benefits, home health care benefits, drug benefits, a far broader range of benefits than most employer plans provide, because they can spend those MSA dollars on anything eligible in the Tax Code.

Why would we not want to offer them that choice? Do we not trust them? I think it is terrific to have sure coverage. And the sicker you are, the better off you would be in an MSA, because once you meet that deductible and you can spend it on everything, then you get catastrophic coverage, and that is the best deal for a really sick person.

In addition, the bill provides new and more affordable choices for small businesses so they can offer coverage to their employees.

In short, let me say that this is a great bill, we should support it, and if we do not open up access, we need our heads examined, because that is the real problem out there. We can do Patients' Bill of Rights and access this week in this House.

Mr. Chairman, I am pleased to rise in strong support of this legislation that will help people afford health insurance. The number of uninsured people has risen dramatically over the past year—a troubling fact, given the growth in our economy and low unemployment and poverty rates. Health insurance is a critical component of personal financial fitness. We should be doing all we can to help people afford health insurance.

This legislation will expand access to health insurance. First, it will offer tax deductions for people who pay at least 50% of the cost of their health and long-term care insurance. At my request, the GAO has examined the impact of a health deduction and concluded that 40 million people would have been eligible in 1997 for a tax deduction for health insurance. Of these 40 million, 25 million were uninsured. We are currently providing over $100 billion in tax breaks to people who have employer-provided insurance regardless of their income. We should do no less for people who have to pay their own premiums. It's a matter of fairness. It's a matter of access to health insurance.

In addition to helping the uninsured through premium deductibility, this bill expands the availability of medical savings accounts (MSAs). MSAs are a preferred way for some people to cover their health insurance costs. I have visited a small company in my district that offers MSAs to their employees. I heard directly from the workers that they prefer MSAs because their health care dollars cover a far broader range of health benefits, better benefits than almost all employers provided plans—dental, vision home care drugs! And gain access to a broad range of doctors, instead of a narrow group covered through an HMO.

In addition, this bill provides new and more affordable choices for small businesses to offer coverage to their employees. Only 28% of employers with less than 25 workers offer health insurance. The main reason for small employers not offering health insurance is the higher costs they face. Their small size means they cannot spread the risk associated with a few unhealthy employees. They also face higher administrative costs.

If we are going to address the problem of uninsured Americans, we must help small businesses, which are one of the fastest growing employment sectors, afford to offer health insurance coverage. People working for small businesses account for 16% of the under-65 population, but 28% of the uninsured. This legislation will help small employers pool together to afford the cost of insuring their workers. It will also create access to health insurance and health care services for people in urban and rural areas by allowing community health centers to serve as insurance networks.

It is critical that we address the problem of the uninsured. CBO estimates that for every 1% increase in health insurance costs, 400,000 people lose their health insurance. If we consider managed care reform legislation without taking steps to increase access to health insurance, we are turning a blind eye to the 44 million Americans who have no health insurance option plus those who will lose their litigation runs premiums up. Our efforts to improve health insurance quality must include equal commitment to increasing the number of insured Americans. H.R. 2990 takes these steps. I urge its adoption.

Mr. STARK. Mr. Speaker, in the interest of explaining how we spend $48 billion to give 160,000 people access, I yield 1½ minutes to the gentleman from Texas (Mr. STENHOLM),

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

Mr. STENHOLM. Mr. Speaker, I rise in strong opposition to this legislation. I do not do so because I do not agree with the goal of increasing access to health insurance. In fact, I support many of the individual provisions in this legislation.

I oppose this legislation because it is fiscally irresponsible to enact legislation that would cost nearly $50 billion, without paying for it and with no clear end game for health care in sight.

Congress should not consider any tax or spending legislation without knowing how it would fit within the context of a comprehensive game plan which balances all of the various health needs of all Americans at an affordable cost. Any decision to fund tax cuts or new spending out of the projected surplus should be made only after we have sat down in a regular committee process in a bipartisan way to make sure there will be sufficient resources for competing needs.

As important as the issue before us today is, we also have a responsibility to deal with the problems of Medicare that threaten rural hospitals, set more realistic discretionary spending levels, deal with the long-term problems facing Medicare and Social Security, and leave room for tax cuts for purposes in addition to health care.

This legislation takes the approach of spend first, figure out if we can afford it, given all the other demands on the surplus later. Some of my friends on the other side of the aisle argue they could not allow the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL) to add an amendment paying for the cost of their bill that we will be considering tomorrow because it was not germane and did not go through the Committee on Ways and Means. I find it very curious we are now bringing up a $50 billion tax bill that did not go through the Committee on Ways and Means and which violates the budget rules. I do not understand that double standard that makes it easy to spend money we do not have and impossible to be fiscally irresponsible.

Mr. CRANE. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Pennsylvania (Mr. ENGLISH).

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

Mr. ENGLISH. Mr. Speaker, in Pennsylvania in 1998, roughly 10 percent of the population did not have health insurance of any sort, and these were not just the indigent, they were small business people, they were self-employed, people who simply could not afford the premiums.

This legislation contains an element fundamental to any balanced debate on health care policy. It would make health care coverage more accessible, not for 160,000, for millions, and, in doing so, blunt the impact of any cost increases that might result from the imposition of health care quality standards.

American families are concerned about their health care. We in Congress must recognize that their concern relates to both the quality of health care and its cost. We cannot and we should not address one without the other.

Mr. Speaker, this legislation is not a poison pill for health care reform, but an essential ingredient to any balanced approach to health care policy. For those of us who support a market oriented incremental approach to improving our health care system, this represents an important step toward the goal of universal access to affordable care.

Mr. STARK. Mr. Speaker, I yield such time as he may consume to the gentleman from Maine (Mr. BALDACCI).

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

Mr. BALDACCI. Mr. Speaker, I appreciate the gentleman yielding me time.

Mr. Speaker, I rise in opposition to this legislation and in favor of the Norwood-Dingell bill, and at the same time to express the worry of Maine's citizens about the out-of-state health insurance companies taking away local control. I am looking forward to working with the gentleman from Georgia (Mr. NORWOOD) and others.

Mr. Speaker, I am very pleased to rise today in support of this bipartisan effort to guarantee minimum standards for access to care for all Americans. This legislation provides crucial protections and preserves the doctor-patient relationship.

Most importantly, this bipartisan bill will hold health plans accountable for their medical decisions. Let's be clear. When an insurance company overrides the decision of a medical professional, that plan is clearly making a decision affecting the health of the patient. This bill recognizes that simple fact.

This bipartisan bill empowers our citizens and assures them that at the very minimum, their relationship with their doctors—relationships built on trust—will not be infringed upon, no matter who owns the plan to which they belong. This bill is necessary in a climate where local control over health insurance is dwindling.

I am deeply concerned about this diminishment of local control which is evident in the current trend of consolidation of health insurers. I am particularly concerned about what this trend means for access to and quality of care for Americans in rura areas.

In my state of Maine, for example, regulators are currently reviewing a proposed merger that will dramatically change the health insurance landscape. If approved, Blue Cross and Blue Shield of Maine will be taken over by an ever-growing regional health insurer. People in my state, one-third of whom are covered under Blue Cross, are experiencing great anxiety about the coverage they will have under an out-of-state insurer with interests spread across the country. The citizens of Maine worry about whether large out-of-state health insurers will take away local control of their plan, reduce benefits while raising premiums, or cut back on quality care.

As the trend of insurance mergers and acquisitions continues, we in Congress ought to continue to review the effects this has on health care delivery and quality of care, especially in rural areas. Although this is not within the scope of this legislation, I would hope that we can soon look further into this trend and ensure that health care consumers' interests are being adequately represented. I hope that Mr. NORWOOD agrees that this is something we should revisit in the future.

I would like to thank Mr. NORWOOD and Mr. DINGELL for their tireless efforts to bring managed care reform and patient protection to the House floor. The American people are demanding change and accountability in this industry. This bill provides real protections for citizens and has the teeth needed to make these protections meaningful. I am pleased to be an original cosponsor of this important legislation, and urge my colleagues to support this bill and to oppose amendments that would weaken it.

Mr. STARK. Mr. Speaker, I yield the balance of my time to the gentleman from Georgia (Mr. NORWOOD).

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Georgia is recognized for 1½ minutes.

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

Mr. Speaker, I have listened to this debate through all three committees, and I am looking for a place to hang my hat. I am very much for the access provisions. I am for medical savings accounts. I am for deductible of long-term care, of insurance. I am for HealthMarts. I even can live with Associated Health Plans if we will put just a little bit of patient protections under ERISA.

But I am not going to vote for this, even though I have a bill that I dropped in the spring that is just like this, because I have concluded, after listening to this debate, that this effort is not to have a law. This bill was not ever intended to be a law. This bill simply is intended to go to conference with patient protections to act as a poison pill, to make sure that we cannot pass those protections that we want.

I know my Republican friends. They would never put up a bill, whether it costs $50 billion, as some say, $43 billion, as others say, $8 billion, as others say, it does not matter, I know we would never put up a bill we intended to be law without trying to figure out how we are going to pay for it.

□ 1630

We are not going to raise taxes to pay for it. We are not going to dip into social security to pay for it. There is no excess in the Treasury, there is only excess of our FICA money. Maybe there will be next year, but this bill does not give us any assurances at all as to how it would be paid for.

This is a bill that can be passed out of the House of Representatives, but it

is not intended to be the law of the land, at least not this go-round. Maybe at another time, another date, we can get that job done.

So I have to oppose the bill simply on the basis that it is a poison pill.

Mr. CRANE. Mr. Speaker, I yield the balance of my time to the gentleman from California (Mr. THOMAS), the distinguished chairman of the Committee on Ways and Means.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from California (Mr. THOMAS) is recognized for 2 minutes.

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

Mr. THOMAS. So, Mr. Speaker, it has come to this. If Members had a chance to actually look at the legislation and they had a chance to vote, let me ask the Members if they would be in favor of this: ''Provide an above-the-line deduction for health insurance expenses if your employer does not pay for it.''

That was in the tax bill that was sent to the President. The President vetoed it. We think it is important enough to bring it back. They said it had not been voted on. It has been voted on.

''Provide an above-the-line deduction for long-term care insurance.'' Would Members like to have that deduction? We want people to have it. We sent it to the President. He vetoed it.

Accelerate, for those who are self-employed, the ability to write off, like corporations, their health insurance, so people who are self-employed could have 100 percent coverage as well. It was in the tax bill that was sent to the President. The President vetoed it. We want people to have it. It is in this measure.

''Extend the availability of medical savings accounts.'' Young people who are not going to get sick maybe want to invest in their health, and if they do not spend the money at the end of the year, they can roll it over, but let them choose. That was in the bill that was sent to the President that he vetoed. We still think it is a good idea.

How about if we want our long-term care insurance to be part of a cafeteria plan, if one has insurance? It was in the bill vetoed by the President. We think we should have it.

How about if someone is taking care of someone in our homes right now, out of the goodness of their hearts and their kin relationship? Would they not like to have $1,000 deduction on the tax form? We believe we should have it on the tax form. We sent it to the President. He vetoed it. We think it is important enough to give it to the American people.

That is what this access bill is all about. It is access in ways people can use. We voted on them, we sent them out of the House, we sent them to the President, and he vetoed it. The problem was, it was in a larger bill that contained a number of other items. Now, these are very specific access issues for people. We think they are important enough. They stand alone. The American people should get them. If we vote for this, they will.

Mr. SANDLIN. Mr. Speaker, the Republicans are again playing games with the American people. They are telling the public what they want to hear, hoping no one will read beyond the title of their bill, the Quality of Care for the Uninsured Act.

Well, Mr. Speaker, I read the bill and it doesn't provide access to health insurance to those who need it most. According to the General Accounting Office, nearly one-third of all uninsured Americans would not be helped by this bill. Why? Because they make so little income that they do not pay income taxes. How will the Republican tax breaks help these families? It will not help them one cent.

Of the 44 million uninsured Americans, of whom 5 million live in the State of Texas, the people this bill aims to really help are the 600,000 uninsured healthy families that make almost $100,000 per year and can afford the risk to opt out of the broader insurance pool. The effect of this would be to drive up costs for those most in need of coverage. In addition, the Ways and Means Committee has also determined that only 160,000 people of those 600,000 families would qualify for access to insurance under this bill. Yet we would be spending 48 billion dollars on this phony access package. Even worse, the bill is not paid for within the budget or by offsets.

Mr. Speaker, my Republican friends on the other side of the aisle continue to ignore budgetary reality in order to push through a 48 billion dollar access bill, the funds for which will come directly from the Social Security trust fund. Like the supporters of this bill, I want to give more Americans a range of options for their health care—they should have at least as many choices in their health care plan as Federal employees. However, this bill does not deliver on what its supporters are promising. The Republican access bill will benefit a small group of people and is simply intended to kill the Norwood-Dingell managed care reform bill that so many of my colleagues on the other side of the aisle are trying to derail.

Republicans have already spent over $25 billion over the Social Security surplus, but here they are again with a tax bill they can't pay for. I urge my colleagues not to raid Social Security. I urge them to vote against this fiscally irresponsible poison pill to the Norwood-Dingell managed care reform bill.

Mr. FRELINGHUYSEN. Mr. Speaker, more than 16 percent of the people of my home State of New Jersey don't have health insurance. The national figure is even more staggering—44 million uninsured in America, one in six Americans goes without health care coverage. Mr. Speaker, these numbers are a wake up call and today we are taking steps to respond to the needs of the uninsured.

The Quality Care for the Uninsured Act (H.R. 2990) improves access, affordability and individual choice for the 44 million Americans who lack health care insurance.

H.R. 2990 includes measures designed to ensure that the nation's health care system is accessible and affordable for all Americans.

Highlights of the tax incentives found in H.R. 2990 are:

100 percent deduction for health insurance premiums—for the second time this year, we will send the President a bill that allows each and every American to deduct every penny they pay for health insurance premiums—hopefully he won't veto it the second time, 100 percent deduction of health and long-term care insurance costs for self-employed Americans, and 100 percent deduction for long-term care premiums for all Americans, relief for taxpayers caring for elderly family members at home, cafeteria benefit plans will now be permitted to include long-term insurance, expands medical savings accounts for more Americans to allow more of our families to save for emergency medical needs.

Helping more Americans obtain health insurance is a top priority and this bill will do just that. I urge my colleagues to support H.R. 2990.

Mr. HILL of Montana. Mr. Speaker, it is clear that a growing number of Americans are looking to Congress and their state legislatures to address their concerns facing our health care system.

They are concerned of the number of uninsured working adults and their dependents. They are concerned about the rising costs of health care. They are concerned about the lack of choice in health plans. They are concerned that important decisions involving their health care are being made by government bureaucrats or insurance company adjusters rather than their physician.

While we enjoy the highest quality health care in the world, our system of financing health care often frustrates patients, providers and employers. People are deeply concerned that their health plan may not deliver the care they need when they are sick.

I believe that we need to promote the three A's in reforming the system—Accessibility, Affordability and Accountability.

Mr. Speaker, today we will be taking up the first two important parts to ensuring patient protection—Accessibility and Affordability.

The best patient protection of all is access to quality, affordable health care. Yet, there are more than 43 million Americans who are currently uninsured. Nineteen percent, or nearly one in every five Montanans are uninsured. More than 60 percent of the uninsured have one thing in common—they are either self-employed, or their family is employed by a small business that cannot afford to provide health benefits.

H.R. 2990 promotes accessibility and affordability by requiring basic protections to ensure high-quality health care coverage. This legislation accomplishes this in three major ways.

First, we accelerate the phase-in of the 100 percent deduction for the health insurance of self-employed individuals to become effective in 2001.

Secondly, the bill establishes a process for certifying association health plan (AHPs). AHPs empower small business owners who currently cannot afford to offer health insurance to their employees, to access health insurance through trade and professional association.

Third, this legislation expands medical savings accounts (MSAs) to increase access to health care services and patient control of health care expenditures.

Through these three and many other provisions in H.R. 2990, today the House will pass a common-sense approach to providing affordable choices and reliable access to health care for consumers.

Again, I urge all of my colleagues to support this bill.

Mr. BARCIA. Mr. Speaker, I rise today in opposition to H.R. 2990. This bill, while ostensibly aimed at expanding access to healthcare for those who are currently uninsured, in reality fails to provide access to health insurance for those who need it most. The authors of this bill have been very creative in drafting this legislation. They tout Association Health Plans, Tax Deductions for the Self-Employed and Uninsured and expanding Medical Savings Accounts. And unlike some of my Democratic colleagues, I have supported versions of these proposals in the past. I have worked with small businesses and local chambers of commerce in Michigan to allow them to form Association Health Plans. I have supported tax deductions for the self-employed and allowing individuals open tax free savings accounts for the purpose of covering their medical expenses. However, I must oppose this bill because of the many clever exemptions included by the authors of this legislation that will ultimately undermine any hope of increasing access to healthcare or providing important patient protections for our constituents.

Under this bill, Association Health Plans will be exempt from important consumer protection, insurance and benefit regulations. Consumers in 33 states that require mental health benefits could lose this protection. Women in 49 states could lose mammography screening. Children in 29 states that require well-child care could face new financial barriers. These new plans intended to increase access will actually open new barriers to much needed health care.

In addition, H.R. 2990 spends $48 billion federal on tax breaks that do more to help the healthy and the wealthy than the uninsured. According to the General Accounting Office, nearly one third of all uninsured Americans are at the lowest end of the income bracket. New tax deductions or medical savings accounts will not help them to purchase health insurance. These hardworking families are completely ignored by this bill.

This morning I received a postcard from the National Federation of Independent Business which I submit for the record. It stated:

DEAR REPRESENTATIVE: On behalf of the 600,000 members of the National Federation of Independent Business, I urge you NOT to help the 44.3 million uninsured Americans by voting for H.R. 2990.

Now I realize this is probably not the argument the NFIB intended to make in an attempt to garner support for this bill, however, the statement does have merit.

H.R. 2990 does not help the millions of Americans who are uninsured. It does not improve their access to healthcare. It does not provide important patient protections. Instead, it grants tax breaks to the healthiest and wealthiest. Instead, it divides the insurance market between the healthy and the sick, undermining state efforts designed to spread health risks broadly. Instead of improving access to health care, this bill ignores millions of Americans who cannot afford the high cost of health insurance.

Mr. Speaker, I urge my colleagues to vote no on this bill.

DEAR REPRESENTATIVE: On behalf of the 600,000 members of the National Federation of Independent Business, I urge you not to help the 44.3 million uninsured Americans by voting for H.R. 2990, which will expand access to affordable health care coverage for small businesses and their employees.

Specifically, H.R. 2990 would lower health care costs for small business while increasing their choices in the health care marketplace. Here's how:

Association Health Plans (AHPs) would give small business the administrative cost savings, economies of scale, and bargaining power now enjoyed by big business;

Tax-Deductible Premiums for the Self-Employed and Uninsured would offer tax equity to level the playing field between the ''haves'' and ''have nots;

Medical Savings Accounts (MSAs) would allow families to exercise control over their individual health care dollars to address their particular needs.

Don't turn your back on the uninsured, the majority of which (3 out of 5) are small business owners and their employees. Increase their access to affordable health care coverage. Vote for H.R. 2990! This will be an NFIB Key Small Business Vote for the 106th Congress.

Sincerely,

DAN DANNER,
Vice President, Federal Public Policy.

Mr. VENTO. Mr. Speaker, I rise today in opposition to H.R. 2990, the Quality Care of the Uninsured Act.

While I am concerned by the burgeoning numbers of uninsured, I am not convinced that this legislative initiative will provide relief to those who most need health care coverage. I am also disappointed that the Republican leadership has used this important forum for debate on managed care reform to resuscitate discredited tax proposals that are not even offset. Last week, the Congressional Republicans promised once again not to use Social Security trust funds; this week, they are advancing H.R. 2990 with no offset. Last week, the Congressional Republicans promised once again not to use Social Security trust funds; this week, they are advancing H.R. 2990 with no offsets, and once again breaking their promise not to spend Social Security funds.

Unfortunately, Medical Savings Accounts (MSAs) are predicated primarily on greater cost-sharing and reduced health care use by beneficiaries. While this may be feasible for the wealthy and healthy, it does not help the sick and poor, and could lead to adverse selection by health plans. Essentially, MSAs are just another tax break for those who need it least.

While I have supported full tax deductibility for small business health insurance in the past, I question policies to promote further segmentation of health care consumers. Association Health Plans and HealthMarts would not only separate the healthy from the sick, but they would allow certain health plans to circumvent state regulation. It is ironic that H.R. 2990 would actually create a more expansive ERISA shield at a time when Congress is trying to close the current ERISA loophole.

Mr. Speaker, while the individual market may offer healthy people affordable coverage, people with substantial health risks will be burdened with disproportionate costs or limited access under this proposal. Disguised by popular bromides such as access and choice, these proposals would only serve to create further disparities in health care utilization in our society.

It is unfortunate that we continue to allow a slow erosion of health care coverage at the expense of some of our most vulnerable workers and their families. Congress should seek comprehensive and responsible measures to reduce the number of uninsured. However, H.R. 2990 will not accomplish that goal. I urge my colleagues to reject this legislation and work towards substantial managed care reform that does not include costly tax breaks which blatantly expend Social Security trust funds.

Mr. STEARNS. Mr. Speaker, I am pleased to support H.R. 2990, the Quality Care for the Uninsured Act. The legislation promotes access to health coverage for the estimated 43 million Americans who are currently lacking health insurance.

Approximately 85 percent of these individuals are employed and either opt to forego such coverage (healthy young individuals) or work for companies who cannot afford to provide such benefits to their employees.

Most people who have health insurance are covered by a health insurance policy chosen for them by their employers. If they work for small companies/businesses that cannot afford to pay for health coverage, they often have no coverage at all. If they are fortunate enough to have employer provided coverage, the possibility remains that if they lose their jobs or decide to change jobs, this valued benefit can be lost. Individuals who are self-employed currently get a 60% tax credit for purchasing their own health insurance, unlike the major corporations who get a 100 percent credit for purchasing health coverage for their employees.

Tax benefits should be moved out of the workplace and shifted over to the individual or family. Everyone—the self-employed as well as those who work for small firms—should get a tax credit to enable them to purchase coverage for themselves and their families. These credits should be larger for those whose medical expenses make up a greater share of their income. These credits should be refundable so that low-income individuals and families should get assistance if they have no tax liability.

Under current tax law, third-party insurance is subsidized and self-insurance is penalized. Every dollar an employer pays for third-party insurance is excluded from employee income. When employee's try to save that money it is taxed.

If we are to have true health care reform, we must provide individuals with the option of being allowed to create Medical Savings Accounts (MSAs). These Medical IRA would enable consumers to use tax-free savings accounts to self-insure for routine, out-of-pocket medical expenses.

By empowering consumers with choice and individual responsibility, a healthy competition among insurance companies to compete for the consumers' health care business would be generated.

One of the proposals in H.R. 2990 to expand access to health coverage is through the establishment of HealthMarts which would shift the decision making power over to the individual or family. Everyone—the self-employed as well as those who work for small firms—should be allowed to purchase coverage for themselves and their families. The consumers would be given the ability to making their own choices. This gives consumers a sense of empowerment and a sense of responsibility which will encourage them to wisely use medical services.

H.R. 2990 provides for the establishment of Association Health Plans (AHPs) to allow national trade and professional associations to

sponsor plans. This would also allow them to buy into plans and pool together for themselves and their employees.

This bill also allows Community Health Organizations to form networks to give community health centers greater control of their resources and to provide comprehensive coverage to the people they assist.

Community health centers offer a valuable service by providing primary health care in our rural and urban communities. I have toured these community health care centers and know full well the valuable services they provide and it is one of the most cost-effective programs in which our government invests to meet the growing demands of the uninsured and underinsured.

I support this important bill that would provide those individuals, many of whom are the working poor, who do not currently have access to health care insurance an opportunity to purchase such care for themselves and their families.

Ms. MILLENDER-McDONALD. Mr. Speaker, the nation continues to cry our for reform of the managed care system. However, I must rise in strong opposition to this bill and the rule that has brought this important issue to the floor. As legislators, we must stop playing games with healthcare. I have great respect for my colleague Mr. TALENT, but I do not believe that H.R. 2990 provides the access to quality health care that our constituents really need.

When we talk about access to health care, those that are most in need are children and those with limited means. This bill does nothing to provide access to those people. Instead it contains ''poison pill'' provisions in an effort to pander to campaign contributors. One-third of the currently uninsured will still not have access to health care. This bill spends federal dollars on tax breaks—when is the last time a tax break benefited the poor and low-income?

I urge my colleagues to vote no against this special interest poison pill package disguised as an ''access'' bill to health care.

Mr. WELDON of Florida. Mr. Speaker, I believe strongly that any discussion of improving the quality of care for those with health insurance must also include a discussion of ways to make health insurance more affordable. Earlier this week, the Census Bureau released the latest figures showing that nearly one million additional Americans were added to the ranks to the uninsured last year. We must take steps to ensure that these Americans have greater access to affordable health insurance.

There is no doubt that the managed care reform legislation that we are considering today will result in higher insurance premiums for Americans. There is significant difference of opinion about how much those premiums will go up. Will it be one percent, three percent, or ten percent? Study after study has indicated that with every one percent increase in insurance premiums 300,000 additional Americans lose their insurance. That is why I believe it is so critical that these issues be considered together.

H.R. 2990 will expand insurance options for uninsured Americans. I am particularly pleased that the bill provides a 100 percent deduction for health insurance premiums and long-term care premiums if the taxpayer pays more than 50 percent of the premiums. This is long overdue. For too long, Americans who pay for their health insurance out of their own pockets have not had the same opportunity to deduct these expenses as do large corporations. This bill fixes that problem.

I am also pleased that the bill provides families with an additional exemption ($2,750) if they care for an elderly family member in their home. This is important in helping families who have made a decision to care for an elderly family member in their own home, rather than placing them in an expensive long-term care facility.

Association Health Plans (AHPs), which are encouraged in this bill, will play a critical role in helping those who work for small businesses have access to affordable insurance. This is the largest segment of uninsured Americans. AHPs enable small employers to pool together to obtain the economies of scale, purchasing clout, and administrative efficiencies enjoyed by employees of larger firms.

H.R. 2990 expands Medical Savings Accounts (MSAs) to increase access to health care services and patient control of health care expenditures. It (1) allows both employers and employees to make contributions to MSAs: (2) makes MSAs a permanent health care choice under the law; (3) eliminates the cap on the number of taxpayers (currently 750,000) that may benefit annually from MSA contributions; (4) reduces the minimum deducitble to $1,000 for individual coverage and $2,000 for families; and (5) allows MSA contributions equal to 100 percent of the deductible;

The bill also allows for the creation of HealthMarts, which are private, voluntary, and competitive health insurance ''supermarkets'' that transfer choice within the current employer-based health insurance market from small employers to their employees and dependents. HealthMarts are similar to the Federal Employee Health Benefits Plan (FEHBP) which gives federal employees greater choice among a host of different plans. They will be established and run by private sector partnerships consisting of providers, consumers, small employers, and insurers.

Finally, the bill permits Community Health Organizations (CHOs) to offer health insurance coverage in a state in which they are not licensed under certain conditions. This change is designed to make it easier for providers to form health care networks to meet needs in medically under served areas.

Again, I believe that this bill, combined with patient protection legislation will play an important role in improving the quality of health care and giving Americans greater access to affordable insurance plans.

Mr. HAYES. Mr. Speaker, over the August recess, I had the opportunity to meet with a number of health care providers in my district, the 8th district of North Carolina. Without exception, these care givers share a common concern. Hospitals and clinics in rural America appear to shoulder a disproportionate share of the spending reductions agreed to in the Balanced Budget Agreement of 1997. Now why do I bring up this subject today. Because our hospitals are currently providing health care for the more than 43 million uninsured Americans and have to absorb the cost.

Hospitals and clinics are faced with the untenable position of having to scale back services or closing their doors altogether. In fact, many of our providers have trimmed services to such an extent that in the near future they may be forced to turn away critically ill patients. As you can imagine, further cuts in Medicare spending expected for next fiscal year will only exacerbate the current problem, leaving our hospital administrators braced for the worst, but financially unable to respond to needs.

If we do not address the desperate situation in which our health care providers find themselves, my constituents, both individuals and businesses, will not have any choice when it comes to health care—hospitals, doctors, nursing homes. I am hearing from hospital and nursing homes that they will be closing their doors within the next year if immediate relief for these budget cuts are not addressed.

Elements of all three health care bills that are being debated later today will become obsolete if our hospitals and clinics begin to close, including: Rural Americans diminished access to health care because they will have to drive too many miles to see a primary care physician; emergency care that will be so far away that patients could die before ever reaching a hospital; and less access to local pediatricians, obstetricians, and specialists.

Bottom line the health care services will be unavailable. I support the intentions of the underlying health care bills, but at what cost? I cannot pass along these costs to the consumer.

Let's pass H.R. 2990—Quality Care for the Uninsured to give small businesses, individuals and early retirees the access to affordable health care. But, let's please be careful how we pass along the cost to consumers. Let's allow patients to speak freely with their doctors. Let's be sure there is accountability. Let's provide choice in primary care physicians and specialists, and give employers the opportunity to provide affordable benefits to their employees. But, if we pass costly new mandates—won't we be passing along the cost to the consumer that we are trying to help with H.R. 2990?

I would also like to urge the Speaker—Let's address Medicare reform this year—so that both of these bills do not become null and void in Rural America.

Mr. RYAN of Wisconsin. Mr. Speaker, I am here today to speak in favor of the Quality Care for the Uninsured Act.

You are going to hear a lot of discussion later today about protecting individuals who are enrolled in health plans in this country; but we have a much bigger problem in this country. A problem that this act provides solution for—the problem of the uninsured.

It is important to make sure individuals who have health care are receiving quality care, but it even more important to find a solution for the growing number of uninsured. The Census Bureau reported that currently 44 million people in this country do not have health insurance—that number has been steadily rising during this administration. We must find a way to provide a better system for them—a system that makes health care affordable and accessible.

This bill does that with healthmarts, medical savings accounts, tax deductions for the self-employed and the uninsured, tax deductions for long-term care premiums, and association health plans. These provisions will help small businesses find a way to offer health insurance for their employees.

I believe everyone in this country deserves quality, affordable health care. This bill provides that through tax incentives and market reform. I urge my colleagues to join me in voting in favor of the Quality Care for the Uninsured Act.

Mr. BALLENGER. Mr. Speaker, I rise today in strong support of H.R. 2990, an important and timely bill designed to help the 44.3 million Americans who have no health insurance whatsoever. These Americans will find little comfort from our debate later today and tomorrow over improvements to managed care plans. H.R. 2990 offers something for them—that is, accessible, affordable and accountable health insurance coverage.

This week, Congress and the American people learned from a Census Bureau report that the ranks of the uninsured has swelled by another one million. I support the efforts of the Republican leadership to give these uninsured Americans more choice in the health insurance market instead of expanding big government plans which President Clinton has embraced.

To this end, H.R. 2990 contains important changes in the tax code which we have championed in earlier tax relief packages, including expanding Medical Savings Accounts (MSAs). We have worked for years to convince President Clinton that expanded eligibility for MSAs is one solution to the problem of the uninsured. The facts are in: 42 percent of individuals purchasing MSAs this year were previously uninsured. In addition to the creation of association health plans and ''HealthMarts,'' H.R. 2990 also accelerates to 2001 the phase-in of the 100 percent deduction for the health insurance of the self-employed Americans. Last month, the President rejected an immediate 100 percent deduction of these costs when he vetoed the Taxpayer Refund and Relief Act of 1999.

I believe we need to add common sense and tax relief to the health care access debate. H.R. 2990 does just that, and I urge my colleagues to vote for it.

Mr. STARK. Mr. Speaker, this is a very tough week for the House Republican leadership. In an attempt to get the spotlight off of bipartisan attempts to curb the power of big managed care companies, the Republican leadership is finally willing to talk about helping the uninsured get access to health care. Unfortunately, while their proposals are expensive, their talk is cheap.

In a very cynical attempt change to the topic from managed care reform, we will see Republicans on the floor today in the House of Representatives claiming to be trying to expand health insurance to the uninsured. Don't be fooled. Their proposal will not help the population the most likely to lack health insurance and it isn't financed at all. It would cost the federal government more than $48 billion over ten years without solving the very problem it proclaims to address.

A record 44.3 million uninsured Americans live in our country today, hoping and praying they do not get sick or injure themselves. More than 32 million of these families have income at or below the 15% income tax bracket. These are people who cannot afford to pay insurance premiums—working families of modest means, people between jobs, students, unskilled workers who do not have the luxury of demanding employer coverage—or have a ''pre-existing condition'' that makes them persona non grata in the individual insurance market. The ''access'' provisions that the Republicans offer do little to nothing to help these people without insurance. Instead, they provide tax breaks to the wealthy and the healthy through a variety of tax changes that don't reach the uninsured.

For example, one of their so-called access provisions would expand a demonstration project on medical savings accounts (MSAs) so that all employers could offer them. Generally, demonstration projects have to ''demonstrate'' some success to be expanded but, in this case, the big insurance companies that offer MSAs have much more political clout with the GOP than the millions of uninsured. Instead of admitting that MSAs have failed, the Republicans are throwing more money into them. With bigger tax breaks, more healthy and wealthy people will use them, but that doesn't do anything for people too poor to afford insurance or benefit from MSAs.

Another provision would expand the deductibility of health insurance that employers and the self-employed receive to people who purchase their own insurance. It would not provide people with up front funds to help them purchase health insurance. Again, since more than 32 million uninsured families are at the 15% or 0% income tax bracket, this provision does nothing to make insurance affordable to them.

The Republicans also do nothing to address the inequities of the individual insurance market. Anyone with a pre-existing condition, anyone who is older, anyone with a genetic history of potential health problems will continue to find it impossible to purchase affordable insurance.

There are also other Republican provisions that would preempt state regulation of insurance in favor of new federal regulations. These so-called Association Health Plans and HealthMarts would undermine successful state-based small group market and individual insurance reforms. They are less comprehensive health insurance policies that would escape state consumer protections. The Republican proposal would let these plans ''cherry-pick'' the healthy, low-cost patients and result in higher health insurance premiums for people in traditional state-regulated insurance.

If the Republicans were serious about providing access to the uninsured, there are a number of affordable, sensible solutions which they could be raising on the floor today, but aren't. Those provisions include items such as:

Passing the Medicare Early Access Act. Introduced again this Congress as H.R. 2228, this bill would allow all people aged 62–64 to buy into Medicare program, people aged 55–64 who have lost their job to buy into Medicare, and would allow people whose employers' renege on retiree health coverage the option of staying in COBRA until they are Medicare-eligible. This bill has only a small cost that can be fully covered by a number of small Medicare fraud and abuse revisions. Yet, we have seen no action on this legislation that would provide a new, affordable option for health insurance coverage for early retirees—the people who are the hardest to insure in the private marketplace and a significant growing portion of the uninsured.

Enacting provisions to protect children whose parents are leaving the welfare rolls for low-income jobs so that they aren't inappropriately dumped out of Medicaid and left without health insurance. The number of people with Medicaid coverage in 1998 was the lowest it's been since 1991, according to the Bureau's historical tables on insurance coverage.

Improving the State Children's Health Insurance Program. This program was passed by Congress with great fanfare in 1997 as a means of extending health insurance to half of the then 10 million uninsured children. According to new census data, we now have 11 million uninsured children after that program has been in existence two years. Clearly, it isn't working as intended. Serious attention should be focused on making this program work or finding a new solution for covering these 11 million children. It's not rocket science to figure out who are low-income children. The Internal Revenue Service could run a match or we could utilize data from the free and reduced price school lunch program to presumptively enroll children.

Passing H.R. 1180, the Work Incentives Improvement Act to allow the more than 8 million people receiving disability benefits return to work without fear of losing their health insurance. This bill has already unanimously passed the Senate and the Commerce Committee, but it has been stalled from reaching the House floor.

These are real, concrete steps that would help the uninsured, but they are not part of the Republican bill. Instead, all of these Republican leadership provisions benefit the well-heeled rather than the uninsured. Essentially the Republican leadership has taken a tax break package for the wealthy and disguised it as a health access bill. But the Wolf's teeth show through the sheep's clothing when one looks at how the bill is financed. Instead of finding off-sets and living within tradition pay-go rules, the Republican leaders decided to tap the surplus needed to shore up Social Security and Medicare and pay down the debt.

Not only are the Republican leaders not proposing a plan to help those who cannot afford health insurance, by using the surplus, they are putting the future of Social Security and Medicare in jeopardy and increasing the amount of debt we leave to future generations.

H.R. 2990 is a poison pill to managed care reform and I urge my colleagues to join me in opposing this legislation.

As further evidence of this point, I submit new data that we have received from the Joint Tax Committee.

As you will see, the Joint Tax Committee has estimated how many people the Talent Access bill would help.

The answer: Almost no one. The tax deduction for individuals paying for more than 50% of the cost of the health insurance will cost $31.2 billion over 10 years and result in 200,000 uninsured people getting insurance. That's $156,000 per new insured person—$15,600 per year.

The acceleration of the 100% tax deduction for the self-employed will help 120,000 previously uninsured and cost about $3 billion over 4 years. That's $6,250 per person per year—a cadillac cost for sure.

JOINT COMMITTEE ON TAXATION,
Washington, DC, October 6, 1999.

Hon. EDWARD M. KENNEDY,
U.S. Senate, Washington, DC.

DEAR SENATOR KENNEDY: This is in response to your letter of October 4, 1999, requesting revenue estimates and other information concerning several of the health care

tax provisions in the conference agreement on H.R. 2488 and two of the health care tax provisions in S. 1344.

The conference agreement on H.R. 2488 contains an above-the-line deduction for health insurance expenses and long-term care insurance expenses for which the taxpayer pays at least 50 percent of the premium. The deduction would be phased in at 25 percent for taxable years beginning in 2002 through 2004, 35 percent for taxable years beginning in 2005, 65 percent for taxable years beginning in 2006, and 100 percent for taxable years beginning in 2007 and thereafter. Taxpayers enrolled in Medicare, Medicaid, Champus, VA, the Indian Health Service, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program would be ineligible for the deduction for health insurance expenses.

The conference agreement on H.R. 2488 also contains a provision that would allow long-term care insurance to be offered as part of cafeteria plans, effective for taxable years beginning after December 31, 2001.

For the purpose of preparing revenue estimates for these provisions in H.R. 2488, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2002 about 9.1 million taxpayers would claim the 25-percent deduction for health insurance expenses. About 100,000 of these 9 million taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 200,000 persons would be newly insured as a result of the 25-percent deduction for health insurance expenses.

We estimate that in calendar year 2002 about 4.7 million taxpayers would claim the 25-percent deduction for long-term care insurance expenses, and an additional 300,000 taxpayers would use cafeteria plans to pay their share of premiums for employer-sponsored long-term care insurance. About 80,000 of these 5 million taxpayers would be new purchasers of long-term care insurance.

S. 1344 contains a provision that would increase the deduction for health insurance expenses of self-employed individuals. Under present law, when certain requirements are satisfied, self-employed individuals are permitted to deduct 60 percent of their expenditures on health insurance and long-term care insurance. The deduction is scheduled to increase to 70 percent of such expenses for taxable years beginning in 2002 and 100 percent in all taxable years beginning thereafter. S. 1344 would increase the rate of deduction to 100 percent of health insurance and long-term care insurance expenses for taxable years beginning after December 31, 1999.

S. 1344 also contains provisions that would eliminate certain restrictions on the availability of medical savings accounts, remove the limitation on the number of taxpayers that are permitted to have medical savings accounts, reduce the minimum annual deductibles for high-deductible health plans to $1,000 for plans providing single coverage and $2,000 for plans providing family coverage, increase the medical savings account contribution limit to 100 percent of the annual deductible for the associated high-deductible health plan, limit the additional tax on distributions not used for qualified medical expenses, and allow network-based manage care plans to be high-deductible plans. These provisions would be effective for taxable years beginning after December 31, 1999.

For the purpose of preparing revenue estimates for these provisions in S. 1344, we have assumed that the provisions will be enacted during calendar year 1999. Estimates of changes in Federal fiscal year budget receipts are shown in the enclosed table.

We estimate that in calendar year 2000, about 3.3 million taxpayers would claim the 100-percent deduction for health insurance expenses of self-employed individuals. About 60,000 of these taxpayers would be new purchasers of health insurance. Assuming an average of two persons covered by each policy, about 120,000 persons would be newly insured as a result of the 100-percent deduction for health insurance expenses.

We do not have an estimate of the numbers of individuals who would be newly insured as a result of the medical savings account provisions of S. 1344.

I hope this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,

LINDY L. PAULL.

Enclosure: Table #99–3 206

ESTIMATED REVENUE EFFECTS OF VARIOUS PROVISIONS RELATING TO HEALTH CARE

[By fiscal years, in millions of dollars]

Provision	Effective	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000–04	2000–08
Health care provisions in the conference agreement for H.R. 2488:													
1. Provide an above-the-line deduction for health insurance expenses—25% in 2002 through 2004, 95% in 2005, 65% in 2006, and 100% thereafter.	tyba 12/31/01	—	—	−444	−1,379	−1,477	−1,803	−3,137	−5,878	−8,299	−8,848	−3,300	−31,264
2. Provide an above-the-line deduction for long-term care insurance expenses—25% in 2002 through 2004, 35% in 2006, 65% in 2006, and 100% thereafter.	tyba 12/31/01	—	—	−48	−328	−964	−417	−677	−1,315	−2,027	−2,146	−741	−7,324
3. Allow long-term care insurance to be offered as part of cafeteria plans; limited to amount of deductible premiums [1].	tyba 12/31/01	—	—	−104	−151	−171	−190	−202	−204	−215	−247	−426	−1,484
Total of health care provisions in the conference agreement for H.R. 2488.		—	—	−596	−1,858	−2,012	−2,410	−4,016	−7,397	−10,541	−11,241	−4,467	−60,074
Health care provisions in S. 1344, as passed by the Senate:													
1. Immediate 100% deductibility of health insurance and long term care insurance premiums of the self-employed.	tyba 12/31/99	−245	−1,007	−1,040	−657							−2,949	−2,844
2. Liberalization of conditions for enrolling in MSAs	tyba 12/31/99	−93	−281	−326	−370	−414	−458	−502	−546	−590	−634	−1,483	−4,214
Total of health care provisions in S. 1344, as passed by the Senate.		−338	−1,268	−1,866	−1,027	−414	−458	−502	−546	−590	−634	−4,432	−7,164

Note.—Details may not add to totals due to rounding.
Legend for "Effective" column: tyba=taxable years beginning after [1] Estimate assumes concurrent enactment of the above-the-line deducation for long-term care Insurance (item 2.)
Source: Joint Committee on Taxation.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 323, the bill is considered read for amendment, and the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. RANGEL

Mr. RANGEL. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. RANGEL. I am, Mr. Speaker, in its present form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Rangel moves to recommit the bill, H.R. 2990, to the Committee on Ways and Means with instructions to report the same promptly back to the House with an amendment in the nature of a substitute that—makes the bill consistent with the President's demand to preserve the projected surpluses until there is action on Medicare and Social Security solvency.

PARLIAMENTARY INQUIRY

Mr. ARCHER. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. ARCHER. I have just listened to the motion to recommit. I have a copy of it in writing before me. I am curious as to what is the amendment that will make the bill consistent with the President's demand.

This says to report the bill back with an amendment that will make it consistent with the President's demand. I am curious as to what the terminology and the wording of that amendment would be.

The SPEAKER pro tempore. These are general instructions from the gentleman from New York contained in the motion to recommit, so they are general instructions and not instructions to report "forthwith", which could be taken up in the Committee on Ways and Means if the motion to recommit is successful.

The gentleman from New York (Mr. RANGEL) is recognized for 5 minutes in support of his motion to recommit.

Mr. RANGEL. Mr. Speaker, I understand the problem that my chairman has in not understanding any amendment that preserves the projected surpluses in social security and Medicare. But this is what the President has been

saying all along, that we can present bills that are paid for, we can reduce benefits and other things, but the bill has to be amended, amended, amended, amended, paid for, paid for, paid for, paid for; not bust the social security trust fund, not bust the Medicare trust fund. That is all the amendment means.

I think we have had enough of partisanship for today. I think it is abundantly clear that the American people want a decent patients' rights bill. That is what they want. That is what Republicans want. That is what Democrats want. We cannot be effective as a body if we truly believe there is a Republican right way to do it or a Democratic right way to do it.

The only way we can do it is putting the party labels behind us and sitting down like the gentleman from Georgia (Mr. NORWOOD) has and the gentleman from Michigan (Mr. DINGELL) has to put together a bill that is not good for our parties, not good for our elections, but good for those people who need solid health care.

That is what we are trying to do. That is why we have a motion to recommit, not to get rid of the bill, but to make certain that we pay for whatever we attach to what is a good bill.

We do not know where Members got the access to health care to tax bills, but obviously if there is a little Republican bag of tricks, then come up with some money to pay for these things. That is all we are suggesting.

It is just not fair to the American people to see that they have lost the support of their own party on a bill that is good for the American people, and instead of just taking it and working with it and seeing where the next struggle would be for bipartisanship, they had to come up with something that not even the Members of the tax-writing committees have seen.

What they have done is to try to poison a good bill. It is not the right thing to do, it is not the fair thing to do, and it should not make Members proud, as Republicans, that they can kill a bill. They have the majority. The real question is, do Members have the determination to work with us so that we can work our will in providing the right thing for the American people?

When people talk about a Patients' Bill of Rights, they are not talking about a tax bill, they are talking about something that we have created together with Republicans and Democrats working together. So I do not know why that side would object to the motion to recommit. It gives them the opportunity to be responsible. It gives them the opportunity to review the access to health care through using the tax system.

If Members really believe we should use the tax structure, that is, no longer pull it up by the roots, no longer reduce it to the size of a postcard, but put another 30, 40, 50 pages there, which certainly the IRS would say that we would need in order to carry out the bill that Members just pulled up.

If Members really want to use the tax code for that purpose, I do not think there would be serious objection on the Democratic side, and not by the President of the United States. But they have to pay for it. This message has been sent out so often that I think the American people understand it a lot better than some of my colleagues on the other side.

All it says here is that the bill be recommitted to the Committee on Ways and Means. That means that we have to meet as a committee. I know that is difficult, but, Members know, no caucus, but Democrats and Republicans come together and report the same bill out promptly, which means all we have to do is to find ways to pay for this bill. Then we report it back to the floor. Then we can get on with the Patients' Bill of Rights.

If Members have no concern about what happens to social security and no concern about what happens to Medicare, then they can say, let us deal with the projected surplus. They can even say, let us do it with smoke and mirrors, whatever makes them feel comfortable.

But the whole thing is, let us not bring a bill to this floor and pass it because they have the numbers, only to have the President of the United States veto it. Do not send a bill like this over to the Senate, only to have them pile on whatever they wish to do in terms of loopholes for large corporations and probably donors to their party.

In other words, it is not Christmas in September. It is time for us to come together as Members of Congress, cut out the partisanship, and work together as a team.

The SPEAKER pro tempore. Is the gentleman from Texas (Mr. ARCHER) opposed to the motion to recommit?

Mr. ARCHER. Mr. Speaker, I am opposed to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Texas is recognized for 5 minutes.

Mr. ARCHER. Mr. Speaker, I listened to the gentleman from New York, and I heard the rhetoric that we are invading the social security trust fund, that we are undermining Medicare. He knows that is not true. There is nothing in this bill that in any way invades the social security trust fund, and it is so certified by the Congressional Budget Office. I do not know why we have to listen to that kind of rhetoric, but, of course, we do.

He says we have to save social security first. I agree with that. I have pushed for a plan to save social security, but I have not seen any specific plan come from the other side. We have been told recently in the media that the Chief of Staff in the White House has said that social security is not a priority anymore this year.

Are we then faced with a standard which says, you have to save social security before you can give tax relief, and then on the other hand, but we will not let you save social security, in effect, just simply saying, we do not want tax relief?

Why is this position being taken? Frankly, I do not know, because in 1997 we had a tax bill that was passed when social security was in worse shape and we had no surpluses, and they voted for it. They made a big point of all of the relief that they had given to the American people. But today they want to stop children from being able to have access to vaccines, a new vaccine that can be an across-the-board preventer of many, many childhood diseases. Sixty-four million children will be denied access to that vaccine. He calls it, or my friend, the gentleman from New York (Mr. RANGEL), calls it a poison pill. Who is poisoned is the children who will not be able to get a vaccination.

What really this is all about, Mr. Speaker, I believe, sadly, is some type of political ploy to get to some end position on the part of the Democrats that might give them an advantage in the elections next year. I cannot imagine what it is, but clearly that must be what they feel.

When the President vetoed our tax bill, he said it was too big. It was irresponsible, risky, too big. But we could have a $300 billion tax bill. Now we have tax relief for health care that will give more access to more people to health care, and it is $48 billion, and it still is not going to be accepted by the other side.

I do not know what is happening. Perhaps it is really that the Democrats want to fight ferociously to keep this money in Washington because they know better how to spend it than the people do in taking care of their own health needs. Perhaps; I do not know. I have wondered about this effort to try to tie something that has no relationship to social security and Medicare into the social security-Medicare mix.

But I do know that if this bill does not pass, we will have millions of Americans who will not have access to health insurance who would otherwise have it. We will have thousands and thousands of Americans who will not get tax relief for taking care of their elderly in their own homes.

□ 1645

We will have, again, millions of Americans who will not have access to long-term care insurance because they will not be given this tax deduction, and we will have a continuation of the inequitable and unfair treatment taxwise of different ways to provide health care; that big corporations get the deduction, the self-employed do not, and the individuals who have to buy their own insurance do not get it. That is wrong, Mr. Speaker. We cure that.

Mr. THOMAS. Mr. Speaker, will the gentleman yield?

Mr. ARCHER. I yield to the gentleman from California.

Mr. THOMAS. Mr. Speaker, I understood that there would be a denial of a vaccine if this measure is voted down.

Mr. ARCHER. That is correct.

Mr. THOMAS. That vaccine is for America's children?

Mr. ARCHER. Mr. Speaker, 64 million American children would have access to a new vaccine that will come on the market in November. But if this bill does not pass, it will not be put on the market.

Mr. THOMAS. So on one hand, it is rhetoric about corporations; and on the other hand, it is vaccine for the America's children.

Mr. ARCHER. Mr. Speaker, this motion is ill-conceived. It is vague. It should be opposed. I urge all of my colleagues to vote no on the motion to recommit.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). 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.

RECORDED VOTE

Mr. RANGEL. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 211, noes 220, not voting 2, as follows:

[Roll No. 484]

AYES—211

Abercrombie
Ackerman
Allen
Andrews
Baird
Baldacci
Baldwin
Barcia
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Forbes
Ford
Frank (MA)
Frost
Gejdenson
Gephardt
Gonzalez
Goode
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (CT)
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Smith (WA)
Snyder
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NOES—220

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Biggert
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth-Hage
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Foley
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Goss
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
King (NY)
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCollum
McCrery
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Ose
Oxley
Packard
Paul
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Saxton
Schaffer
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NOT VOTING—2

McKinney
Scarborough

□ 1707

Messrs. SIMPSON, CUNNINGHAM, CASTLE, POMBO, and Ms. DUNN changed their vote from ''aye'' to ''no.''

Mr. STUPAK, Ms. ROYBAL-ALLARD, Messrs. RODRIGUEZ, DAVIS of Florida, and SNYDER changed their vote from ''no'' to ''aye.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). 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. ARCHER. 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 227, nays 205, not voting 2, as follows:

[Roll No. 485]

YEAS—227

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Biggert
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth-Hage
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Cramer
Crane
Cubin
Cunningham
Danner
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Dooley
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Foley
Forbes
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
King (NY)
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (KY)
Lucas (OK)
Maloney (CT)
Manzullo
McCollum
McCrery
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Moran (VA)
Myrick
Nethercutt
Ney
Northup
Nussle
Ose
Oxley
Packard
Paul
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Saxton
Schaffer
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)

Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NAYS—205

Abercrombie
Ackerman
Allen
Andrews
Baird
Baldacci
Baldwin
Barcia
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Campbell
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Crowley
Cummings
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Ganske
Gejdenson
Gephardt
Gilman
Gonzalez
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Luther
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Morella
Murtha
Nadler
Napolitano
Neal
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Snyder
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NOT VOTING—2

McKinney
Scarborough

□ 1724

Mrs. ROUKEMA changed her vote from ''nay'' to ''yea.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate agrees to the report of the Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2606) ''An Act making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes.''

The message also announced that pursuant to Public Law 104–1, the Chair, on behalf of the Majority and Minority Leaders of the Senate and the Speaker and Minority Leader of the House of Representatives, announces the joint appointment of the following individuals as members of the Board of Directors of the Office of Compliance—

Alan V. Friedman, of California;

Susan B. Robfogel, of New York; and

Barbara Childs Wallace, of Mississippi.

PERSONAL EXPLANATION

Mr. WATTS of Oklahoma. Mr. Speaker, this afternoon I recorded my vote by electronic device in favor of the rule to consider the Quality Care for the Uninsured Act, H.R. 2990. Subsequently and unexpectedly, that vote was reordered due to a failure with the electronic eqipment, and I was not advised of this in time to return to the Capitol to recast my vote.

BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

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

□ 1725

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2723) to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, with Mr. HASTINGS of Washington in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Virginia (Mr. BLILEY), the gentleman from Michigan (Mr. DINGELL), the gentleman from Pennsylvania (Mr. GOODLING), the gentleman from Missouri (Mr. CLAY), the gentleman from Texas (Mr. ARCHER), and the gentleman from New York (Mr. RANGEL) will each control 30 minutes.

The Chair recognizes the gentleman from Virginia (Mr. BLILEY).

Mr. BLILEY. Mr. Chairman, I yield myself 6 minutes.

Mr. Chairman, over 5 years ago, Republicans in Congress stood efficient against a very bad idea, an attempted Government takeover of our Nation's health care system. Back then, we opposed President Clinton's vision of health care reform primarily because of the negative effects his proposal would have on employers and the negative effects it would have on consumers' ability to choose their own physicians.

Mr. Chairman, we won that debate over how to best reform our health care system. We won that debate because the public agreed that Government micromanagement of our health care system was wrong. The public agreed that imposing expensive new burdens on employers would result in an increase in premiums and would cause businesses to drop their health care coverage.

Now today we are faced with another debate about the direction of our Nation's health care system. Mr. Chairman, once again, we must decide whether we want to move toward a Government-controlled health care system or instead enact reasonable protections for patients that maintain quality without driving up costs. I stand here today with a firm hope that we will prevail in this fight similar to the way we did 5 years ago.

Mr. Chairman, I do not think that anyone would question my long-standing commitment to ensuring that the United States maintains its high quality health care system and that Americans of all walks of life have access to that system.

□ 1730

Unfortunately, I believe that H.R. 2723, the Norwood-Dingell bill, is misdirected in several fundamental ways and ultimately will harm the very people it intends to help.

My views on health care reform are fairly straightforward. First, we should do no harm. Doctors take the Hippocratic oath; we legislators should follow a similar injunction. We should vote down health reform legislation that harms patients. We should avoid legislation that increases the number of uninsured in this country. For all the attention that has been given in this debate to denied care, I think we should focus on the worst kind of denial, and that is denial to any form of health insurance at all.

Forty-four point three million persons are uninsured today, and we ought not be adding to that number; we should be subtracting from it.

Second, when we do enact patient protections, they should be just that, patient protections; not provider protections, not insurer protections but patient protections. That is why I have been an ardent supporter of a fair and just external review process.

My colleagues have heard me say ''care, not court.'' A patient in need of care needs medical treatment not legal treatment. In my opinion, H.R. 2723 goes way too far on liability and will simply be a treasure trove for trial lawyers.

By overreaching on the constraints it imposes on valid cost containment techniques, this bill poses a real threat to the voluntary, employer-sponsored health insurance system prevalent today.

I know how price-sensitive employers are. I was a small business owner myself some time ago. The Norwood-Dingell bill takes a reasonable idea, and then it takes it way too far. As a result, costs will needlessly go up and not always for the betterment of health care quality. For example, the bill does not have a point-of-service exemption for small employers. Due to this omission, many small business owners, who can least afford to contribute to health care coverage for their employees, will be left with the choice between providing Cadillac care or no care at all. Many of their employees will lose their employer-sponsored insurance because the point-of-service mandate will drive health care costs up.

The bill's whistleblower provision is another example of a reasonable idea gone bad, and the list goes on.

This bill micromanages a plan's utilization review requirement.

It gives too much secretarial authority in the selection of external review entities and in specifying the standards of review.

Even the bill's definition of medical necessity extends beyond what is needed to ensure that patients receive the most appropriate care.

Mr. Chairman, I could go on and on and discuss other concerns I have and point out the breadth of the bill's onerous ''any willing provider'' provisions and the lack of a conscience clause, but there are other Members here who wish to have their say.

Let me simply conclude as follows: As the chairman of the Committee on Commerce, I have reached across the aisle to draft reasonable patient protection legislation with my colleagues. While some amount of this bill reflects that effort, in the end the authors went too far, as I have said. This is unfortunate, and this is why I have cosponsored H.R. 2926 instead.

As I have said, my goals throughout have been to provide better, not worse, care to the American people; to provide access to needed medical care, not to courts of law; and to provide patient protections, not protections for the interests of providers or insurers.

Mr. DINGELL. Mr. Chairman, I ask unanimous consent that I may yield 15 minutes of the time available to me to the gentleman from Georgia (Mr. NORWOOD), to be controlled by him.

The CHAIRMAN. Is there objection to the request of the gentleman from Michigan?

There was no objection.

Mr. NORWOOD. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I appreciate the opportunity finally, after 5 years, for us to come together and decide an issue that has really confronted this body for 5 years, but the truth is it has confronted the American patient for 25 years.

The issue is whether managed care insurance companies can be held truly accountable in court when they breach their contract and someone is injured or dies.

Since 1974, this Congress has given HMOs a free pass to deny promised benefits without any legal responsibility for the damages that they do and have caused.

Are we willing to correct this injustice, finally, after 25 years? If so, we simply must pass a bill that can become a law which reverses that 1974 mistake, and a bill that we are certain will be signed by the President. We must also be able to answer in the affirmative the following question: If someone makes a wrongful medical decision or breaches their contract and a member of someone's family dies, will that family have an absolute, unconditional right to seek redress in court? Yes or no, no strings attached?

There is only one bill that we will consider that can pass this test, and that is a bipartisan bill supported by both Republicans and Democrats. I believe that everyone in this body knows that to be a fact. To cast a vote really for any other bill is to cast a vote to block managed care reform.

Not one Member of this body will be able to hide behind a vote for a watered-down bill that cannot become a law and claim to be on the side of patients. We know better. The American people know better. Vote no, Mr. Chairman, on every substitute. Vote yes on the only legislation that has really a chance of becoming law and changing the disaster that this Congress visited on the American people with the 1973 HMO Act and the 1974 ERISA Act.

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

Mr. DINGELL. Mr. Chairman, I yield myself 3 minutes.

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

Mr. DINGELL. Mr. Chairman, this is an old story. Last year, the industry spent $75 million to defeat legislation similar to that which we are considering today. Reports today indicate they will be spending in excess of $100 million for that purpose. Tonight they will be launching another new ad campaign with pictures of sharks and music from Jaws.

What scared them so much? Could it be they are afraid of paying for someone's cancer screening? Are they terrified of paying for surgery to some person who needs it? Is it the threat of paying for prescription drugs that has them petrified? Or maybe they are afraid of letting ordinary people make the decisions that affect their own lives.

Maybe they are afraid of the mother whose child has leukemia and wants the pediatrician to decide what care her child needs or perhaps a terminally ill cancer patient who has no other treatment available to save his life, other than a clinical trial.

Perhaps that patient needs to have an oncologist as his principal medical advisor. Maybe it is a woman in her second trimester of pregnancy whose doctor is dropped from the health care plan, or maybe it is a woman with breast cancer who has a mastectomy and is sent home that same day, or the man with a stroke who needs follow-up visits to a physical and speech therapist to regain full function.

The Norwood-Dingell bill would help each of these people get and continue the health care they need. None of the other substitutes can truthfully make that claim. The gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) and I have been working on these issues for years. Our bill has been totally vetted. We have even incorporated suggestions from other Members, including the gentleman from Oklahoma (Mr. COBURN) and the gentleman from New York (Mr. HOUGHTON).

We are going to hear a lot of rhetoric about lawsuits, and it is one thing which is perhaps one of the significant differences between these bills. Yes, we allow patients to hold their health care plans accountable if they cause harm or death when they make a medical decision. That should be. A right without a remedy is of no value.

All we have done is the same thing they did in Texas, where a law enacted during the tenure of Governor George Bush does these things. In 2 years since that law has been in effect, Texas has had exactly 5 lawsuits. The cost of such a situation, according to Coopers & Lybrand, a major accounting firm, amounts to 13 cents a month.

Let me remind all here, only one of these bills that is considered today was written before yesterday. They are all brand new, except the one which is offered by the gentleman from Oklahoma (Mr. COBURN), the gentleman from Iowa (Mr. GANSKE) and I.

All of our bills have been examined in broad daylight. The others have not. There is only one bipartisan bill. There is only one that has a chance of being signed into law. Only one has been endorsed by more than 300 organizations, including doctors, teachers, consumers, union members, specialists, women and others, including the league of voters, and all of the consumer organizations.

Only one has a chance of really making life better for people who buy health insurance and only one gives the people a clear right to the care which they need and which they deserve. Only one will be signed by the

President. Vote for Norwood-Dingell and support a bill that is going to benefit the people.

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

Mr. BLILEY. Mr. Chairman, I yield 5 minutes to the gentleman from Tennessee (Mr. BRYANT).

Mr. BRYANT. Mr. Chairman, I thank the gentleman from Virginia (Mr. BLILEY) for yielding time to me.

Mr. Chairman, as a former attorney who practiced malpractice law and defending health care providers, I can say part of the problem with our health care system is the cost of that. It is simply too expensive. A lot of that cost is driven up by lawsuits where doctors have to practice defensive medicine in the event they might be sued later on. Common sense would tell us that if we are going to try and work in this situation and make health care more affordable and more accessible, then common sense would tell us that we ought to be able to try and reduce the cost here so that we can make health care more affordable and keep more people in the health care market. That would be the commonsense approach.

Now, the other approach, which is supported by the President and some here in Congress, would seem to allow the public to sue their way to more affordable health care; but according to the Congressional Research Service, expanding liability in an unrestricted fashion could result in private employer-sponsored plans, and these are the people who provide insurance to their employees, it could cause these plans to increase by 70 to 90 percent in premiums.

Just as medical malpractice liability induces health care providers to practice defensive medicine, again do this so I will not be sued or in case I am sued I have myself covered here, so would expanding liability to managed care in an unrestricted fashion. It would result in those employers and insurers and HMOs and third party health plan administrators beginning to approve unnecessary or inappropriate tests and procedures that are expensive, that will drive up the cost, all out of a fear of being sued. These added costs would then have to be passed on to employers who would then have to pass them on to their employees in the form of increased premiums and planned administration fees or simply do the easy thing and that is just quit providing health insurance to their employees.

Why fight that? If someone thinks suing a company for $4 million for a spilled cup of coffee was excessive, wait until they see some of the lawsuits and some of the awards which could result from the passage of this plan.

With health care representing over one-seventh of our economy, the odds of hitting the lawsuit lottery will expand exponentially. If the cost of providing health insurance actually goes up under this plan, which is supported by the President, who actually benefits? The discussion from the other side would have people believe it is the public; but if the costs go up, I fail to see how it is going to help those 44 million Americans that we have talked about heretofore afford health care coverage.

So who, in reality, does benefit from more lawsuits? Well, who gets over one-third in fees of the millions of dollars which have been awarded in our lottery-style court system? I think if we answer that question, we will find out who actually is being protected here; and those are some of those trial lawyers.

□ 1745

Mr. Chairman, this is not hard. Let us not turn this patient protection effort into a lottery. Let us instead try to find a way to find a balance here that would hold managed care people accountable, they ought to be held accountable, but yet do so in a fashion which does not drive up the cost of this health care; does not cause them to practice defensive medicine for fear of being sued or for these lottery-style judgments, but yet do the right thing and also keep these employers in the business of providing insurance for their employees.

What we do not want to do by this plan is to put more people into that 44 million uninsured classification simply by virtue of the fact that it is just easier, less expensive, less risk involved if they do not provide health care insurance for their employees, and I think we can do that.

Mr. Chairman, I trust this Congress has that ability to pass such a law that would provide that proper balance of accountability weighed against the cost and exposure and the risk and people dropping out of the market. I hope we can.

Mr. NORWOOD. Mr. Chairman, I yield myself 1 minute which I need to respond to my friend from Tennessee.

I am delighted that our lawyer friends would like to see some type of legal reform.

Would I agree that we need to stop the extortion, and frivolous lawsuits and all those things that cause defensive medicine prices to go up that I have lived with all of my life? Absolutely right. But legal reform can never mean that we take the civil rights or the due process away from 160 million Americans across this country and simply say, In your case with health care insurance you're on your own, baby.

Now we have got external review that is going to stop most of that anyway; it is going to be very hard to be negligent. And I think we are not going to find this big rash of lawsuits. But to say, Americans, the justice system is not there for you when somebody denies you a benefit that damages you and kills your child, what kind of justice system is that? Are we going back to six guns and the OK Corral when one is wronged? No, I do not think so.

The good news is that ours is very modest. We go back to the States where we took this away from them in 1974.

Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. HORN).

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

Mr. HORN. Mr. Chairman, for all the controversy surrounding this debate the issue is very simple: responsibility. Just as doctors are held accountable for the care they provide, just as manufacturers are held accountable for the safety of their products, so too should HMOs be held accountable for the consequences of their decisions.

Mr. Chairman, the Norwood-Dingell-Ganske bill simply sets up mechanisms to enforce the existing contractual agreements between patients and their health insurance providers. No health insurance plan should be allowed to avoid paying for necessary medical treatment for those who have faithfully paid their premiums each month by inventing its own definition of medical necessity. When health plans tell consumers that a requested treatment is not medically necessary, they are practicing medicine as much as a doctor who reaches the same conclusion. This shield of ERISA allows HMOs to escape the consequences of their decisions.

I know of no other business in America which has such immunity. With this bill we want to drive the quality of health care in this country not by encouraging lawsuits, but by encouraging HMOs to use the best medical science when providing care instead of using the bottom line. Medical necessity must be determined by physicians and their patients, not by MBAs and people that have not had a medical experience and not by profit margins and HMO bureaucrats. Norwood-Dingell-Ganske is the only bill that does just that. Support it.

Mr. Chairman, for all the controversy surrounding this debate, the issue is very simple. Responsibility. Just as doctors are held accountable for the care they provide, just as manufacturers are held accountable for the safety of their products—so too should HMOs be held accountable for the consequences of their decisions.

The Norwood-Dingell bill simply sets up mechanisms to enforce the existing contractual agreements between patients and their health insurance providers. No health insurance plan should be allowed to avoid paying for necessary medical treatment for those who have faithfully paid their premiums each month by inventing its own definition of ''medically necessity.'' When health plans tell consumers that a requested treatment is not ''medically necessary,'' they are practicing medicine as much as a doctor who reaches the same conclusion. This shield of ERISA allows HMOs to escape the consequence of their decisions. I know of no other business in America which has such immunity.

With this bill, we want to drive the quality of health care in this country—not by encouraging lawsuits, but by encouraging HMOs to use the best medical science when providing

care, instead of using the bottom line. Medical necessity must be determined by physicians and their patients, not by profit margins and HMO bureaucrats. Norwood-Dingell is the only bill that does just that.

Mr. BURR of North Carolina. Mr. Chairman, I ask unanimous consent that I be permitted to control the time of the gentleman from Virginia (Mr. BLILEY).

The CHAIRMAN. Is there objection to the request of the gentleman from North Carolina?

There was no objection.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Chairman, I rise in very strong support of the Bipartisan Consensus Managed Care Improvement Act of 1999. I commend the gentleman from Georgia (Mr. NORWOOD) for his heroic leadership in this issue.

The passion of the gentleman from Michigan (Mr. DINGELL) for health care was inherited from his father, John Dingell, Sr., who introduced the first bill in Congress to make health care available to all Americans, and I am sure that he would be very proud of his son today. At last we can enact real managed care reform and improve patient care across this country. The Norwood-Dingell bill was not written by special interest groups. It is the result of listening to what I call the other voices, those of patients and providers who have been left out of this dialogue.

As a nurse, I am also speaking on behalf of over 2 million nurses who have known for a long time that HMO reform is necessary, and I am proud that the American Nurses Association has offered a strong endorsement of this legislation, and I enter their letter as part of the RECORD:

AMERICAN NURSES ASSOCIATION,
Washington, DC, September 29, 1999.

Hon. LOIS CAPPS,
House of Representatives, Washington, DC.

DEAR REPRESENTATIVE CAPPS: As the House prepares for floor consideration of patient protection legislation, I am writing to express the American Nurses Association's strong support for the Bipartisan Consensus Managed Care Improvement Act of 1999, HR 2723.

The American Nurses Association is pleased to endorse this bill and is encouraged by the cooperation and compromises made to achieve real progress on managed care reform. This legislation constitutes an important step in assuring that strong, comprehensive, and enforceable protections will be in place for all insured Americans.

ANA believes that every individual should have access to health care services along the full continuum of care and be an empowered partner in making health care decisions. Given the nursing profession's preeminent role in patient advocacy, ANA is particularly heartened by the steps proposed to protect registered nurses and other health care professionals from retaliation when they advocate for their patients' health and safety. As the nation's foremost patient advocates, registered nurses need to be able to speak up about inappropriate or inadequate care that would harm their patients. Nurses at the bedside know exactly what happens when care is denied, comes too late or is so inadequate that it leads to inexcusable suffering, which is why the strong whistleblower protection language in this bill is critical to patient protection legislation.

ANA also believes that accountability for quality, cost-effective health care must be shared among health plans, health systems, providers, and consumers. The provisions of HR 2723 that assure a truly independent appeals system and legal accountability for health plans are reasonable and necessary if we are to have reform that is comprehensive and enforceable for all participants in the health care system.

This important bipartisan compromise also includes an important requirement that health plans allow patients to have access to a full range of health care providers, with no discrimination against some providers solely on the basis of type of licensure. ANA also strongly supports the provision assuring that women have direct access to providers of obstetric and gynecological services.

The American Nurses Association, which represents registered nurses throughout the nation who practice in every health care setting, urges support for HR 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999, the only patient protection bill to be considered by the House that will bring about genuine reform in our health care system.

Sincerely,

BEVERLY L. MALONE,
President.

This bill contains common sense provisions so important in the lives of ordinary Americans. It allows patients to choose their doctor and hospital and to see needed specialists. It leaves the determination of medical necessity with doctors, not insurance clerks. It guarantees emergency room care and ensures access to clinical trials. It allows patients recourse when they have not received proper care. This bill also includes whistle-blower protections which prevent nurses and other health care professionals from being fired if they report dangerous abuses.

Mr. Chairman, in my travels around the central coast of California it is heartbreaking to listen to so many families whose HMO horror stories have ruined their lives. In this, the greatest Nation of the earth, the time has come to put patients before profits. Let us pass this bipartisan bill. Stop the abuses of managed care.

Mr. BURR of North Carolina. Mr. Chairman, I yield 3 minutes to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. I thank the gentleman from North Carolina for yielding this time to me.

As my colleagues know, several times today we have asked ourselves why we are here, and what we have already heard in the first part of the debate is some of us are here to take a cheap partisan shot, some of us are here to build a career in Congress, some are here to get an electoral advantage. I am here to help patients, and I have already heard that the only bill that can do that is the bipartisan bill, and I adamantly and flatly disagree with that.

The American public needs to ask themselves why the persecution complex of the American Medical Association would say because we get sued so much we want everybody else sued.

There is a 1990 study out of the University of Indiana that says American doctors at that time ordered $33 billion worth of tests that were unneeded because of the fear of being sued. It is a legitimate concern to consider what the unintended consequences of uncontrolled lawsuits are going to be. Some will say we are going too far. That is what people say about the bipartisan bill. Some would say we are not going far enough. That is what they say about the Boehner bill. What we have to do is find a balance between both extremes, one that holds plans accountable, that does not raise costs and in fact can be enacted.

There is some perverse incentives out there that my friend, the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Iowa (Mr. GANSKE) have worked hard to try to change with their bills, and I applaud them in their efforts to doing that. But to get a bipartisan bill, what happened is the group of people that they listed in support of their bill, they just happened to fail to mention that the trial lawyers are in strong support of their bill. Why would they be? Because one out of every $3 that is ever going to come out of this system to, quote, ''protect patients'' is going right into their pockets.

So there needs to be a balance; there needs to be accountability. We can do that.

And some have talked today about poison pills. We need to be real careful with that because, if in fact we care about patients, there is no such thing as a poison pill, there is no such thing as a poison pill. If my colleagues care about fixing the great inequality in our laws for patients, if my colleagues care about the future of voluntarily giving workers benefits, if my colleagues care about restoring the responsibilities on both sides of the doctor and patient relationship, then we cannot have too far reaching either way. We have got to have a balanced approach.

There is going to be several votes that we are going to take. If my colleagues care about fairness and finally again if my colleagues care about patients, they are going to consider the one that is just right, the one in between, the one that holds plans accountable, that does not raise the costs.

And, Mr. President, I would say to him, When you talk about vetoeing a bill that has access, that has limited liability, what you are saying is you really don't care about patients either. What you care about is a partisan political advantage and the fact that we will not enact a law that will save our patients and give them the freedom that all the rest of us have.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself 2 minutes.

I am going to vote for the Norwood-Dingell-Ganske bill and against all the substitutes, and here is why:

The Norwood-Dingell-Ganske bill is the product of negotiations among

three Members of Congress who believe in patient protections so strongly that they have devoted more than 3 years to the passage of comprehensive reform. They know what they are doing, and the Norwood-Dingell-Ganske bill gets it. To protect patients we just cannot fix discrete problems as they pop up. We would be at that task forever. We need to make it in HMO's best interest to do the right thing without hand holding or without prompting. That is what accountability is all about; that is what the Norwood-Dingell-Ganske bill does.

As most of my colleagues know, Texas allows its citizens to sue managed care plans in State court. This bill says that all Americans should have that same right as people in Texas do. Most of my colleagues probably also know that there have been only five cases in the 2 years since the Texas law went into effect.

One of those cases should silence every single opponent of the Norwood-Dingell-Ganske bill. It involves a doctor who refused to refer his patient to a specialist. Why? It turns out that the patient's HMO told this doctor that if he referred even one more patient to a specialist, he would be kicked out of the provider network permanently and financially penalized. Apparently, Mr. Chairman, he had passed his quota.

Managed care organizations take huge gambles that they perceive as benign business decisions at our expense. We need to raise the stakes. That is what the Norwood-Dingell-Ganske bill does. If we want to protect patients now and in the future, it is the bill we should all vote for.

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

Mr. BURR of North Carolina. Mr. Chairman, I yield 30 seconds to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Chairman, I think we just need to address what was just said because what was just said was misspoken.

The State of Texas allows a suit on quality of care only, not on benefits. The Norwood-Ganske-Dingell bill covers both of those. The coalition bill allows any State to set up the same law that Texas has, but it reserves the right for benefits to the ERISA plans where they should be reserved.

So any State can do what Texas can do under either of the two options.

□ 1800

Mr. NORWOOD. Mr. Chairman, it is my great privilege, pleasure, and honor to yield 3 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I thank the gentleman from the great State of Georgia, who has led the fight on patient protection, for yielding me this time, and my colleagues on the other side of the aisle, the gentleman from Michigan (Mr. DINGELL), and so many others that I recognize from the many nights we have had here on the floor.

Mr. Chairman, why are we here? We are here because patients have been harmed by HMOs because they have made medical decisions. It started out a couple years ago. Remember, we had 285 cosponsors to ban gag clauses.

Here we have a cartoon, a doctor is talking to his patient, he says, ''Your best option is cremation. $359, fully covered.'' The patient is saying, ''This is one of those HMO gag rules, isn't it doctor?''

There were problems with all sorts of denials of care; right? Here is the HMO claims department. ''No, we don't authorize that specialist. No, we don't cover that operation. No, we don't pay for that medication.'' And the lady at the desk at the HMO suddenly hears something and she says, ''No, we don't consider this assisted suicide.''

Or how about the HMOs that decided they were going to do drive-through deliveries. Here we have the counter at the hospital drive-through window. ''Now only 6 minute stays for new moms.'' And we have the mother there, her hair like this, getting her baby.

And, do you know what? This affects real people. This lady here with her family is no longer alive because an HMO made a medical decision where she lost her life.

This lady who fell off a 40-foot cliff found that her HMO would not pay her bill because she did not phone ahead for prior authorization.

This is a patient of mine, a child born with a birth defect. Guess what? Fifty percent of the surgeons who correct this have found that HMOs deny coverage for this birth defect because it is ''cosmetic.''

And this little boy, this beautiful little boy, clutching his sister's shirt sleeve. Guess what? After his HMO care, he no longer has any hands and feet, and the judge that looked at that case said that HMO's margin of safety was ''razor thin.''

Look, I call upon my colleagues on both sides of the aisle: Vote for the bill that will correct these HMO abuses. Vote for a bill that will make sure that patients do not lose their hands and their feet before it happens. That is the Norwood-Dingell bill. It is the only bill that has been endorsed by over 300 organizations. It is the only bill that has been endorsed by nearly every consumer group, by nearly every patient advocacy group, by the provider groups, by the AMA. It is the only bill that the AMA has endorsed. The AMA is recommending a ''no'' vote on all substitutes. Look, why is that? It is because we need to fix this Federal law.

Mr. BURR of North Carolina. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, let me say that I hold in high regard my colleagues on both sides of the aisle that are here on different sides of this debate.

I hope the fact that we have seen the works of political satirists and comics is not an indication that health care policy in this institution will be driven by the jokes that we see in the newspapers but that it will be driven by the policies that we should adopt about those real people.

Mr. Chairman, I think that the forgotten folks in this debate are the 200-plus million people that are insured, many of whom are happy with the system. You know, we do have the best health care delivery system in the world, and I hope that that is not something that would be challenged on this floor. It is not a system that we want to change the gold standard that we have set. Nor is ours a system where the American people want to wait for procedures, like they do in other countries.

I am confident that it is, in fact, the wish of the American people that Congress do no harm to the system. Is there room for improvement? There always is. I remember when I became a Member of Congress, I took the same health care coverage that I had in North Carolina, only to find out that the cost of it was some $30 higher than the 50-person company I worked for. It was, needless to say, something that I had to inquire as to why.

That health care company said to me, ''Richard, never let the Federal Government negotiate your health care.'' That stuck with me ever since then, because it gets at the heart of cost, and it also gets at the heart of the quality of the services provided.

I am hopeful that through this debate we can separate the rhetoric and the policy and truly come up with the right direction.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentleman from Massachusetts (Mr. MARKEY), a member of the committee.

Mr. MARKEY. Mr. Chairman, back 4 years ago the gentleman from Iowa (Mr. GANSKE) and I introduced a gag bill, a bill that said that physicians should not be gagged in telling a patient that they might need some additional help, some additional services outside of the scope of what the HMO might want to provide. We had 169 cosponsors on our bill in the 104th Congress. We had 302 cosponsors on that bill in the last Congress, but the Speaker of the House would not allow us to debate it out here on the floor of Congress.

We have come a long way since that point, not that long ago, when that was controversial in the minds of the majority, of the Speaker, a gag rule.

The gentleman from Iowa (Mr. GANSKE) and I are looking back at that as though it is ancient history, because this debate has moved far beyond that now. The majority wishes they could just work on the gag rule now, ''How do we go just on that?'' But that issue is passed by, and as each issue goes to the public and they understand it more, the Republicans get educated more.

Now we are down to the question of whether or not, if an HMO engages in practices which are really wrong, that an injured family should be able to sue,

to say something went wrong; my family member got hurt. The public understands this issue. It is 75–25. ''Give me and my family the right to be able to protect ourselves. Allow me to be able to sue someone who harmed my family member.''

They are debating on this final issue now, but it is going to go in. If it does not go in this Congress, it is going in the next Congress. And you should view that gag rule as past being prologue. Vote for this substitute today, and give the American people what they need, protections for their families today across our country.

Mr. BURR of North Carolina. Mr. Chairman, I am pleased to yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Chairman, when we come to the well of the House to speak, we can make speeches about the things that divide us. And we can do that for partisan reasons or other reasons. Or we can choose to come and talk about the things that unite us and then try to examine our differences. We are, in fact, united within the Republican Party and among Republicans and Democrats on most of what will be debated today and most of what will be debated tomorrow.

We all understand that managed care has brought us savings, but it has also put insurance companies between doctors and patients, and that is not good.

All of us, all of the plans, all four of them that will be debated agree on that and have good provisions to protect patients. We are not fighting about that. What we do have a legitimate difference of opinion about is the extent to which patients ought to be able to sue their insurance companies. That is a legitimate difference.

In fact, three of the four versions that we will vote on, two Republican and one Democrat version, will allow patients to sue their insurance companies if they have been harmed by them, so we are not even fighting about that. The one plan that does not allow suits, as everybody knows, that is going to fail and get the least number of votes of all of them.

So now the whole debate about which people will try to make political hay for reasons of elections is really about what is the best structure to allow patients to get accountability and to get redress when they are really hurt, which does not create a feeding frenzy for the trial bar. That is what this is about.

The gentleman from Georgia (Mr. NORWOOD), whom I respect immensely, a good friend of mine, has one version. Our bill, which we now call Goss-Coburn-Shadegg-Greenwood, et cetera, has another version, and the gentleman from South Carolina (Mr. GRAHAM) has yet another version.

We are going to have a good debate for the next two days. And if we can stop trying to make political hay out of it and try to figure out what is good for the American people, I have a feeling that this House will pick the right and wise position.

I advocate for the position that the gentleman from Colorado (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) and I and the gentleman from Florida (Mr. GOSS) have structured. We think it is the midpoint. We think it allows accountability, unlike the Boehner proposal, but it does not allow wide open accountability, which we think would generate too many lawsuits, which would then be settled by the insurance companies day in and day out, raise the cost of insurance, and cause employers to stop offering insurance to their employees because the cost is high.

So we think that our version, the Goss-Coburn-Shadegg-Greenwood substitute, strikes the midpoint, and I would urge all of my colleagues to support us in that position.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from New Jersey (Mr. PALLONE), who worked incredibly long hours in support of this legislation.

Mr. PALLONE. Mr. Chairman, I have great respect for the previous speaker, the gentleman from Pennsylvania, but I think he suggests that somehow there are not great differences between these various bills. And I do not think that is true.

There are two goals in the Norwood-Dingell bill, and each of the other substitutes that we are going to vote on tomorrow takes away from those goals I think in a significant way. And that is why Members should vote for Norwood-Dingell and not any of the other three substitutes.

Those two goals, which I have spoken about many times in the well, are as follows:

One is the issue of medical necessity. The bottom line is the decision of what kind of care you get, whether you get a particular operation or procedure, whether you can stay in the hospital a certain number of days. That basically is defined by what is medically necessary.

What the Norwood-Dingell bill says is that that decision, what kind of care you get, what is medically necessary, is going to be made by doctors and by the patients and not by the HMOs, not by the insurance companies.

The second goal in the Norwood-Dingell bill is to enforce your rights. If that decision about what kind of care you make goes the wrong way, you should be able to go either through an independent review board or through the courts, if necessary, in order to enforce your right. It is an enforcement issue.

The bottom line is that the Norwood-Dingell bill provides for a very good enforcement mechanism. It says that when you want to appeal a decision because of a denial of care, you are going to go to an independent review board, not under the authority, if you will, of the HMO. And they are going to define what is medically necessary, what kind of care you get, and they can overturn a denial of care. Failing that, you can go to court.

All of the substitutes take away from those two goals, and that is why you should vote against the substitutes and vote for Norwood-Dingell.

Mr. NORWOOD. Mr. Chairman, it is now my great pleasure and honor to yield 2 minutes to the gentlewoman from New Jersey (Mrs. ROUKEMA).

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

Mrs. ROUKEMA. Mr. Chairman, I want to say this is really wonderful. I want to congratulate the gentleman from Georgia (Mr. NORWOOD), the gentleman from Iowa (Mr. GANSKE), the gentleman from Michigan (Mr. DINGELL), and all of the others who cosponsored this legislation, because we are finally getting past bureaucrats and HMOs practicing bottom line medicine.

□ 1815

We are putting the medical decisions back in the hands of the medical professionals, where they belong. I think that has been more than adequately explained by those who have come before me.

I guess I have to recognize that there has been another straw man put up here, and misinformation on lawsuits and so forth, in that somehow this legislation is an open door to the courthouse. That is not true. That is not on the facts. There are strict appeals processes, strict grievance procedures, and lawsuits are only the last resort.

Mr. Chairman, I guess I also have to say that I had an interesting conversation with a host of a radio show the other day that I think more than anything explains why this provision for appeals process and Federal and State court access to the legal liability is necessary.

This was a Christian radio station. They were interviewing me. The host was a conservative-oriented host, okay? We discussed a number of things. All of a sudden he says, Congresswoman, you know what, a builder who built my house, we closed on the house and I thought I had a good contract with him. I thought everything was well explained. But I no sooner moved into the house than the foundation was weak, the roof leaked, I had to replace the roof, and by God, he was refusing to deal with it, Congresswoman. Of course, I went to court.

Would you tell me that if my mother died because of a denial of treatment by an HMO, that I should not have the ability to go to court?

Mr. Chairman, knowing that these procedures are very specific, can we really say to our constituents, conservatives and liberals alike and everybody in between, no, you cannot file a grievance procedure when your mother died, but you can take your homebuilder to court?

Mr. Chairman, last year, the House conducted a similar debate on the future of health

coverage for working Americans—an issue of critical importance for every family in our Congressional Districts. At that time, I stood on this floor and asked, ''Is this as good as it gets?''

The answer last year was a disappointing ''no.''

But 1999 may be different. The debate over who makes medical decisions for our family members—doctors or insurance company bureaucrats practicing ''bottom line medicine''—has moved forward significantly.

Today, after this debate, the House will vote on no less than three pieces of legislation that protect a patient's access to necessary medical services AND ensure a patient's right to hold health plans responsible for their treatment decisions.

All three have been drafted by Republican Members of this House and all three move the public policy debate in the right direction. This is a victory for families everywhere.

So, ''Is this as good as it gets.''

Well, if this House passes the Norwood measure then the answer will be yes. The Norwood bill, which I am a proud co-sponsor, includes many significant improvements in Patient Protections. It includes:

Emergency Services.—The bill says that individuals must have access to emergency care, without prior authorization, and under a ''prudent layperson'' standard.

Direct Access to ob/gyn care and services, including direct access to all covered obstetric and gynecological care, including follow up care and direct access to a broad array of qualified health professionals for ob/gyn care.

Direct Access to Pediatric Care by ensuring access to appropriate specialists for children and pediatricians as primary care providers. The list goes on.

But let's face it—the crux of this debate is about one issue—protecting a patient's ability to hold HMOs accountable for any negligent actions—the ability for patients to sue.

But an important point must be understood here. This legislation is not an open door to the courthouse. The bill contains a strict grievance procedure if a plan denies a claim, including a legally binding independent external review done by a panel of medical specialists. If a plan does not follow the recommendation of the grievance procedure than the patient may seek judicial relief in state court. Since the external review language is so prescriptive, most claims should be taken care of at this level, rather than the courthouse. This bill reduces the need for costly court cases by setting up a straightforward appeals process for grievances.

Lawsuits Are the Last Resort.—The bill only allows suits for personal injury or wrongful death and this greatly limits the type of suits that can be filed under the bill. The bill does not allow suits and damages for persons who weren't harmed and does not allow suits and damages for benefits that weren't covered by the plan.

Employers Are Protected.—Much has been said that opening plans up to liability will trap small businesses in a swamp of litigation that will eventually force them out of business.

Well let's set the record straight. Small employers usually contract out with insurance companies to administer the health plans, thus these small employers don't exercise discretionary authority. In an explicit provision in the Norwood bill, only employers who exercise discretionary authority (i.e., make medical decisions/pre-certification and utilization review) can be held liable along with the health plan.

So, Mr. and Mrs. Small Business, unless you are at the table with your insurance company bureaucrats using discretionary authority to design your own health plan, you are shielded from liability. So the claim that you will be sued out-of-business simply does not hold water.

Mr. Chairman, I don't know if this is as good as it gets, but it is better than last year and a world of difference from current law where insurance company clerks and accountants are making medical decisions about our loved ones.

Support the Norwood bill.

Mr. BURR of North Carolina. Mr. Chairman, it is my honor to yield 1 minute to the gentleman from Florida (Mr. MCCOLLUM).

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

Mr. MCCOLLUM. Mr. Chairman, well-intentioned HMOs have run amok, and tomorrow we are going to have an opportunity to correct some of the more glaring deficiencies and to allow more choice, more right to choose the doctor you want, and for doctors to get more control over their patients' care.

The principal bone of contention we have in this legislation and the choices we have is over the decision-making with regard to redress and negligence, when that occurs in the HMO circumstance. Norwood-Dingell allows tort claims in State courts as the last resort, but fails to require the exhaustion of administrative remedies before administration, and contains no caps on damages that can be awarded. It also leaves open the possibility of employer liability, not just HMO liability.

On the other hand, Coburn-Shadegg requires the exhaustion of all administrative remedies before litigation when relief is sought, but the right to seek court relief is too narrow, and suits are required to be brought in Federal courts, which are already overworked, and simply an inappropriate place for dumping this garden variety type of litigation.

I hope that tomorrow we send a strong message and pass an appropriate Patients' Bill of Rights, but work out these problems in conference, because once the House-Senate meets to bring back a bill to us, it needs to be right. We need to have the exhaustion of remedies. We also need to have the remedy.

Mr. NORWOOD. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, dead people really should not have to go to external review. Of course we exhaust all administrative remedies, unless there is bodily harm or death which occurs before you get to external review. If you do not do that, we encourage those people to drag it out forever until someone can die.

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

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from Massachusetts (Mr. TIERNEY).

Mr. TIERNEY. Mr. Chairman, I thank the gentleman from Ohio for yielding time to me.

Mr. Chairman, in 1994 the insured population was swelling while the cost of health care was rising higher and higher, even higher than the rate of inflation. We were paying more and getting less, but we backed off and walked away from health care reform because we were told there really was no health care crisis.

Yet, when we look at the picture now, things have only gotten worse. The Census Bureau tells us that the number of uninsured continues to rise. Health care costs are still escalating, and the Federal employees' health benefit premiums are going to 9 percent this year. The managed care organizations who were supposed to solve the problem of cost have not only failed to do so, but have added new problems of their own.

The system is still in need of major reform that would make health care universal and that would eliminate the inhumaneness of our current system, which leaves millions without coverage. But in the meantime, even our imperfect system has things that can be improved.

Managed care should not be allowed to run rampant over patients by denying emergency care arbitrarily, by interfering with doctors' professional clinical judgments, and by injuring patients who have no legal redress.

Only the Norwood-Dingell bill allows access to lifesaving clinical trials and prescription drugs outside the plan-defined formulary. Only the Norwood-Dingell bill has whistle-blower protections for doctors and nurses who advocate for patients. Only the Norwood-Dingell prohibits plans from giving financial rewards to health care professionals when they limit care. Only this bill will hold plans accountable through strong external review processes, backed by a nonwaivable right to sue in court, as people should have.

When we buy health coverage, what we really are purchasing is peace of mind and the security that we will be taken care of in the event that something unforeseen occurs. Without some way of holding plans accountable to what they have promised, we can never be certain that our care will not be denied. We have to support the Norwood-Dingell bill.

Mr. BURR of North Carolina. Mr. Chairman, it is my pleasure to yield 3 minutes to the gentleman from Arizona (Mr. KOLBE).

Mr. KOLBE. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I think the significance of today's debate cannot really be overestimated. This legislation and the many permutations that we are considering is going to affect the lives of 160 million working Americans, every small business owner, every self-employed person, every corporation in America. The decision that we make here today and tomorrow has the potential to fundamentally alter the

structure of the U.S. health care system, and with it, the quality and the quantity of health care that every American enjoys.

The task that we have before us today and tomorrow is to strike a balance between assuring access to health care and assuring accountability for those who provide it. We have to rise above the rhetoric, the heated rhetoric, which we are going to hear in these next 2 days and find the truth. If we do not and we respond with knee-jerk legislation, that in the end will only cause more harm than good to patients.

Let us be honest, there are no easy answers in this debate, but we can begin by acknowledging that under current laws, HMOs are not held truly accountable for their health care decisions. When the agent responsible for delivering health care services is the same agent that is responsible for controlling costs, then the quality of health care gets short-changed, and rationing of care results.

I have heard the cries of people in Arizona, and I have listened to the angry complaints of physicians who serve them. I have heard the horror stories I know many of my colleagues have about cancers that went untreated, physical deformities that went uncorrected, lifesaving therapies that were denied.

I believe HMOs should be held accountable for their decisions. But unfortunately, the suggested remedy in the underlying Norwood-Dingell bill establishing the unlimited right to sue an HMO I find equally troublesome. Already 44 million Americans have no health insurance, and that number is rising. Another significant number of Americans are underinsured. There can be no doubt that permitting unlimited liability will increase both the cost of health insurance and the number of uninsured.

How do I say this? How do I know that I can say this? In the first instance, simple economic logic tells us that insurers will pass the cost of increased risk of litigation along to someone else, and that someone in this case is going to be the consumer.

We have plenty of empirical evidence about the second concern, the loss of coverage for working people. I have in my office dozens of letters from companies in my area that say, in effect, any expansion of liability will force us to drop health insurance for our employees. The reason is straightforward. A company always seeks to reduce unknown and unquantifiable business risks. Norwood-Dingell is an open-ended liability, a brand new lottery for trial lawyers.

I am concerned that instead of 44 million uninsured Americans, we should all worry that in 4 or 5 years, with unlimited right to sue, the ranks of uninsured Americans will swell to 144 million people. That is what I mean by a knee-jerk response to a very ugly problem.

I urge my colleagues to reject the Norwood-Dingell bill and to support the Coburn-Shadegg bill.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Chairman, every day I hear from my constituents enrolled in HMOs who are crying out for help.

Most Americans want guaranteed access to emergency room care, and so do I. Most Americans want to be able to see doctors who are specialists, and so do I. Most Americans want the ability to choose their own doctors, and so do I. Most Americans want doctors, not accountants or bureaucrats, to make decisions about their medical health care. So do I. Most Americans want protection of the doctor-patient relationship. So do I. Most Americans want the ability to sue their HMOs if they are injured by deficient medical care, and so do I.

It is ludicrous that in New York City if you were injured in a taxicab, you can sue, but if you are injured or killed by deficient medical care, you would have no right to sue. That cannot continue to happen in the United States.

The Norwood-Dingell bipartisan bill is the only one which guarantees these consumer rights. It is the only one which will ensure that Americans will have quality health care. It is the only one that will ensure that Americans who understand the needs of health care get access to quality health care.

I commend the gentleman from Georgia (Mr. NORWOOD) for his courageous stand, and the gentleman from Michigan (Mr. DINGELL) as well. Americans will not be fooled. Americans want quality health care. So do I. Support Norwood-Dingell. It is the only bill that assures them that quality.

Mr. BURR of North Carolina. Mr. Chairman, I yield myself 1 minute.

Mr. Chairman, I want to tell a quick story about a town in North Carolina in my district, a town with a high concentration of textile workers and companies, companies that are forced to compete on margin, struggling to find cost-effective health care for their employees.

They banded together and self-insured. They supplied a greater benefit package to their employees than they ever could have had they gone through an insurance company. Their creative, innovative approach to quality health care for their employees is in jeopardy with what we do here in the next 48 hours, because if we extend liability to those employers, they will no longer offer health care as a benefit.

For us to talk about the human face hopefully is not to show that face of the future uninsured because of our actions. I would encourage my colleagues to vote against the Norwood-Dingell bill and to support the Coburn-Shadegg bill.

Mr. Chairman, I yield 2 minutes to the gentleman from Arizona (Mr. SHADEGG).

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

Mr. SHADEGG. Mr. Chairman, I rise in strong support of the Goss-Coburn-Shadegg-Greenwood alternative substitute, but I want to begin by talking about the Norwood-Dingell bill and about what it does.

I want to talk about the fact that it simply goes too far. When we look at the legislation, it makes liability too available and it turns the entire system over to the lawyers.

I want to focus in my remarks particularly on an issue that concerns the employers in my district. That is, can those employers be held liable when all they do is buy insurance for their employees. The reality is, the sad truth, is that my good friend, the gentleman from Georgia (Mr. NORWOOD) wrote language which he thought protected employers, but which does not do so. It says quite clearly that if an employer exercises discretionary authority, that employer may be sued.

□ 1830

Discretionary authority is a very broad concept. Indeed, the decision not to do something can be construed as the exercise of discretionary authority. I want to contrast that with our efforts to protect employers. We said, no, we should not make employers liable. We ought to make health care plans liable.

So how can we do that? Because we want employers to pick a health care coverage plan. So we wrote that employers cannot be sued for picking a health care coverage plan. We want employers to participate on behalf of their employees. We want them to be able to advocate on behalf of their employees. That is the exercise of their discretion. We want to them to be able to make a decision not to advocate an employee in a particular case without being suable for just that decision.

Let us look at the language in our substitute. It does not say if one really exercises discretion as an employer one can be sued. It says that one may only be sued if one chooses as an employer to directly participate in the final decision to deny care to a specific participant on a claim for covered benefits.

We had written an airtight provision that says one cannot sue employers. We did it precisely because we want employers to pick a plan. We want them to offer health care coverage. We want them to get involved and advocate on behalf of their employees. All of those are the exercise of discretion.

Sadly, the Norwood-Dingell bill allows suits by anyone. One does not have to show actual harm or does not have to be sustained by a panel like ours does. One can sue at any time. There is no requirement that one goes through administrative remedies.

One can sue over everything. Ours is limited to just covered benefits. One can sue even when the plan does everything right, that is, the plan makes the right decision that is sustained on external appeal. One still can sue under

the Norwood-Dingell bill. Sadly, they put in place no limits.

I know that doctors across America do not like the fact that they can be sued; and in some States, there is no tort reform. We need tort reform. We do not need lawsuit lotteries against doctors, but we also do not need them against plans driving up costs and driving patients away from the system because they cannot get coverage.

Mr. NORWOOD. Mr. Chairman, it is my pleasure to yield 1 minute to the gentleman from New Jersey (Mr. FRELINGHUYSEN).

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

Mr. FRELINGHUYSEN. Mr. Chairman, I thank the gentleman from Georgia for yielding me this time.

Mr. Chairman, judging by the amount of time and money that some Washington lobbyists are spending on character assassinations and other ridiculous paraphernalia that we have received in our office in an attempt to defeat the Norwood-Ganske-Dingell bill, I am more certain than ever of supporting this bill.

This bill deserves our bipartisan support. This bill is right on target. It puts patients first. That is what we are here for, for our constituents. I support the Norwood-Dingell-Ganske bill.

Mr. Chairman, judging by the amount of time and money some Washington lobbyists have spent in recent weeks on character assassinations and other ridiculous paraphernalia in an attempt to defeat this bill, I am more certain than ever that voting for this bill is the right thing to do.

The Norwood-Dingell-Ganske bill is the only legislation that puts patients—our constituents—first!

We've all heard that question posed, ''is there a doctor in the House?'' when someone is in dire need of expert medical care. One always hopes that someone with some sort of medical training is nearby to assist. Well, Mr. Chairman, we must pose that question here today: Is there a doctor in the House?

As my colleagues are already well aware, indeed there are physicians in our Congressional ranks—bona fide caregivers, medical experts, right here among us. Because we are in need—because the American public is in dire need of expert medical advice—we ought to listen to the professionals among us.

Why is it that ''the doctors in this House'' support legislation with stronger patient protections?

Because they have been on the front lines of this debate—they have been there to see the look in the eyes of a mother who discovers her health plan won't cover the next phase of her child's cancer therapy.

They've been there when an insurance company accountant dictates to them what medical options are available and what essential information cannot be disclosed to their patients.

Mr. Chairman, patients, men, women, and children and their families rely on doctors in life and death situations, a heavy responsibility. But that resonsiblity is even greater under our current managed care system as insurance companies burden doctors with making medical decisions that too often coincide with the company's business decisions.

Mr. Chairman, our nation's doctors went to medical school because they were passionate about helping people. They could have gone to business school if they were interested in helping companies make a profit.

And Mr. Chairman, Americans want to be assured that when they step into their doctor's office, they will be seen by a doctor, not an accountant!

Realizing that managed care is here to stay, and that health maintenance organizations will always be in the business of making a profit as much as they are in the business of keeping patients healthy, we must not miss the opportunity to strengthen the system and make it more accountable. We must bring balance to the system—balance that ensues doctors are free to provide compassionate care to their patients, balance that ensures doctors are free to provide compassionate care to their patients, balance that ensures providers are protected, too, yet held acountable when a decision ultimately proves wrong, and balance that, most importantly, assures patients that they are the number one priority for their health care provides.

We can do that by passing H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 of which I am a proud co-sponsor. The Bipartisan Consensus bill provides important choices for everyone—the most important being the passage of a law that provides for the best health care possible in the next century.

The Bipartisan Consensus bill provides access, accountability and strong patient protections. It also: gives patients the ability to appeal a decision by their health plan; won't allow health plans to prevent doctors from informing their patients of all treatment options; gives female patients direct access to OB/GYN care and services, and children direct access to pediatricians; provides all patients with access to emergency services; and ensures that medical decision makers would be held responsible if someone suffers injury or dies as a direct result of that decision.

With just these few simple provisions, this legislation would eliminate some of the most egregious and unfair abuses by some health insurers.

Mr. Chairman, in the year or so since our last attempt to reform managed care, nothing has improved. In fact it has only gotten worse as we learned earlier this week of reports that said another one million people have joined the ranks of America's uninsured. This is a startling revelation considering our robust economy.

If this bill is defeated, another year will go by, maybe more time, and we will start the 21st century having missed an opportunity to provide Americans with the right to control their own health care. Indeed, we are afforded a rare opportunity here to prove to an already cynical American public that when the United States Congress debates the bottom line in managed care reform, we refer to protecting people, not profits.

Mr. Chairman, in closing, I remind some of my colleagues that no one political party owns this issue. All of us have heard from our constituents who tell us about their unhappy experiences with their health plans. I think it is the desire of every member to make health maintenance organizations more accountable—no one is interested in promoting more litigation; we simply support basic protections for all Americans.

As the greatest nation in the world counts down the days until the start of a new—millennium—there is no better way to prepare for a strong, healthy America than by putting people in control of their health care. Let's pass the Bipartisan Consensus bill (H.R. 2723), and let's return medical decisions to doctors and their patients.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Chairman, I thank the gentleman from Ohio for yielding me this time.

Mr. Chairman, I rise in strong support of the Norwood-Dingell-Ganske bill and in opposition to the other substitutes. I believe it is important to point out the strengths that the real Patients' Bill of Rights, the Norwood-Dingell-Ganske bill, has. There are two of them.

The first is that the key aspect of liability is not simply the claims on which people can prevail in court and make their specific case winnable. It is the behavioral change that liability will introduce throughout the managed care system. It is a decision that will be made with people understanding that there are real consequences.

The key to the Norwood-Dingell bill is not the suits that will be brought. It is the suits that will not be brought because the right decisions will be made in the first place.

The second advantage of this bill is its medical necessity standard. It is very important for us to lay out very clearly, as the Norwood-Dingell bill does, that disputes will be resolved under an objective standard of medical necessity defined by the best practices of those who practice in a given medical field, not by the arbitrary economic discretion of the insurance carrier.

For reasons of medical necessity and the benefits of liability on corporate behavior, it is important that we reject the other substitutes and strongly support the Norwood-Dingell-Ganske bill.

Mr. NORWOOD. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, however one views this debate, it is exciting. Think about where we have come in 5 years. I mean, here we are, all members of the Committee on Commerce. All of us know each other well. We are generally good friends. The gentleman from Oklahoma (Mr. COBURN) and I do not disagree on probably three things on this Earth.

We are actually sitting here all talking about the same thing. We are talking about a managed care system, Mr. Chairman, that has gone awry, where it allows people to practice medicine who simply are not licensed to do so. Even if they are licensed to do so, usually it is a dermatologist telling a cardiologist how to treat their patient; and they are 2,000 miles away, looking at a computer screen. They have never touched that patient. They have never listened to their heart. They have never listened to their lungs. They are 2,000 miles away, and they say, Doctor, you cannot possibly be right. I know better. I have got a protocol in front of me. That is what we have allowed to happen in this country.

Now, have some people been killed? You bet. Why do my colleagues think the insurance industry said to Congress in 1974, give us the system. We will manage the costs. We will make it cost cheaper. By the way, we are going to have to deny some benefits to do that. We are going to kill a few people. For God's sakes, give us immunity, too. And we did. They are the only industry in America where we say they are absolutely protected from being responsible for their actions.

We do not believe that. We tell everybody they need to be responsible for their actions, do we not? We tell welfare mothers. We tell deadbeat dads. We tell teachers. We tell everybody. One has to be responsible for oneself. When one harms somebody, one has got to step up to the plate.

Do I want anybody sued? No. I am not interested in lawsuits, and I never have been. But the people who are practicing medicine without a license are being paid to do so. They are incentivized to do so. They lose their job if they do not do it.

Do I want a hammer over their head? Yes. Do I want that insurance clerk to think twice when he says to that mother, I know the pediatrician thinks your child needs to be hospitalized, but I know better. I have got it on my computer right here. I want that clerk to think twice about it.

If that clerk makes a decision that denies a benefit that is in a plan and causes death or injury, then, by golly, maybe we should go to court on that. We ought to go to State court. I strongly believe that now.

A lot of us do not disagree on a lot of this. We do disagree a little bit on the liability. I want to just tell my colleagues that, in our bill, employers who do not make medical decisions cannot be held liable on H.R. 2723. It states that a cause of action may only be filed against an employer when the employer exercises discretionary authority to make a decision on a claim for benefits covered under the plan and the exercise of such authority results in injury or death.

What that means is that the employer has the ability to make some decisions. If one of those decisions it makes is a medical decision, if it absolutely denies one of the patients a benefit that is in their plan, and they die from it, yes, we are saying the employer needs to be responsible for that and needs to be called up.

The only system of justice we have in this country, where does one right a wrong if one does not do it in a courtroom anymore? We are not going back to the O.K. Corral. We are not going back to six guns to solve our problems.

We have only one system of justice; and to say to an entire industry in this country, no, they never have to be held accountable for the decisions that they make, even though the Congress of the United States told them they could do all of this, discretionary authority does not include an employer's decision to include or exclude from the plan any specific benefit. What that says, they can have anything in it that they want to.

Now, we agree on a lot of things, but the one thing that is a must, my colleagues must vote for the bipartisan bill if they want to protect patients because that is how we get to a law.

Mr. BURR of North Carolina. Mr. Chairman, I yield 3 minutes to the gentleman from Oklahoma (Mr. COBURN), still a practicing doctor.

Mr. COBURN. Mr. Chairman, I love the gentleman from Georgia (Mr. NORWOOD). What he just expressed to my colleagues in his heart is right. The conclusion he has drawn on how we accomplish what he wants to accomplish is dead wrong.

Let us just use their definition of protecting employers. I happen to have a son-in-law that is a lawyer. He likes their bill because he knows he is going to make a lot of money off of it, because the very subtleties of going to State court to solve the problem that the gentleman from Georgia (Mr. NORWOOD) so eloquently just described, which we all want to solve, we all want to solve that, says that that lawyer is going to file a suit against that company, not because he thinks he can and not because he thinks he will win, because that is the person with the deep pockets. Then he is going to work hard, and then he is going to extort, and he is going to say I am going to settle.

They do not care about the patients most of the time. What they care about are their pocketbooks. The reason we are in this shape is too many doctors in this country care about their pocketbook more than doctors in the first place, or we would never have had HMOs, or we would never have had the abuses of HMOs.

So if my colleagues really care about patients, and if they really want a solution that will meet the needs of those patients and not the needs of the trial bar, then we have to back up. We have gone too far. We have created a system that is going to result in the extortion of dollars from every employer in this country.

Mark my words, those guys are smart. They are going to find every crack every time. They are going to claim it under doing something good. But the motive is not going to be pure; the motive is going to be money. Just like the motive today with too many HMOs is money. It is not about patients to either side, but it should be about patients to this body.

The only way we have to fix it is with a middle ground that protects the very supplier of that care in the first place, does not undermine it, does not cut it. If they truly make a medical decision under the Coburn-Shadegg bill, they are held liable. They cannot be penetrated unless they are not. So let us hold them accountable. Let us do it in a way.

Let us get a good bill to the Senate. Let us get a good a bill that the President is going to sign. Let us fix the problem. Let us reverse the cynicism of this body. Let us talk about patients and not politics.

The CHAIRMAN. All time has expired for the Committee on Commerce.

Under the rule, the gentleman from Pennsylvania (Mr. GOODLING) and the gentleman from Missouri (Mr. CLAY) each will control 30 minutes.

The Chair recognizes the gentleman from Pennsylvania (Mr. GOODLING).

Mr. GOODLING. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, over the last several years, the Committee on Education and the Workforce has tackled the issue that should be number one when we talk about health care problems in this country, because the number one issue that needs to be fixed before anything else is the fact that we have 44 million uninsured people in this country, most of which work or have someone in the family that works.

That is very, very expensive to health care because, of course, the cost shifting that takes place is dramatic. Someone has to pay for the bills for the uninsured.

So today we have an opportunity to make a real difference in the lives of many Americans. As I said to the committee over and over again, there is a very fine line. Our job is to make sure the 44 million get insured and at the same time make sure that the 125 million do not get uninsured that are already insured.

We can thoughtfully provide real patient protections, including a binding external review by independent medical experts, that will ensure that Americans who currently have health care coverage get the care they are entitled to when they need it.

Unfortunately, we also have an opportunity to do great damage to a very successful system of employer-sponsored health care coverage and add to the ranks of the 44 million Americans who are presently uninsured. I would hope that we would make the wise choice.

□ 1845

One of the great casualties of this debate has been the reputation of one of

the most successful Federal laws ever enacted: The Employee Retirement Income Security Act, better known as ERISA. Enacted in 1974, ERISA has provided the foundation for employers to voluntarily offer health care insurance to their employees. It has given employers who operate in multiple States the ability to provide uniform benefits and administration to their health plans. This has resulted in more than 125 million Americans having coverage through their employers.

In 1998, more than 2 billion claims were filed under employer-sponsored health plans. The overwhelming majority of these claims were approved and participants and providers were reimbursed in a timely fashion. Because some small percentage of these claims are disputed or denied, some Members of this body believe that litigation and trial lawyers are the best way to bring about accountability.

But what if we could guarantee that any benefit disputes could be resolved by an independent panel of medical experts in a time frame that takes into account a patient's condition, and then, if warranted, provides care immediately, not a courtroom, which finally makes a decision after they have died. What need would anyone have for courts and lawyers? The answer is none. And that, frankly, is what so upsets supporters of H.R. 2723. They put their entire faith in the hands of lawyers and courts that are blind to a process that would ensure proper medical care without the need of litigation.

The various bills that we consider today, all of them, and tomorrow, have all of the patient protections that are needed. All of us have the right for women to have direct access to OB–GYNs; the right for parents to designate a pediatrician as a primary care physician for their children; the right for unrestricted communication between a doctor and a patient. They all have these. The right to seek care if a person reasonably believes they are in an emergency situation; the requirement for greater disclosure of information from health plans and that the information be communicated in easy-to-understand language. They all have continuity of care for pregnant mothers, those awaiting surgery, and the terminally ill. And they all have access to specialists and the right to go to doctors outside a closed network.

What has become the focal point of the debate is whether we provide a system that guarantees quality medical care or begins a new era of expensive, lengthy, and self-defeating litigation. The Dingell-Norwood bill, I believe, would quickly take us to a medical decision by court order. It would result in a significant increase in health care costs, and will, make no mistake about it, result in many more Americans joining their 44 million fellow Americans in the ranks of the uninsured. It is bad medicine and bad policy. All Members should think long and hard before they entrust the future of medical care to lawyers and courtrooms. Get them into hospital rooms when needed, not courtrooms.

I urge all Members to oppose expanded liability and support an approach that provides people with the care they need when they need it: binding external review of any disputed health care claim. A bill almost like that passed last year out of committee and on the floor of the House.

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

Mr. CLAY. Mr. Chairman, I yield myself 2 minutes.

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

Mr. CLAY. Mr. Chairman, during the past few years, health care consumers have expressed increasing concern about the manner in which managed care plans are operating. Patients are being denied emergency care. Patients are being denied access to specialists. Patients are being denied needed drugs, and patients are being denied the ability to hold plans accountable for these coverage denials. Clearly, Mr. Chairman, this situation is intolerable, and the enactment of Federal legislation is needed to remedy it.

Though several comprehensive managed plan reform bills have been introduced during this session of Congress, I first decided to cosponsor H.R. 358, the patients' bill of rights introduced by the gentleman from Michigan (Mr. DINGELL), because it would best deliver the comprehensive and enforceable patient protections that health care consumers demand.

In addition to the patients' bill of rights, I also decided to support the compromise now before us, introduced by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL). This bill retains all of the essential protections found in the patients' bill of rights. Among them are access to enforcement in State courts if an individual is injured by their health plan's actions and a fair and responsive grievance and appeals process.

Despite the initial attempts by the Republican leadership in both bodies to block consideration of the patients' bill of rights, those interested in real health care reform continued to fight for its consideration. Now, with H.R. 2723, we have a reasonable compromise that can become law. I urge a ''yes'' vote on H.R. 2723 and ''no'' votes on all three substitutes.

I would like to take this opportunity to briefly discuss the bogeyman known as ERISA. I have been on the primary committee of ERISA jurisdiction, which is now known as Education and the Workforce, for over 30 years and I have watched how this statute has been repeatedly misconstrued by the courts and employers.

First and foremost, ERISA, the Employee Retirement Income Security Act, was enacted in 1974 to protect the pension and other employee benefits promised to workers and their families. Plain and simple, ERISA was intended to protect workers, not be used against them.

ERISA was primarily directed at pension plans. It contains extensive standards that employers must comply with in order to ensure that workers receive promised benefits. With respect to health benefits, ERISA contained few standards. That was because Congress was already debating health care reform in 1974, and Congress expected to shortly enact national health care legislation. Unfortunately, that legislation never came to be.

ERISA contains two key provisions that have repeatedly been misinterpreted by the courts and used to undermine the employee benefit protections of ERISA. First, although ERISA permits individuals to sue for violations of the law, ERISA only permitted individuals to seek ''appropriate equitable relief.'' The reason for this was that pension law derives from trust law and under trust law equitable relief includes money damages. Unfortunately, the initial courts that interpreted ERISA did not consider ERISA's underlying trust law basis.

Second, ERISA preemption. ERISA did intend to preempt states from directly enacting laws that regulate benefit plans. But, ERISA specifically included a provision that permitted state laws that regulate insurance. Historically, health benefits have been provided through insurance companies and the states have always been the primary regulators of insurance. Unfortunately, here too, the courts misinterpreted ERISA and encroached upon traditional state authority. ERISA always intended for states to continue to be able to regulate the activities of insurance companies, which includes managed care companies.

Mr. Chairman, let's make ERISA what it was intended to be—a law to protect the pension and employee benefit rights of workers and their families.

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

Mr. GOODLING. Mr. Chairman, I yield 5 minutes to the gentleman from Ohio (Mr. BOEHNER), a gentleman who truly cares about those who are uninsured and truly cares about those who need quick medical attention.

Mr. BOEHNER. Mr. Chairman, I thank the gentleman from Pennsylvania for yielding me this time; and I would like to follow up on his earlier remarks.

In America today, about 125 million lives are insured through employer-based plans. Earlier today, we passed an access bill that would give Americans more choice, give them an above-the-line tax deduction for health care that I think will empower them to have better choices in the system we have today and begin the process of developing a more competitive private market.

But the fact is today employers do, in fact, provide most of the health insurance that we have out there. I have letters in my office, one from Mike Toohey, a former staffer here in the Congress who now works for Ashland Oil, who wrote to me, and I will quote, ''Because I have leukemia, I am not insurable except through my corporate health care plan.'' Mike went on to say, ''My company's health care plan saved my life and paid for those costs.''

Employer-based health care is what made it possible for James Barton, a retired employee from Tulsa, Oklahoma, to get quality care for his wife after she had a stroke in 1998. He wrote and said, and I will quote, ''During the past year, my company's health plan has been a godsend,'' Mr. Barton wrote recently. ''We could not have gotten by without it.''

Employer-based health care is what made it possible for Simon Scott, a patient from Columbus, Ohio, to afford the expensive treatment he needed when he was gripped by cancer. He wrote, ''These choices were critical to me and allowed me to afford the medical care that I needed. Please oppose any legislation that will cause my costs and those of my company to rise at alarming rates, resulting in less coverage and less ability of my company to provide the quality care that I need.''

That is really what this debate is all about, Mr. Chairman. We have the underlying bill here, the Dingell-Norwood bill, and while the sponsors of the bill are dear friends of mine, and I would never question their judgment nor what their motives are because they believe strongly in the bill that they have before us, it is just that I and many Members believe it goes way, way too far.

Employer-provided health care in America today is a voluntary program, started back in the 1950s, then codified in the ERISA act that the gentleman from Pennsylvania (Mr. GOODLING) talked about earlier, that has allowed this program to grow successfully. But it is a voluntary program. If we put too much weight, if we put too much regulation, and, most importantly, if we put too much liability, we will drive employers away from offering this coverage to their employees. And when we look at the Dingell-Norwood bill, it does put the Federal Government more in charge of our health care by empowering the Secretary of Labor and the Department of Health and Human Services to look at health plans to make sure that they have network advocacy and all other types of Federal mandates.

Most importantly, and I think where we will see this debate go over the next day and a half or so, is in the area of lawsuits. Because under the Dingell-Norwood bill not only are health insurers and health care providers liable for insurance, but, in my view, employers are also subject to lawsuits. I do not believe we can sue our way to better health care in America today.

The sponsors will say they have shielded employers from any liability, and I will say that they have made an attempt to do that. But the fact of the matter is that under ERISA, employers have to provide discretion. And if they provide discretion under the Dingell-Norwood bill, they are now subject to liability.

I think there is another way, a better way to provide the care that Americans want, when they want it; and that is through a binding external appeals process that has severe penalties to make sure that employers and health care plans provide the care that the outside reviewers have determined that the patient ought to get. This independent review, this third-party review, has real binding teeth in it. It allows a reviewer to look at the care that is out there and available and would allow them to determine, within the contract, what appropriate care was right for that patient.

If the patient won the fight, they get the care. They do not have to wait around for a courtroom or wait around for a judge or a lawyer to get there. They get the care. And if the health plan or the employer drags their feet, it is a $1,000 a day penalty on that health plan or employer, with no cap. And if they willfully deny that coverage after it has been granted by an external reviewer, it is $5,000 a day, no cap. And while they are waiting, if they are dragging their feet, that individual has a certificate from an external reviewer that they can take and get their care at any medical facility they want to go to.

I think this is a much better way to provide the care that patients want without going to court. Let us do the right thing, the responsible thing and, at the same time, not undermine the employer-provided health care that millions and millions of Americans appreciate today.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Chairman, the managed care insurance industry has used the threat of lawsuits as a red herring in this debate. The insurance industry has chosen to use the oldest trick in the book to oppose the Norwood-Dingell bill, that is to say the problem is the lawyers. After all, no one likes lawyers, until they need one.

The insurance industry knows that the law in Texas, that the Norwood-Dingell bill is modeled after, has not resulted in litigation. In fact, I was a part of helping that legislation become law in Texas when it was first introduced in 1995. Since its enactment in 1997, we have had only five lawsuits filed.

In our Nation, there are two solemn principles guaranteed every person, rich or poor, wealthy or powerful, and even to the weak, and that is equal justice under the law and due process of law. Access to the courts ensures that every citizen, every business, every organization is accountable for their negligent actions. Only one group in our system of law is immune from litigation, and that is foreign diplomats. The insurance industry in this debate tonight wants to add one other group. That is the insurance companies themselves want to be immune from liability.

Now, no one wants to go to court, and the Norwood-Dingell bill has embraced a full internal and external review process to avoid having to go to court. But in the last analysis, the protections the American people deserve under our constitution is the right to have access to the courts.

The Congressional Budget Office estimated the cost of legal accountability would be 12 cents per month per patient. And the CBO says that half of that cost would be because the insurance companies would implement review standards to be sure that no patient is denied quality care. Sounds like a pretty good investment to me.

Every individual, every business understands that they are accountable for their negligent acts in our society; that they can land in court. Managed care insurance companies should be accountable too.

Support the Norwood-Dingell bill. It has worked in Texas, and it will work for all Americans.

Mr. CLAY. Mr. Chairman, I yield such time as he may consume to the gentleman from Indiana (Mr. VISCLOSKY).

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

Mr. VISCLOSKY. Mr. Chairman, I rise in support of the Norwood-Dingell bipartisan consensus bill.

Ann is a 60-year-old diabetic from Lake Station, IN who had always taken care of her condition. She refused to drink or smoke, and carefully monitored her insulin and sugar levels. However, the disease continued to progress and her doctor scheduled regular kidney tests to make sure that her kidney function did not deteriorate to emergency levels. Then Ann switched to a Health Maintenance Organization (HMO), lured by promises of lower costs and prescription coverage. Her first primary care doctor continued the same regimen, keeping a close eye on her kidneys and monitoring her heart function and sugar levels as well. This doctor was dropped from the HMO. The new doctors she was allowed to see did not think regular testing was necessary. In fact, when Ann came down with an infected foot, a common symptom in diabetics whose condition is worsening, the approved doctors she visited were unmoved. Finally, a member of Ann's family realized she was in potential danger and took her to the emergency room. There she was found to be in congestive heart failure. She was also anemic and her kidney function had dropped to a dangerous level. The painful process of kidney dialysis became necessary. Several days later, Ann received a call from her HMO. Although her daughter had taken her to an approved hospital, neither the emergency room physician nor the two specialists she saw were on the approved list. Ann was forced to pay out of pocket for this emergency care.

Sadly, Ann's case is not unique. Certainly, many HMOs provide excellent medical care at a reasonable cost. However, there are far too many which routinely abuse their members, refuse to pay for necessary treatments, and, in many cases, prevent doctors from conducting treatments that they consider too costly.

Ann's story and others' from Northwest Indiana demonstrate just how desperately we need to reform the managed care industry. I

believe doctors and patients should make decisions about health care, not insurance company bureaucrats. That is why I support the Norwood-Dingell Bipartisan Consensus Bill.

Certainly not all HMOs abuse their patients, but there are far too many horror stories from real patients to think all HMOs act in a responsible and reasonable manner. The Norwood-Dingell bill will set a standard in which emergency room coverage is guaranteed as long as the prudent layperson considers the situation an emergency. Along with guaranteed emergency room care the Norwood-Dingell bill outlines common sense patient protections that provide access to specialty care, continuity of care, opportunities for patient grievances and appeals, and accountability for decisions made by HMOs regarding patient care.

This bill has the support of approximately 300 organizations, including the American Medical Association and the American Public Health Association. I am glad to see that the leadership of the House has finally addressed this important issue. I have been fighting to see that real HMO reforms be addressed in the House for the past three years. I am glad to see that we finally will be allowed a straight up or down vote on real HMO reform.

□ 1900

Mr. GOODLING. Mr. Chairman, I yield 3 minutes to the gentleman from North Carolina (Mr. BALLENGER), a member of the subcommittee.

Mr. BALLENGER. Mr. Chairman, I thank the gentleman from Pennsylvania (Mr. GOODLING) for yielding me the time.

Mr. Chairman, let me talk a minute about the 125 million people who could lose their insurance. H.R. 2723, or Norwood-Dingell contains language that would expose employers to lawsuits for voluntarily providing health care benefits to their employees and thus jeopardize the employer-based health care system.

The bill opens the flood gates for trial lawyers. It mandates greater cost and liability to employers of all sizes. Yet, defenders of this bill believe that employers would be shielded from liability unless they used discretionary authority on a benefit decision.

However, what is discretionary authority? In reality, nearly any health care decision made by employers entails the use of discretionary authority. This open-ended term leaves trial lawyers drooling over the possibility of litigation and employers considering whether to pull the plug on the health care benefits. Trial lawyers will continually test the term ''discretionary authority'' in the courts, which will cost employers millions in the realm of attorneys and defense.

An ad in today's Washington Post put it best. ''The patients' bill of rights is actually the lawyers' right to bill.'' When faced with the specter of liability and the ambiguous term ''discretionary authority,'' employers will opt to stop voluntarily offering health care and give employees the monetary equivalent. In a recent poll, 57 percent of small businesses said they would drop health care if faced with increased liability and cost.

We do not need more litigation spurred on by greedy trial lawyers. We need health care reform that supports both patients and the employers who voluntarily provide these important benefits. The solution is not liability but accountability, and the Boehner substitute does just that. This substitute strengthens the internal and external review process and holds health care plans liable for up to $5,000 a day if the plan refuses to adhere to the decision of the review process.

H.R. 2723 would jeopardize employer-based health care plans for over 120 million Americans. Support the Boehner substitute and let small businesses and employers continue to provide health care for the American workforce.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Ohio (Mr. KUCINICH).

Mr. KUCINICH. Mr. Chairman, I support Dingell-Norwood-Ganske because I believe the people have a right to decent health care in the United States of America. This is a life-and-death matter that transcends the narrow needs of insurance companies.

Do my colleagues know that the total cash compensation received by the CEOs of just the largest three HMO companies totaled $33.3 million. The insurance companies have enslaved our health system. They hold patients and doctors captive. They operate a modern-day plantation where servitude to their profit is their only objective.

The old spiritual says, ''Let my people go. Go tell it on the mountain.'' Well, we are here on Capitol Hill, and it is time to send a message to the insurance companies: let my people go. My people are being denied decent health care because of the insurance companies' profit motives. My people are being denied the doctor of their choice because of the insurance companies' profit motives. Let my people go.

My people are being charged confiscatory prices for prescription drugs. Let my people go. My people are being told they should not even have legal help in dealing with these same insurance companies because the insurance companies' profit motive is there.

The insurance companies may rule health care like modern-day pharoahs, but soon they will have to meet the awesome wrath of the American people. If we are worthy of the promise of government of the people, by the people, and for the people, we will free our people from the rule of the insurance companies, we will lead them out of this valley of tears to better health care, we will let them live longer, better healthier lives, let their children grow up healthy.

We have a chance to write a new chapter in this country's history where government of the people means better health care. Pass Dingell-Norwood-Ganske.

Mr. GOODLING. Mr. Chairman, I yield 30 seconds to the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Chairman, I think the point here is that if we allow open-ended litigation in health plans what will happen is employers will let their people go, employers will let their people go without insurance because they will no longer be able to afford it.

The idea here is to keep the costs down by keeping the litigation down.

Mr. GOODLING. Mr. Chairman, he is not a Moses so I don't know whether he will let his people go, but I yield 3 minutes to the gentleman from South Carolina (Mr. GRAHAM), a very important member of our committee.

Mr. GRAHAM. Mr. Chairman, no, I am certainly by no means Moses. Do my colleagues know what I was before I was in Congress? I was a trial lawyer. I was glad to do what I did for a living. Because when somebody came into my office, I tried to help them where I could, and I would always be honest: you do not have a case. I am sorry. It would be a waste of your money and my time.

But every now and then people would come in like the folks that the gentleman from Iowa (Mr. GANSKE) have displayed on the floor tonight. And if my colleagues think suing a hospital or a doctor is easy, they have never done it. They have got to find an expert that will be willing to say the standard of care was not adhered to. And most people that come into the office do not have enough money to pay the bill, so we have got to go into our own account and advance costs.

The most dramatic form of litigation I have ever been involved in is suing health care professionals because most people in the community want to support their doctors and to give them the best benefit of a doubt, as they should. It is traumatic; it is emotional for the doctor and their family. And it is traumatic for the patient; and it is very, very expensive. But it needs to occur in situations where people are wrongfully treated.

We need to have liability over HMOs' heads. When they make a decision for the plan participant, they need to understand that if they nickel-and-dime folks and they do not treat them fairly, they could wind up in a courtroom.

But having made my living in courtrooms, let me tell my colleagues, we could do better than all the options that we have heard about tonight. To say that legal liability does not affect insurance and the ability to have health care is wrong. Legal liability is something employers look at very hard.

I believe, when it is all said and done, that there are no guys with white hats and black hats in this debate. I support Norwood-Ganske-Dingell, and I will vote for it no matter what happens because I believe the Senate Republican bill does not get us where we need to go as a country.

I am going to ask my colleagues to listen to one thing at the end of this debate. I am not a doctor, and I am not

going to practice medicine because it is not what I know how to do. But I am a lawyer. I can tell my colleagues this: we can create a fair day in court for people in this country, but we have got to look long and hard at how we do it. Because one day, if we do not watch it, we are going to drive people out of the health care business.

If we allow State court lawsuits for companies that do business in more than one State, I believe we will have a legal conversation that goes like this: the corporate lawyer is going to tell the company, You are subject to 50 different legal theories of liability. There are 50 different rules out there. And you are going to have to think long and hard if you want to stay in this business.

To give this back to the State where there is no uniformity is going to drive up cost, and it is going to be very complicated to administer. What I suggest is let us keep the Federal court system as it is but allow full range of lawsuits. If they have a bodily injury, sue for the complete recovery of their damages, but let us make it uniform so people do not lose their health care and have some damage limitations.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I appreciate the comments of my colleague from South Carolina (Mr. GRAHAM).

Mr. Chairman, I am a doctor and not a lawyer. So what did I do? When we were looking at drafting this law to help protect employers, we put in a provision that said, unless the employer makes a discretionary decision, they are not liable.

Most employers, most small business people, most doctors, what do they do? They hire an HMO or they hire a health plan, and they do not get involved in the administration of the plan; and so, under our bill, they are not liable.

And so, do my colleagues know what? Since I am not a lawyer, we asked some experts to make sure that our language truly did protect the employers. We asked the senior attorneys at the Employee Benefits Department and Health Law Department at the law firm of Gardner Carton and Douglas to look at our language, does it really protect employers. And guess what they said. They said that it protects employers if they are not involved in that decision-making.

That is what they said in their legal brief on this. They said the provisions in the Norwood-Dingell bill, section 302(a) that protect plan sponsors would be interpreted under the Supreme Court's well-established ''plain meaning'' analysis. Such an analysis supports the Norwood-Dingell bill that the clear intention to continue to preempt any State law liability suits against employers that do not involve an exercise of discretion by them in making a benefit claim decision resulting in injury or death. Other types of discretionary plan sponsor action would not be affected and would not be subject to State law liability claims.

Interpretations of the Norwood-Dingell bill which characterize it as a broad employer liability provision require one to ignore critical elements of section 302(a) which means under the ''plain meaning'' analysis of the Norwood-Dingell bill that employers will not be liable when the HMO that they contract with makes the decision.

That is the lawyers' opinion.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Chairman, I thank my colleague for yielding me the time.

Mr. Chairman, every so often this body gets an opportunity to decide on an issue that has direct impact on the lives the people we represent. Today is one of those days.

At long last, we have an opportunity, through passage of the bipartisan managed care improvement act, to balance the scales of health care delivery in favor of our constituents. And it is long overdue.

The opponents of justice for health care consumers say that we should not pass the Norwood-Dingell-Ganske bill because it would drive up the cost of health care. But they are not telling the American people the truth. The premiums are going up now, but they have not risen disproportionately in the States that have enacted HMO reform.

The American people understand that we cannot put a price on the right to get justice when an HMO refuses to pay for care that was ordered reasonable by a doctor and the patient suffers harm or dies.

My colleagues, the American people are a lot smarter than the HMO industry; and our colleagues who are against this bill give them credit. They can tell whether a particular piece of legislation is good and whether it is not.

How many good doctors have been fired by HMOs just because they continue to deliver a high standard of health care? Norwood-Dingell-Ganske is the only bill that would change that.

Among the other things in H.R. 2723 that the American people support is the fact that it will ensure that people have direct access to OB-GYN services from the health care professional of their choice. Under the Norwood-Dingell bill, if someone has a chest pain, they can go to an emergency room and be seen immediately; if they have a heart attack, they can be treated and stabilized and not have to be transported for emergency care.

My colleagues, a number of States and the courts have already begun to do away with the exemption from being held accountable that HMOs currently enjoy.

Should not all Americans, not just the ones in California, Georgia, Texas, and now Illinois also enjoy this right?

We are having an opportunity to do right by the American people today. Let us not squander that opportunity. Let us pass a right kind of managed care reform, the only bill that does what the American people have asked us to do. Vote yes on Dingell-Norwood-Ganske and no on all the other substitutes.

Mr. CLAY. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. MENENDEZ).

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

Mr. MENENDEZ. Mr. Chairman, I rise in support of the Dingell-Norwood bill because it is the only bipartisan bill that addresses the needs and concerns of some families in my district who need a level playing field in dealing with their managed care plans.

I am hopeful, however, we will have the opportunity to provide the funding offsets we were denied on the floor today. This issue is simply too important to families like the one in my district in which a child was denied post-operative care by their managed care plan and, as a result, suffered severe life-long health complications.

It is these families for whom we should level the playing field. And the Republican leadership should be having breakfast with them, not the fat-cat insurance companies who want to kill the Patients' Bill of Rights.

□ 1915

We can ensure that doctors, not insurance bureaucrats, make medical decisions in the best interests of the patient not the health plan.

This is not about lawyers. It is about empowering patients by giving them the right to hold their plans accountable when they are denied care.

The Dingell-Norwood bill levels the playing field, empowers patients and, as a result, ensures access to quality health care for all Americans.

Mr. GOODLING. Mr. Chairman, in passing I might mention that I think that law firm referenced might represent the AMA. I think I heard that somewhere.

Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Mr. Chairman, good HMOs manage care. Bad HMOs manage costs. Good managed care has physicians making those decisions not bean counters. Bad managed care has bureaucratic bean counters making health care decisions to cut costs, and that is the problem we should have fixed first.

The good guys and gals who are out of this debate are our employers. Where are they in this proposal? Were they at the table? No. The manufacturers, the contractors, the restaurateurs, the retailers, NFIB, the Chamber, people who make this country work, employers who pay the bill.

I also find it is interesting, are Medicare recipients covered by this? No. Medicaid? No. Veterans? No. Federal employees? No. We pay for their health

care and are responsible. They are not covered.

We are building a Federal bureaucracy like HCFA for our employers to deal with, the good guys. Our employers are frightened by this proposal, and they should be. They were left out in the cold. They were not adequately protected. This proposal takes a meat axe to an issue that a sharp surgical knife could have fixed. We should have made sure managed care used physicians to manage care, not accountants and bureaucrats to manage costs.

Our employers who pay the bill should have had their concerns resolved. That did not happen. The Dingell-Norwood bill will increase the number of uninsured, and what recourse do those who have no insurance have? Nothing is given to them.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentlewoman from Ohio (Mrs. JONES).

Mrs. JONES of Ohio. Mr. Chairman, I thank the gentleman from Missouri (Mr. CLAY) for yielding me this time.

Mr. Chairman, I am sure tired of hearing the other side say that it is lawyers who are causing this dilemma. There is a doctor seated in here this evening who had to sue to be able to practice medicine in California. And he sued and he won. His name is Dr. Thomas Self. There are a ton of people who keep saying the lawyers are keeping the patients out of the hospital and keeping the doctors out of the hospital. Well, we want to be able to get in doctors' offices and hospitals, but it seems the only way we can do that is to sue them because the HMOs will not let us in the hospital.

Now, my friends, the Selfs, and my friend Miles Zaremski, my law school buddy, submitted an open letter to Congress and I would like to include that in the RECORD.

AN ''OPEN LETTER'' TO THE HONORABLE MEMBERS OF THE UNITED STATES HOUSE OF REPRESENTATIVES REGARDING MANAGED CARE LEGISLATION

(By: Thomas W. Self, MD, FAAP, Linda P. Self, RN, BSN, Miles J. Zaremski, JD, FCLM)

SEPTEMBER 29, 1999.

DEAR HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES: We hope that our remarks that follow will be able to be part of the floor debate that will occur on managed care legislation, scheduled for early next month. While we have endeavored to communicate with several of you, either by letter, phone or by in-person conferences with you or your staffs, we feel our individual, yet collective, wisdom on the underpinnings of this legislation before you is critical and important. Two of us have a unique experience not shared by other health care providers in our country. The other has considerable expertise based on experience and writings on managed care liability, what our courts have done with ERISA preemption, and what is likely to be done in the future by our judicial system. Two final introductory remarks. First, there is so much that needs to be said that brevity in our remarks could not be achieved. Second, while this letter comes from the three of us, we refer to each of us in the third person.

THOMAS W. SELF, MD,
FAAP,
LINDA P. SELF, RN, BSN,
MILES J. ZAREMSKI, JD,
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Our plea comes not as Democrats, Republicans or members of other political parties. Our plea comes to you as a physician, nurse and lawyer, representatives of those at the crossroads of medicine, health care and law. Our plea comes to you also as people who are deeply and passionately concerned about the quality and delivery of health care for America's patients, all patients, and the legal and legislative efforts to do the right thing—insure fairness and accountability for patients and by those delivering health care.

To quote a famous line from a motion picture of some years back, the battle cry of patients is, ''We are mad as hell and we are not going to take it anymore!'' Patients and providers alike should not be subject to the grave inequities foisted upon them by what managed care has done to the delivery of health care. Linda and Tom Self are fitting and, perhaps, unfortunately, unique examples of what has to occur before managed care moguls will listen.

As a San Diego doctor trained at Yale and UCLA, who ran afoul of managed care and who was actually fired for spending ''too much time'' with his patients, Dr. Self is unique among health care providers in that he fought back against the medical group that fired him and won a three year ''battle'' that culminated in a three month jury trial. His victory is the first of its kind in the nation, and was profiled by ABC's ''20/20'', on August 6, 1999.

His experience, where managed care profit motives infiltrated and contaminated the professional ethics of his medical group, shows clearly the murky and often brutal influences wielded by HMOs which have only profit, not quality of care, as their goal. In this scenario, patients become ''cost units'' and doctor is pitted against doctor, undermining the very foundation of medicine and throwing to the winds the Hippocratic axiom, ''first of all do no harm''.

With the art and science of medicine controlled by managed care forces, it is not surprising that the number of patient casualties continue to soar. The ability of a clerk with no medical training, in the employ of a payor thousands of miles away, to overrule medical decisions of a trained physician is allowed in no other profession, but is the standard of practice under managed care! Furthermore, this type of employee and also the managed care entity which acts as the puppeteer behind the clerk are completely immune from any legal accountability when their faulty medical decisions cause patient harm. That this situation is allowed to continue is also peculiar only to the medical profession. This is unfair and inequitable.

As an experienced diagnostician with the reputation of being thorough and careful, Dr. Self was criticized under managed care dictates as a physician who ordered too many costly tests and as a ''provider'' who ''still doesn't understand how managed care works.'' Sadly, this situation continues nationwide, as more and more experienced doctors are unjustly censored, dropped from managed care plans or terminated from medical groups anxious to conform to managed care policies, leaving their needy patients feeling confused, frightened and abandoned.

This pillage and waste of medical resources (under the yoke of managed care which destroys the very quality and continuity so necessary for a positive outcome from medical treatment) is running rampant in America. Dr. Self and his wife have put their lives and their careers on the line to combat the wrongs caused by the health care delivery system called managed care. Now, representing, in microcosm, all health care providers, they turn to you as lawmakers, representing all past, present and future patients, to stop the horror and carnage by health plans by voting for the Norwood-Dingell bill, H.R. 2723, and restoring quality, decency and humanity to health care for the American people.

Linda Self, a registered nurse, is, like her husband, a healer. Always active in charitable activities, she returned to nursing full time four years ago to work with her husband when he lost his job. After being away from nursing for many years, she realized that her compassion and love for the art of healing was now even stronger, especially after raising two children, one of whom had a serious illness. Devoted to caring for children with chronic disease and giving support to their families, she was shocked and unprepared for the massive de-emphasis on patient care that had been fostered by health plans. Linda realized that her commitment to people had not changed nor had the needs of such children—what had changed, and changed for the worse, was the indifference to patient suffering held by the managed care system. She realized that in order to care for sick patients and their families in the 90's, there is, and was going to be, a constant controversy with the managed care bureaucracy involving patient referrals, treatment authorizations and, above all, the daily need to appeal treatment decisions lost, delayed or denied by their patients' health plans.

As if also in microcosm to what other private medical practitioners face, this office ''busy work'', in addition to the requirements of providing necessary medical support to sick patients, has created enormous frustrations among health care providers as well as increasing the costs of running a practice. Conversely, reimbursements from health plans have steadily diminished, regardless of the severity of the patient's illness or the increased amount of physician and nursing time expended.

Additionally, in her dual role as nurse and office administrator, Linda works daily to insure that patients receive the appropriate medical care they need and deserve without suffering the indignity and humiliation of having their health plans ignore, delay, or deny health care that is not only medically necessary, but for which the patient has already paid insurance premiums. This endless paper shuffle mandated by managed care with its cost cutting mentality further decreases the amount of time that a nurse can devote to patient care. This Dilemma has driven competent and caring paraprofessionals from the medical field in droves, thereby further weakening the overall quality of medical care needed by patients nationwide. The resulting upswing in poorly trained, undedicated office personnel hired to replace the nursing flight has created a hemorrhage in medical care delivery which, if not stopped, will hasten the demise of American medicine as far as any vestige of quality of care which still remains.

Patients must not be considered commodities to be batered by health plans. Payors must be held fully and judicially accountable wherever their pressures on physicians to curtail tests, delay or deny treatment plans, or by clogging the wheels of medicine with mountains of paperwork cause patient harm. Therefore Linda Self, speaking as a mother, a patient, and a nurse brings her experiences to the House floor and adds her plea to those of Dr. Self and Mr. Zaremski to bring dignity and salvation to the practice of medicine.

Those in the House, listen, as we have done for years, to the voices of the grass roots populace when they cry out for help and relief from a medical system that harms, not

heals. Read, if you will, the numerous e-mails and other written communications from viewers of the ABC ''20/20'' program on Dr. Self and other well wishes after he and his wife's historic jury verdict, which we have included as an attachment to this letter. A sampling of quotations from these communications follows:

As an R.N. I have had similar experiences as Dr. Self concerning HMO's. He is the type of doctor HMO's do not want, since he actually takes enough time for each patient, and does the right thing. A warning to all patients: do not choose an HMO if you have a chronic or rare illness! They will hasten your demise; they are Goliath and you are David. * * * Until patients become better-informed and less passive about their health care, and until doctors start standing up, like Dr. Self, HMO's will continue to run over the patients they are supposed to serve.—Sheryl W. McIntosh

Your August 6 piece on Dr. Self who was fired for ignoring his group's bottom line and putting his patient's needs first was excellent. This is happening more frequently than people realize. Only when people have access to information like you provided—or when they get sick and learn firsthand—do they realize how corporate managed care has affected American lives. I hope you will talk to other medical caregivers and deal with other facets of this complicated problem.—Frances Conn

This might be just the tip of the iceberg. Our health care should not be treated as a commodity, i.e., something to make money on at your or my expense. Neither should it be a political football where the vote goes to the place with the most political donations. * * *''—James A. Eha, M.D.

* * * At first HMOs were VERY good but every single year that passes it gets volumes worse. Now, it is so hard to get a referral, a prescription, a test or an office visit. * * * My husband has to take off work because you have to take the appointment they give you. * * * They make it nearly impossible to get care. They have those drug lists that they are always changing so the doctors are changing your meds all the time making you very sick. They do not allow doctors to do their jobs * * *—Diann Wolf

An identical story happened. . .with my brother who is a family practitioner. . . .He dealt mostly with AIDS patients and the HMO found that to be too costly. He and his fellow practitioners in his office decided to leave the medical practice and regroup mentally to figure what to do. They had spent many months without pay at all due to the methods of saving costs by the HMO. . . . And just so the HMO's could make some money, good doctors are leaving the profession.—Michele Drumond

. . . For the past 11 years I have cared for people in long term care. . . . Just imagine the lack of incentive there is for good care of the elderly or disabled. Many newer meds are not covered as they are not cost effective . . . patient loads rise but staffing does not, rules and regulations of documentation rise, staff does not nor does equitable pay. The diagnosis to dollar mentality is ripping the caring soul and commitment out of medicine. Everyday I ask God to give me both compassion and wisdom in my job, but my soul feels that the battle of excellence in care and cost will always be won by cost. I feel called to this job, and just have to do what I do the best that I can, but NEVER would I want any of my four children involved in direct patient care. The physical, emotional and psychological load is becoming too great!! I strongly believe we will see life expectancy decline.—Barbara Harland, RN

. . .I work for a doctors office. . .I do all referrals, authorizations and surgery precerts for our patients. It has become a nightmare to approve any surgeries without going thru the third degree for patients. They can't begin to realize what we in the ''field'' go thru to get these things approved.—Susie Wallace

'There are men too gentle to live among wolves' to a gentle and courageous man & woman [Tom and Linda Self].—Brian Monahan,

. . .It is a great irony that, after a generation of tremendous growth of our knowledge and our ability to care for patients and diseases in a manner far better than we ever could before, greedy companies are seeking to limit our doing so.—Herbert J. Kauffman, M.D.

. . .I deeply respect what you've accomplished and appreciate the way in which your victory benefits patients and those of us who choose to treat patients according to sound clinical decision-making versus adherence to the masters and dictates of those more concerned with profit than quality patient care. . .—Robert Alexander Simon, PhD.

. . . Seven years ago I was hired as a homecare Social Worker. . . . Then, managed care entered the scene—frequently denying approval for a social-worker's services. Since urgent social worker intervention was often necessary with our patients, there were many times that I was dispatched to the patient's home to provide emergency services . . . only to later receive a ''denial of payment'' from the managed care company . . . [Hospital] required me to find any excuse possible to visit those patients whose insurance would pay, and would cram as many patients as possible every day into my schedule. It was all so very, very wrong. For months this unethical practice tore me apart—and eventually made me very ill. I quit my job. . . . I had been forced to compromise my ethics in order for [Hospital] to maximize their profits. I applaud your courage, and I just wanted you to know that I am proud to be the parent of one of your patients.—Ruth Bronske

You stood tall for yourself and set a perfect example for the rest of us. I am so pleased.—George Jackson, M.D.

. . . Congratulations on winning your lawsuit! Truth always comes out triumphant. Hopefully the HMOS . . . of the world will put the patients' interest first and the bottom line at the bottom as it should be from now on . . .—Faith H. Kung, M.D.

. . . Dr. Self stuck his neck out and he lost his job, but he stood up for what he believed in and hopefully other doctors will do the same. He should be commended for what he did. I hope . . . that if something really bad ever happens to me and I need tests run or extensive surgery done, the doctor better not look at what kind of insurance I have rather than giving me the best medical attention I need that could save my life . . .—Kim Lewis

. . . I have quit the medical field in the past month because medicine is no longer about patient care and needs. It is only about how much money can be made off of them. Thank you for letting me see it is not just the employee that is affected!—Linda Copp

As a legislator, you can therefore appreciate first hand, the anger, frustration, and hopelessness expressed by your constituents such as what we have quoted above. Then, recall the quote by Margaret Mead, ''Never doubt that a small group of dedicated people can change the world. Indeed, it is the only thing that ever has.'' The ''rank and file'', the grass roots populace is, we think, what Ms. Mead had in mind when it comes to health care in our country.

The third major thrust of our letter pertains to the three of us having seen and heard the disingenuous expressions of opponents of what patients really need and which is embodied in the Norwood-Dingell bill. First, we have heard that lifting the ERISA preemption will cause employers to terminate health plans for their employees, that lifting this so-called shield will cause premiums to increase and that trial lawyers will gain an avenue to sue. To all of this, and with all the passion we can muster, we say, ''absolutely not!''

First, ERISA, enacted in 1974, had nothing to do with shielding managed care plans from accountability for their medical decision-making process. There has never been anything in the legislative history on ERISA having to do with this subject. The American Bar Association, not known at all for representing trial attorneys, voted last February 302–36 to lift the ERISA shield.

Next, allowing for accountability by health plans to patients, as contained in HR 2723, provides for real equity in distributing responsibility to all those persons and entities involved in the medical decision-making process. This does *not* mean increased or additional litigation! The liability exposure to managed care entities that would exist with removal of the ERISA preemption shield will force these entities to insure improvement in patient care, by, for example, not allowing clerks to override physician treatment decisions, providing a review process to all treatment denial determinations, etc. As a result, the number of bad-outcomes leading to litigation will likely decrease, leading to less litigation. And where bad-outcomes do occur, allowing direct suits against health plans will not create more lawsuits, but will rather lead to roughly the same number of lawsuits—with one additional defendant. this one additional defendant will better allow a trier of fact to equitably distribute liability to the persons and entities responsible for the harm. In the end, there are fewer bad-outcomes, less litigation and better equity in the distribution of fault.

Also, realize that HR 2723 provides for accountability and responsibility of health plans according to state laws. State courts are where this area of responsibility and accountability for health plans should reside. For example, if your state has ''caps'' on the amount of money that an injured person could receive, such as in California, then those caps would equally apply to exposures faced by health plans.

And if the Texas state statute on holding HMOs responsible is any example, fears of increased litigation are totally without any basis in fact. In the three years since that state's law was enacted, there have been less than a handful of cases filed against health plans in that state. Also, in joining with Georgia legislators, the California[1] state assembly of 80 members (overwhelmingly) passed legislation recently providing that HMOs can be held accountable for their medical decision-making. On September 27, 1999, Governor Grey Davis signed into law this legislation, and, in so doing, stated, ''It's time to make the health of the patient the bottom line in California HMOs.''

In conclusion, we implore each and every one of you to do the right thing. Vote your conscience by voting for the rights of each and every American who has been, or will be, a patient in our health care delivery system. Remember that a person's health is *unlike anything* that can be bought, traded, negotiated or sold. Don't hold hostage human sickness and injury to a ''bottom line'' mentality. Keep in mind the words of a colleague in medicine who wrote Dr. Self after his jury verdict, ''The rewards of being a doctor are largely measured in indentifying what is

[1] California is said to be the ''birthplace'' of managed care.

best for the patient and then having to do what one believes is correct and best for the patient.'' Again, we reiterate the quotation by Mead: ''Never doubt that a small group of dedicated people can change the world. Indeed, it is the only thing that ever has.'' In passing HR 2723, each one of you will heed her message, and, accordingly, insure that the tendrils of greed and disregard for legal accountability in managed care will no longer be able to find fertile soil in which to take root and grow.

Thank you.

Sincerely,

THOMAS W. SELF, MD, FAAP,
LINDA P. SELF, RN, BSN,
MILES J. ZAREMSKI, JD, FCLM.

They say that Norwood-Dingell will restore medicine to physicians not bureaucrats. They say that it will provide for medicine over money and not the bottom line. They say that it will provide for patient care over profits. They say that it will provide judicial accountability for all entities involved in the medical decision, and I agree with them.

Dr. Self said to me, remember that a person's health is unlike anything that can be bought, traded, negotiated, or sold. He said, do not hold hostage human sickness and injury to a bottom line mentality.

Mr. Chairman, I strongly support H.R. 2723, and we will ensure that greed and disregard for legal accountability and managed care will no longer find fertile soil in which to take root. Support H.R. 2723.

Mr. CLAY. Mr. Chairman, I yield 5 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from Missouri (Mr. CLAY) for yielding me this time.

Mr. Chairman, in this debate we have come a long way. We are actually beginning to agree on some things. I am proud of my good friend, the gentleman from Ohio (Mr. BOEHNER), for having an external review provision in his bill. In fact, we all do, because all of us understand that is precisely the better way to get our patients the care that they need.

I would like to speak to the gentleman from Pennsylvania (Mr. PETERSON) before he leaves. I noticed that he made a couple of remarks about employers, that they are not involved.

I will say, I have been doing this a long time, 5 years, and I do not know many employers I have not met with. I am sure there are not many I have not begged to come to my office over the last 5 years, from General Motors, to Wal-Mart, to IBM, to Caterpillar, to you name it.

I have asked them to come. I have said, look, guys, we have a serious problem going on out here. Help me with this bill. I am not after them. I am simply trying to get people to quit practicing medicine that are not licensed.

They did not want anything to do with it. They did not help. They absolutely did everything that they could do to make sure we do not want anything to happen; we like it like it is; we are in control, and that is what we want.

They did not work with us at all, but I worked with them. I worked with them for 3 years, hard. We met with one of them every day. Here is the bill, help us with it. They would not.

Many employers, and I am sure not all, but many employers have had the opportunity to help us make it better and what they want is absolutely nothing.

Now, why? Well, there are two types of employers. Seventy-five percent, I would say, of the 160 million Americans, are in insurance plans that are partially funded and partially administered, and those employers typically they do not practice medicine. They really do not. That is why we have worked very hard in this bill to make certain those people would not be made liable, because they are not sitting there every day, the CEO, trying to tell the administrator, no, this patient cannot have that surgery but this patient can.

The problem is that other 40 million Americans that are under plans, very good plans, too, the big guys, really good stuff, they do practice medicine, though. The gentleman said they did not, but they do. Just because they make tires does not mean they do not have an insurance company in the backyard. I can guarantee they do, and they make decisions of medical necessity, long distance, untrained people, planned and paid to deny care. That is what they do for a living. These medical directors make big money. They do not last long if they do not deny care.

My problem with that is that they are looking at a computer screen. They are not using the art of medicine, the science of medicine. They are going down a mathematical screen on a computer. People are going to be killed like that. Medicine cannot be practiced that way if the patient is at least not looked at.

They never talk to the patient. They just call up and say, no, my computer screen says no. How could that cardiologist possibly know anything, that has been seeing someone as a patient for 30 years, that is a next door neighbor that a lot is known about?

That is the problem; it is that group.

Do I want them out of this? Yes, because basically they do try to do a good job, and basically have very good plans, but there is not a way to take them out of it because they are practicing medicine without a license; and that, Mr. Chairman, is what the problem is.

If we had it all to do again and go back 5 years ago, what would I do? I would make it a Federal crime to practice medicine without a license. That would stop this mess, because that is indeed what is going on.

Now, why are the employers scared? And they are. I am in sympathy with them about that. They are scared because the insurance industry scares them. They have great practice at this, Mr. Chairman. They have been doing it in States across America for the last 20 years. They go in and scare the bejeezus out of these employers. They say, gosh, if this is not done, if that bill is not killed, costs are going up 25 percent. Guys, if this is not done, we are going to find that everybody gets sued every day.

We do not say that in that bill. My word of mercy, I am for employers, too. We have to support, Mr. Chairman, to change the system, a bipartisan bill. That is the only way that I know to get a law in a split Congress with a Democratic president, but it is so important we have to get it done now. This window of opportunity, where we have my friend the gentleman from Ohio (Mr. BOEHNER); my friend the gentleman from Oklahoma (Mr. COBURN); my friend the gentleman from Iowa (Mr. GANSKE); my friend the gentleman from Michigan (Mr. DINGELL); my friend the gentleman from Arizona (Mr. SHADEGG); we are all pretty close to agreement because we all have recognized the fallacy in a system of practicing long distance medicine by people who make their living by denying those claims.

Mr. GOODLING. Mr. Chairman, I yield 5 minutes to the gentleman from Kentucky (Mr. FLETCHER), a member of our committee.

Mr. FLETCHER. Mr. Chairman, I thank the gentleman from Pennsylvania (Mr. GOODLING) for yielding me this time.

Mr. Chairman, I appreciate the opportunity to come and speak. It has not been too long ago since I was sitting face-to-face with patients, practicing family practice, primary care.

We also had a program in Kentucky where we cared for those without insurance. We provided that treatment free of charge. And we saw a lot of folks that would like to have insurance. But they were not able to afford it, or the small business that they worked for could not afford it.

We also solved problems with HMOs, and I have the utmost respect for my colleagues, the gentleman from Georgia (Mr. NORWOOD), the gentleman from Iowa (Mr. GANSKE), and the other folks that certainly have addressed this issue long before I arrived here.

I have had the privilege of working in health care in the State of Kentucky, and I do know that projections of increase in costs and those sorts of things are tenuous. The real fact is we do not know how much any of this is going to cost.

I think there was an article yesterday, an editorial in The Washington Post, that advised us to be careful, to go incrementally, to take very careful steps because, in fact, we do not know how much this is going to increase costs and how many more people this is going to leave without insurance and without health care.

We have 44 million people, increasing almost by a million people a year, that are uninsured and have no health care. And we do not need to take health care dollars and run them into another system. We need to make sure they are running in to providing care for patients that really need it. That is why I came here, and I trust that is why all of us came here.

Since I have arrived here, I found one thing out, Mr. Chairman. There are some very loud voices here. I have heard the loud voices of trial lawyers, or people that take that position, providers, employers, insurance companies. Sometimes those voices get so loud that we cannot hear the patients back home. We cannot see the number of folks that are getting the kind of health care that they need because their employer voluntarily provides that.

I have companies like Toyota and 3M, Caterpillar, Johnson Controls, Trane, Cooper Tires, and I could go on and on, Dana, et cetera, et cetera, that offer the kind of health care, and I visited those plants and I have gone through, and I have asked the employees about this. They have some of the best health care in this country. I do not want to threaten that, but we do need to do something to make sure that physicians make decisions not insurance companies.

I think we have done that with many of the bills. We have said, let us make sure we have internal review. And I am glad that we want to make sure it is a physician in many of the bills, but we also say there is an independent panel that can look and decide, a panel of experts decide what is medically necessary and what is needed. And then the decision lies with physicians not insurance companies. I think that is important.

We need to look at the other provisions of the bill. Certainly we want to make sure they have access to emergency room, they have access to the OBGYN and their pediatricians, that they can go to the emergency room so we do not see the kind of problems the gentleman from Iowa (Mr. GANSKE) has brought out about a patient that wanted to go to the emergency room and had to go to a distant one. Our bill takes care of that.

I am very concerned about the Norwood-Dingell bill, because I am concerned about where would some of the money go of increased costs. I want to hold insurance companies accountable, but to open up unfettered liability is something that I have felt like has increased costs. And I think many other folks have documented the increased costs over the years, and I do not think there is any question that it will increase cost and more money will go into the pockets of trial lawyers instead of providing care for patients.

According to the General Accounting Office, it takes an average of 25 months, more than 2 years, to resolve a malpractice suit. At the same time, patients typically receive only 43 cents on the dollar.

□ 1930

Defensive medicine, Mr. Chairman, is the practice of ordering tests, and the American Medical Association has said that about 8 out of 10 doctors practice defensive medicine because of the fear of trial lawyers. One study touted by the AMA, was in 1996, reported by Daniel P. Kessler and Mark McClellen of Stanford University, published in the Quarterly Journal of Economics.

This study found that tort reforms directly limiting the liability of medical care providers could reduce hospital expenditures by 5 to 9 percent within 3 to 5 years of adoption basically by eliminating unnecessary testing associated with defensive medicine.

I want to make sure that physicians make the decision, but I do not want us to put money in trial lawyers or to have the practice increase of defensive medicine. I think it is important, and we have got one estimate of Stanford researchers that extrapolating the savings to the national level of researchers, if we had some tort reform, unlike what is in the Norwood-Dingell bill, would save an estimated $50 billion per year.

I think we need to be very careful as we are doing this. As my colleagues know, we can always come back a year, 2 years, or whatever and improve what we are doing; but I think this leap to the Norwood-Dingell bill, a leap that will increase the costs, decrease the availability of health care, and I discourage or I encourage my colleagues to vote against the bill.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Chairman, I rise today in support of the Dingell-Norwood bill, in support of this bipartisan managed care reform legislation, a bill that puts patients ahead of politics and allows us an opportunity to address American's concerns regarding health maintenance organizations. This bill provides important patient protections such as ensuring that medical judgments are made by medical experts, not insurance bureaucrats, ensuring that individuals have access to emergency medical services, clinical trials, prescription drugs.

In addition, this bill ensures that individuals have a right to see a specialist, access to out-of-the-network providers, and holds HMO plans accountable when their decisions to withhold or limit care injures the patient.

We have an opportunity today to listen to the over 80 percent of the individuals in health plans who have cried out for reform of HMOs. We have an opportunity today to make sure that women do not have to see a gatekeeper before seeing their OB/GYN specialist. We have an opportunity to improve the quality of health care individuals receive.

In my congressional district we have 22 hospitals, three VA medical facilities, countless community health centers, half a dozen HMOs all providing quality health services throughout Illinois. This bill will facilitate opportunities for doctors and patients to form a strong relationship and make important decisions regarding their health treatment.

Let us take a historic step forward. Let us vote in favor of Dingell-Norwood. A vote for Dingell-Norwood is a vote for real reform of managed care.

Mr. CLAY. Mr. Chairman, I yield 3 minutes to the gentleman from New York (Mr. NADLER).

Mr. NADLER. Mr. Chairman, I rise in support of the Norwood-Dingell bill and in opposition to the three substitutes that will be offered. This legislation will restore medical decisions to where they belong, to patients and their doctors.

Mr. Chairman, quality health care should be the right of every American, but this principle seems to have been lost in recent years as more and more people have been forced into a managed care system in which HMOs are involved in a zero-sum gain. Every dollar not spent on health care is another dollar of profit for the HMO. Every incentive in the system is not to allow the specialist referral, not to allow the diagnostic tests, not to allow the treatment. The HMO has every incentive to overrule the doctor's judgment or to exert financial pressure on the exercise of that judgment, and they do so every day.

Mr. Chairman, this destroys the confidence a patient should be able to have in his or her doctor's judgment and often causes unfavorable medical outcomes, avoidable deaths and suffering. The American people are crying out for reform, and this bill provides it.

One of the most important provisions of this bill will prohibit an HMO from providing a financial incentive to doctors to limit treatment for their patients. It is wrong to put doctors into a conflict of interest situation between their medical judgment on the one hand and their pocketbooks on the other.

I introduced a bill to prohibit this practice in 1993, and I am pleased that it has been incorporated into this bill.

We have seen a lot of negative publicity surrounding this bill. The insurance industry has waged a campaign of misinformation. They claim this bill would open up a flood of lawsuits against employers, but anyone who takes the time to actually read the legislation will find that it is a balanced bill that protects the interests of employers, doctors, and patients.

The greatest distortion concerns the liability provision. This provision says that whoever is directly responsible for making a decision that harms a patient must be held accountable for his or her action. If an HMO practices medicine, if it does so negligently, and withholds necessary medical care and the patient is hurt by this, the HMO should be liable to a malpractice lawsuit.

This is a matter of simple justice. It is also the only effective way to deter withholding necessary medical care in order to save money.

Every other person or corporation in this country is held responsible for the consequences of their actions, responsible at law if necessary. Why should HMOs be the only entities in this country not held responsible for the consequences of their actions at law?

Contrary to what the insurance companies would have us believe, this bill would not open employers to liability if their involvement was simply to contract with a negligent HMO, nor would an employer who advocates on behalf of his or her employees be held responsible. This bill would eliminate the common HMO gag rules so that information can flow freely between doctors and their patients.

It would ensure full access to clinical trials, greater choice of doctors and plans, continuity of care, access to services for women and access to emergency care and specialists, and it would hold insurance companies accountable for their decisions. It would go a long way toward ensuring that people have access to the treatment they need. We must not settle for less.

Mr. GOODLING. Mr. Chairman I yield 4 minutes to the gentleman from Arizona (Mr. SHADEGG).

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

Mr. SHADEGG. Mr. Chairman, I thank the gentleman for yielding this time to me, and I want to begin by pointing out the bill. Would the gentleman bring me a copy of the bill? I want to point out that in this debate there is a lot of misinformation. One piece of misinformation that is going around is that this legislation does not protect existing lawsuits authorized by State law.

Here is a copy of the Norwood, excuse me, of the Coburn-Shadegg substitute. If we turn to Page 91, any Member can read the language; and it plainly says for Texas, for Georgia, for Louisiana, every State action has been preserved; and it says that not only are State actions already created at State law by State legislative conduct, preserved, but those authorized by future legislation are preserved as well.

Now let us turn to some of the debate that I think goes to the issue of Norwood-Dingell.

I respect my friend, the gentleman from Georgia (Mr. NORWOOD). I know his intentions are good in this debate. I believe that he has done a great service by forcing this debate to occur here tonight.

But the reality is there are two extreme positions in this debate which is going forward on the floor tonight and will continue tomorrow. Those two extreme positions are represented by the HMOs on the one side who say we must continue to have absolute immunity. On that issue I could not agree more with my friend, the gentleman from Georgia (Mr. NORWOOD), or my friend, the gentleman from Iowa (Mr. GANSKE).

A good friend of mine in Arizona said the other day why would we want people who have to get a license to practice medicine to be held liable, but people who do not have to get a license to practice medicine, not to be held liable? So on that issue, on the concept of liability I agree that we must change the system. But if immunity is one extreme, we cannot ever be held liable when we kill Mrs. Corcoran's baby.

Mr. Chairman, I have to point out that absolute liability is the other extreme; and my friends on the opposite side, from the Democrat side, my friend, the gentleman from Georgia (Mr. NORWOOD), when he joined with them embraced the other extreme in this debate, and that is absolute liability, and let us talk about one example of that.

In their enthusiasm to deal with this, they swept into their legislation fee-for-service plans. I will tell my colleagues fee-for-service plans regulated at the State level should not be brought into your legislation, but they are. They are already regulated at the State level. The State insurance commissioners cannot handle them, and they can already be sued. But my colleagues sweep them into their regulatory net. That is going too far.

Let us talk about lawsuits that can be brought without exhausting the administrative review. My colleagues' bill says the minute somebody becomes dissatisfied with the plan, they can file a lawsuit. It is like simply having to allege that a marriage is irreconcilably broken. All one has to do is decide they want out, decide they want to go to court and they are in court. Well, that is no system. We ought to force patients to at least ask the plan to do the right thing. But my colleagues allow them to sue without any exhaustion of administrative remedies. They just open the door at any time.

Let us go beyond that. Lawsuits over anything.

Our bill says the Coburn-Shadegg substitute says we allow suits over covered benefits. If they cover this benefit, then they got to provide the benefit, and if they do not provide the benefit, we will allow an appeal; and we will probably allow a lawsuit. But my colleagues allow a lawsuit over anything, not just covered benefits; and what that means is that a panel of doctors or a court can come in after the fact and say, you may not have thought you covered this, but we are going to mandate that you should have covered it.

Now think about that from the insurance policies position. They thought they insured this podium, but they have just discovered they insured the table as well, and nobody told them. That is not fair. It is the other extreme of the end of the pendulum.

And what about lawsuits without limits? Nobody, nobody in this system does not understand that if we, and I implore, I implore colleagues to look at the costs that they can drive. If we allow too many lawsuits, we will produce a million more uninsured Americans.

I urge my colleagues to support the Coburn-Shadegg amendment.

Mr. CLAY. Mr. Chairman, I yield 4 minutes to the gentleman from Iowa (Mr. GANSKE) to respond to the gentleman who just spoke.

Mr. GANSKE. Mr. Chairman, let me respond to a couple comments that have been made. I appreciate the comments of my good friend from Kentucky (Mr. FLETCHER). I just wish that he would listen to some of the arguments by the American Academy of Family Physicians that endorses the Norwood-Dingell bill. I would also point out to him a study. He is concerned about costs, costs of litigation? Well, here is a study by Coopers and Lybrand. This study was conducted for the Kaiser Family Foundation. They looked at group health plans where one can sue their HMO. Okay. They researched the litigation experience of Los Angeles School District, California Public Retirement System and the Colorado Employee Benefit System, and what did they show? That the incidence of lawsuits was very low, from 0.3 to 1.4 cases per hundred thousand enrollees per year and that the cost of that was 3 to 13 cents.

Now let me talk about some of the comments that my good friend from Arizona made. I hardly have time. I am glad that now on the fifth or sixth draft of the Coburn-Shadegg bill we are finally going to have an exemption for California and Texas. It has been hard to pin this bill down; it has been changed so many times.

I would also point out, yes, the Coburn-Shadegg bill requires that a patient has to exhaust all available administrative remedies before going to court. That does not make any sense in situations where the patient has already been seriously injured, or even worse, has died.

My colleague is correct. The Norwood-Dingell bill allows patients who have already suffered harm to go to court. How can you justify a provision in yours that says that, Gee, you have to exhaust all of your appeals. They can be dead before that, or they are already injured.

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to my friend from Georgia.

Mr. NORWOOD. Mr. Chairman, I would like to ask my friend a question. If that provision were to hold, then would the insurance companies not just simply delay getting them through all these appeals until the patient dies? Then they do not have to pay any benefits.

Mr. GANSKE. Absolutely, and I also point out that the punitive damages relief provision in our bill is applicable to all insurance.

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Mr. Chairman, let us look at the issue of how the Norwood-Dingell bill applies it to everyone. Yes, it applies to fee-for-service plans. Do Members know why? Because that is a benefit to the independent insurance policies.

We have a provision in our bill that the Democrats were kind enough to go along with, a very Republican provision, that says, if a health plan follows the advice of that independent panel, they cannot be held liable for any punitive liability. Think of that. That is tort reform. That applies not just to group health plans, that applies to all health plans.

That means that the Blue Cross-Blue Shield plan in Pennsylvania now will get a total punitive damages liability if they have a dispute and then they follow that independent panel's decision. They do not have that now. That is a very good provision in our bill.

Mr. NORWOOD. If the gentleman will continue to yield, Mr. Chairman, one of the reasons we wanted to make sure that we had good tort reform that would particularly protect the fee-for-service plans is that under State law, which we are pretty fond of, there are only 22 States that cap punitive damages, so we wanted to get them all. We have them all under there. But under State law, there are 24 States that limit non-economic damages.

There is not any Federal tort reform. We have tort reform at the State level. That is where we always have dealt historically with problems in the health care field with medicine, malpractice, and tort, is at the State level. We like it there, because it has these wonderful, absolute limits in there.

Mr. GANSKE. I would remind my good friend, the gentleman from Georgia, is it not Republicans who stand in this aisle who say the States are the laboratory of democracy? Is it not my good friends, the Republicans, who say, hey, we want to get power back to the States? Do Members want to support a bill that eats up States? I do not think so.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentlewoman from California (Ms. LEE).

Ms. LEE. Mr. Chairman, I want to thank my colleague for yielding time to me, and for his commitment to health care for all Americans.

Mr. Chairman, I rise in strong support of H.R. 2723, which will provide protection for patients in managed care plans.

Patients should not have to face obstruction when they seek basic health care, and they should have the right to sue HMOs when careless or questionable decisions are made. Patients should not have to agonize with obtaining proper medical care while they struggle with their health problems. During these periods of life, times should be less stressful, rather than more burdensome.

This bipartisan bill allows patients to appeal their grievances when they are denied basic health care. It is wrong that millions of Americans and their families are still denied these simple rights, and continue to be denied for so long now. It is about time that medical decisions be made by the patient and his or her physician, rather than account executives or insurance bureaucrats.

In my home State of California, our Governor, Governor Davis, just signed legislation to enact historic health care reform within the State. These laws offer similar proposals to H.R. 2723 in allowing dissatisfied patients the right to appeal and seek redress from HMOs.

California patients now have many more protections than the rest of the country. Patients across the Nation, however, should also have these protections. We must not limit access to health insurance, but we should put the health of all Americans before the interests of special interests. Let us vote for H.R. 2723, and put people first when it comes to life or death decisions.

Mr. CLAY. Mr. Chairman, I have no further requests for time, and I yield back the balance of my time.

Mr. GOODLING. Mr. Chairman, I yield myself the balance of my time.

The CHAIRMAN. The gentleman from Pennsylvania (Mr. GOODLING) is recognized for 3 minutes.

Mr. GOODLING. First of all, Mr. Chairman, I want to make sure that if the Norwood-Dingell bill is a tort reform bill, I sure hope the leadership does not ask them to write some major tort reform bill. We are in trouble if that happens.

Let me close by first of all indicating what the Washington Post said recently. I quote: ''Those who favor regulating the industry do so in the name of preserving access to care for those it insures. But to regulate in such a way as to weaken cost containment and price more people out of the market would likewise have the effect of reducing access, just for different folks.''

They continue, ''The need is for greater balance than an increasingly partisan debate such as this may allow. You should legitimatize managed care by keeping it within acceptable bounds without crippling it.''

They close by saying, ''Our first instinct would be to try an appeals system first, and broaden access to the courts only if the appeals process turned out, after a number of years, not to work.'' So I repeat the call I made to my committee so many times, and now make it to the entire Congress.

When the final bell rings, after the conference is concluded with the Senate, if we have not insured the 44 million who are uninsured, we have done a great disservice not only to those 44 million, but to all Americans who are now picking up the burden in the cost-sharing process that goes on. If we have not, at the end of this day or the end of that conference, made sure that we did not uninsure, no matter how unintentional it may have been, uninsure those who are presently insured, then, again, we have done a great disservice. If one person becomes uninsured because of any action that we take here in the House or in conference, again, we have done a great disservice to the American people.

It is my hope that by the end of the time when the conference is over, that, as a matter of fact, we have tackled the number one health care issue in this country, and that is, insuring the uninsured. All should have that opportunity to be insured, and at the same time, making very sure that we do not uninsure by destroying a system that has worked so well that provides health care insurance for 125-plus million people in this country.

Thanks to the Employee Retirement Income Security Act, that has worked. So my hope would be that we build the whole program on the Boehner-Goodling program, so that we do not make a mistake and destroy what it is we are trying to do; build incrementally, starting with Boehner-Goodling.

The CHAIRMAN. All time has expired for the Committee on Education and the Workforce.

Pursuant to the rule, the gentleman from California (Mr. THOMAS) and the gentleman from Maryland (Mr. CARDIN) each will control 30 minutes.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Chairman, I would ask the gentleman from Maryland to proceed.

Mr. CARDIN. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I have been listening to my colleagues debate this issue for the last 2 hours. I marvel more about the fine work that the gentleman from Georgia (Mr. NORWOOD), the gentleman from Michigan (Mr. DINGELL), the gentleman from Iowa (Mr. GANSKE), and the gentleman from Arkansas (Mr. BERRY) have done. They have given us a bipartisan bill, a consensus bill, that will move forward on the Patients' Bill of Rights. It is a good bill. It will make a lot of progress in areas that we need to do.

The first question is, why do we need to pass Federal legislation in this area? There is a very simple explanation. It is called Employee Retirement Income Security Act. We at the Federal level have prevented our States from effectively providing protection to many people in our own State. We have preempted the States, and yet we provide no protection at the Federal level for many of our people who are insured under Employee Retirement Income Security Act plans. Therefore, we need to enact Federal legislation.

The concerns out there are great. We know that in too many cases, medical decisions are being made by insurance company bureaucrats, not health care professionals. We know that HMOs are putting roadblocks in the way of our constituents needing necessary medical services by requiring them to go

across town to see a primary care doctor before they can see a specialist, over and over and over again.

The Norwood-Dingell bill is a reasonable bill that establishes national standards to protect our constituents. Let me just mention a few of the provisions I am particularly pleased with, that I have worked on for many years with many of my colleagues in this body.

There is access to emergency care. We have been working on this bill for many years. I thank my friend, the gentleman from California, for the work that he did in expanding these protections to our Federal health care plans, including Medicare and Medicaid.

Many States have already enacted access to emergency care, as my own State of Maryland has. But the Maryland law does not apply to over half the people in Maryland because of the preemption under Employee Retirement Income Security Act.

Access to emergency care will say that if your symptoms dictate that you need emergency care, the HMO must pay for that emergency care. That is reasonable. Too many times a day HMOs are denying payments of emergency needs because the final diagnosis was not life-threatening. Sometimes we think that they want you to die before they are willing to acknowledge that there is an emergency.

Then there is the independent appeal that I have been working on with many of my colleagues for many years to guarantee that if you disagree with your HMO, you have the ability to have a review of that decision by individuals that do not have a financial stake in the outcome of that review. That is only fair. We have that, again, in many of our States, we have that in our Federal health care plans, but it is not there for Employee Retirement Income Security Act plans, because we have preempted the States' ability to act.

The use of clinical trials. In many cases it is the best health care available for our constituents. The gentlewoman from Connecticut who was on the floor has been very instrumental in moving forward with the clinical trials issues. This bill will provide basic protection to our constituents to be able to participate in clinical trials.

There are many, many other provisions in the bill that go to eliminating the gag provisions, the availability of specialists. Let me deal with some of the issues that the opponents have raised, because I do think they are without merit, and the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) have both done an excellent job in explaining that.

As far as compliance, the Employee Retirement Income Security Act shields the HMOs from liability. We cannot bring cases against them today for the consequences of their negligent acts. We all agree that that is wrong, so the Norwood-Dingell bill says, okay, let us do it this way.

First, we are not going to hold employers liable unless they are directly involved in the management of the plan. Secondly, in regard to the insurance company, if they follow their appeals process, we protect them from punitive damages. That seems like a reasonable compromise on compliance.

Let me deal with the issue of cost. We have heard over and over again, this is going to increase costs. Mr. Chairman, we have these reforms in place, including the compliance provisions, in many States in the Nation. We have not seen any dramatic escalation of costs. Many of these reforms are already in our Federal health care plans, and we have not seen an escalation of costs. I think good health care will reduce costs, not increase costs.

Mr. Chairman, we have heard it is going to be tough for a multi-State company to comply with laws in different States. Mr. Chairman, historically insurance has been subject to State regulation. That is what we thought was best. A multi-State company has to comply with the different State laws on workers' comp and unemployment compensation. This is not a burden for them to understand how the local court systems work. After all, they are located in these States.

It is for all these reasons and many more that over 300 groups, including health care professionals, consumer groups, the League of Women Voters, urge us to pass the Norwood-Dingell bill, and I urge my colleagues to do that.

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

Mr. THOMAS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am sure that by now people trying to follow this debate are thoroughly confused. When we look at the plans, there are significant portions of the various bills that are identical. The reason for that is that in 1997, when we worked together to produce the most significant change in the Medicare system since the beginning of Medicare, the gentleman from Maryland (Mr. CARDIN) and others joined together with me to produce a bill which we thought was responsible in the area of emergency rooms, gag rules, and most of what is in, in a specified fashion, all through the bills.

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Obviously that is not what is at issue tonight and tomorrow. It is the question of who can sue whom, when and how.

If my colleagues look at that and examine the various bills in that regard, what we hear over and over again in an attempt to defend Norwood-Dingell and its reasonableness or appropriateness dealing with employers is ''unless,'' ''if,'' ''and,'' ''but.'' What we have is hedging. Because, frankly, at the end of the day, employers, through no fault of their own, can be liable under Norwood-Dingell.

When employers are faced with potential liability on something which is an option to begin with, which has continued to increase in cost to the employer, there will be some employers who say I have had enough.

In contrast to that, if my colleagues will look at the Goss-Coburn-Shadegg-Greenwood-Thomas substitute, we can say this: employers cannot be held liable if they provide health care coverage, in selecting a plan, in selecting a third-party administrator, in determining coverage or increasing or reducing coverage, intervening on behalf of an employee, or declining to intervene on behalf of an employee.

When we look at what is available in terms of remedies, one of the things that concerns people is the open-endedness of the ability to sue. When we compare, for example, the Norwood-Dingell bill, it basically says that someone has a right to sue for something that is denied to them under a health plan. One also has the right to sue for something that is not under the health plan.

Now, how in the world, when it is entirely possible that a benefit request that is requested for external review does not have to be under contract, and a court can grant a benefit that is not under contract, that creates an open-ended opportunity.

In contrast, the position that the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) have been willing to modify with the gentleman from Florida (Mr. GOSS), the gentleman from Pennsylvania (Mr. GREENWOOD), and myself says that what is adjudicated is in the contract. More importantly, if the plan follows the contract, internal review, and external review, the plan is not liable.

That cannot be said about the Norwood-Dingell plan. If, in fact, there is an ability to bring a charge, no matter how remote, no matter how qualified, it is not the number of cases that are critical. It is the case that says it is not under the plan, and one followed all the rules, but one can still be sued.

No matter how qualified that position is, it is absolutely true that, under the Norwood-Dingell plan, no matter how remote, that can occur.

When an employer looks at that potential exposed liability, there will be, and if one does it, that is too many, a number of employers who will say that exposure, no matter how limited, is too much. That is one of the real key differences that we should be discussing, how much exposure, how much protection, how many safeguards are reasonable and appropriate.

On that ground, I think my colleagues will find that Norwood-Dingell is too open ended, too exposed, too much relying on third parties able to impose themselves and make decisions that are different than were contained between the two parties who originally

wrote the contract. That contract in opposition to the coalition bill is, I think, protected on a far, far higher level.

The gentleman from Georgia (Mr. NORWOOD) has been standing in the well; and if the gentleman from Maryland (Mr. CARDIN) wishes to yield him time, I would be more than willing to respond to him.

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

Mr. CARDIN. Mr. Chairman, I yield 30 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I just simply want to read from our bill about the exercise of discretionary authority. We say very clearly, unlike the gentleman from California (Mr. THOMAS) just described it, we say very clearly in this bill that an employer under any circumstances cannot be held liable for what they want to put in a plan or for what they do not want to put in a plan. That is totally their business, none of mine. They cannot be liable regardless of what happens to anybody. The only way they can be liable is if they deny a benefit, a treatment that is in the plan, and that results in the death of a patient.

Mr. CARDIN. Mr. Chairman, I yield myself 30 seconds to clarify what the gentleman from Georgia (Mr. NORWOOD) was saying.

Not only does the bill specifically provide that there is no cause of action if they do not provide a particular benefit, but what the Norwood-Dingell bill does is say that, if we have a plan of 50 employees in the State of Maryland, that is currently subject to State law, and one that is creative enough to come under ERISA, then we are going to treat both of the plans the same as far as their responsibility is concerned. I think that is a matter of basic fairness.

Mr. Chairman, I yield 3½ minutes to the gentleman from Maryland (Mr. WYNN).

Mr. WYNN. Mr. Chairman, I thank the gentleman from Maryland for yielding me this time.

Mr. Chairman, I rise in support of the Dingell-Norwood bill. It is the truly bipartisan approach that we need to address the issue of HMO reform.

Now, there are several alternatives, and I believe they are well intentioned. I believe, however, Norwood-Dingell is the better bill for several reasons. First, it is bipartisan. It is the only bipartisan alternative which reflects the thinking of both Democrats and Republicans who are serious about reforming our HMO system.

Second, I want to go to the crux of this debate, which has to do with the right to sue. Again, I believe Dingell-Norwood is a superior piece of legislation. Now, if we listen to the opponents of Dingell-Norwood, we would believe that citizens who need health care really want to buy a lawsuit. That is not what people pay their premiums for. They pay their premiums to get quality health care.

The issue of liability, the issue of suits only arises when benefits are denied, care is improper. Under those circumstances, the citizen, the taxpayer, the consumer, the patient gets the best protection under the Dingell-Norwood bill.

Now, some people, opponents of this bill, would have my colleagues believe that this is really just a boon for trial lawyers, and, for some reason, we on the Democrat side in particular, as proponents of the bill, just want to provide welfare for trial lawyers. Nothing could be further from the truth.

Understand this: the value of the right to sue is not in the lawsuit. It is in the deterrence. Because when HMOs understand that they can be sued, they have a strong deterrent to provide best quality, the best quality of health care. That is the ultimate point. The number of suits in relation to the number of patients is ultimately going to be very small.

But the question is, are we motivated by profit or greed, or are we motivated by the fact that, if we do not provide good care, one's patient could possibly sue one.

Now, my colleagues will also hear, well, this will result in a proliferation of lawsuits, and this will overburden the system and increase costs. Not so.

We have an empirical example in Texas which has implemented a program similar to Norwood-Dingell. They have not seen a significant increase in the number of lawsuits. Quite the contrary. Because, keep in mind, lawsuits are time consuming, cumbersome; and, remember, people do not pay premiums for lawsuits. They pay premiums to get quality care.

Now, Dingell-Norwood says one cannot just rush right into court at any rate. First one has to exhaust an administrative process that allows for both internal review within the HMO and independent third-party review by an impartial arbitrator who can look at the situation. In most instances, that will resolve the case one way or the other. At least based on the Texas experience, that is the case.

On the other hand, if one still believes one is aggrieved and the issue is not resolved, one has the opportunity to go into court to get redress for one's grievances.

The bottom line is simply this, we have maximum deterrence to encourage best practices when we have the optimal right to sue. We do not have an experience that tells us that we are actually going to get an explosion of lawsuits. We have, in fact, a system that has very few lawsuits and protection for consumers. Is that not really what we are trying to accomplish?

I believe Dingell-Norwood best accomplishes this goal and best protects the consumer-patient in the purchase of health care services. I urge adoption of Dingell-Norwood bill.

Mr. THOMAS. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, notwithstanding that statement, there is a phrase ''discretionary authority.'' My colleagues can qualify it. They can argue that is what it means. It is not defined.

I guess the most ironic aspect, though, of this discussion is the constant argument that doctors are no longer making decisions, that we have got to put doctors back in the decision-making key positions.

I hope somebody finds that ironic that, in the Norwood-Dingell bill, the question of whether or not someone has been physically harmed is not determined by a medical doctor. It is determined by a jury.

Under the coalition plan, both on the internal review by medical doctors and the external review by medical doctors, that decision is made. In Norwood-Dingell, there is a hole one can drive a medical malpractice case through because one alleges harm and one goes to court. A jury determines something that they have been constantly pleading ought to be in the hands of a doctor.

By the way, was not it desirable for doctors to have medical malpractice? Where is it in the bill? Ironically enough, the argument that they are doing this for doctors does not contain the thing that the doctors have always said they wanted so they would not have to practice defensive medicine, so they would not have to overutilize to protect themselves. Something as simple as medical malpractice, which is present in a number of States, is not available in this bill.

Mr. Chairman, it is my pleasure to yield 7½ minutes to the gentlewoman from Connecticut (Mrs. JOHNSON), a member of the Subcommittee on Health of the Committee on Ways and Means, someone who has worked long and hard on these issues, has examined them, not only from someone who deals with this issue in the Congress of the United States, but who is very familiar with it from her close relationship in the medical community.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I am very pleased that we are having this debate on the floor of the House tonight. I believe that, due to the real intense focus of a group of Members on this issue over the last few months, we have before us three very thoughtful bills.

I do not want the citizens of this country who are watching this debate to miss a very important fact, and that is that any one of these bills would force accountability for health care decisions made by HMOs and able patients to get the care they need.

It is essential that we act during this Congress to pass meaningful patient protections because patients need it, doctors need it, and HMOs need it. For the first time, a national independent external review process will help us identify those plans that routinely deny necessary care.

If we hold them publicly accountable, I guarantee they will change their ways or dramatically lose their patient enrollment. We will also identify those

plans that are providing timely access to quality care and give them the public attention and support they deserve.

Most importantly, a strong external appeals process will reestablish the role of physicians in the health care delivery system as plans must use physicians to review claims internally, and the external review can be made only by physicians with appropriate specialty of training.

So there are many bills before us tonight, but they all have certain core benefits in common. This internal-external appeals process for the first time makes evident nationally controversial decisions made by health plan.

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And that will provide us with the information we need and the power we need to guarantee that patients get the care they need in a timely fashion.

All the bills provide access to OB–GYN care, access to specialists, access to better pediatric care, access to emergency services, continuity of care, access to far better information about benefits, access to clinical trial coverage, and prohibits gag clauses and incentive plans that discourage the delivery of appropriate care. One can hardly say this is a partisan debate when the two parties have come together in agreement on the majority of the issues at hand, and when passage of these positions would address major concerns of the American people and have a substantial impact on the way Americans receive their health care coverage.

Now, there is an additional issue that is controversial and, unfortunately, has turned partisan. Many of us have come to the conclusion that assuring all Americans the right to sue is an important component in increasing health plan accountability. Unfortunately, many of us are also keenly aware that if we create this right to sue in the wrong way that we will create so many opportunities for litigation that the cost of insuring all those possibilities will drive premiums up.

This is an important point, because many Members have said there have not been many suits. Of course there have not been many suits. There is no clear right to sue. But if we look back at physician liability, we can see how suits do drive up costs and how one has to insure to the possibilities not just to the existence. The possibilities of suit contained in the Norwood-Dingell bill will, without fail, increase the number of the uninsured because it will drive premium costs up.

Equally important, if employers perceive themselves as liable, and this is just as big a point, if employers perceive themselves as liable by sponsoring a plan or negotiating benefits, they will drop plans, whether we say they are technically protected or not. So this bill is fraught with dangers, and we must do this job right.

My goal is to place doctors and patients back in the driving seat of health care decisions. Many who have spoken today have worked long and hard to make that kind of reform of the system possible and to assure that patients get the care they need at the earliest stage of their illness. In my opinion, the Dingell-Norwood bill would create systemic incentives to choose lawsuits over timely, independent, external reviews, driving up costs, forcing small employers to drop plans to protect themselves against the possibility of suit, and increasing the number of uninsured Americans.

Without nationwide public review of care decisions, as the external and internal appeals process will provide us, we, as a society, and health insurance, as a product, cannot develop a health care system capable of providing appropriate, timely, and affordable health care. That is why adding the right to sue must be done exactly right and must not be done in a way that creates an explosion of litigation with all the attendant consequences.

I am a cosponsor of the Coburn-Shadegg coalition substitute, because I believe lawsuits are a necessary remedy for patients who have been wronged by their managed care plan's decisions, but I oppose opening up opportunities for lawsuits where none should exist. Let me give my colleagues an example of what I believe to be the systemic incentives to lawsuits contained in the Dingell-Norwood bill.

In laying out the appeals process, internal and external, that bill says the decision must be made within 14 days or as soon as possible, given the medical exigencies of the case. Now, first of all, imagine the Department of Labor writing regulations to define what the medical exigencies are; and imagine the medical community trying to figure out how to comply with those regulations. That is a problem. But the bigger problem is that this passage now creates a case-by-case deadline for the reviewers to meet that can be reevaluated retroactively.

So it is not a 14-day decision. It is a 14-day decision unless it can be done earlier. And that can be a point that can be litigated when we start from the back end of the line and go back and say this process could have made this decision earlier and, therefore, harm has been done and liability is established.

It is that kind of phrase in the Dingell-Norwood bill that gives that legislation, and there are many others I could quote, that create within that legislation a systemic incentive for litigation.

Mr. Chairman, let me close by saying that my goal is to put doctors and patients back in the driving seat of health care decisions. Lawyers driving these decisions is no more desirable in America than insurance companies driving these decisions. The right answer is the 85 percent of these bills that provide greater access to specialists and timely access to appropriate medical care.

On the issue of the right to sue, we must guarantee it protects patients who are harmed by the egregious practices of health plans, and we must provide a clear simple process that avoids the ambiguities that delight trial lawyers, explodes litigations, drives up costs, and drives small employers out of the business of providing health care. The Coburn-Shadegg substitute is the right answer.

Mr. CARDIN. Mr. Chairman, I yield 1½ minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. I wonder if the gentlewoman from Connecticut would return to the mike.

The gentlewoman from Connecticut (Mrs. JOHNSON) is to be commended, because she has really worked hard on a lot of health care issues, but she and I have had a discussion several times on this medical exigencies part. And she has a concern about that.

I think it is necessary to have that in a bill in order that a health plan does not slow walk to the definition. But let me ask the gentlewoman, because I know she feels differently. The gentlewoman would not support a bill that has medical exigency language in it; is that correct?

Mrs. JOHNSON of Connecticut. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. That is correct, I would not support that bill, unless it has a very good appeals process in place.

We were one of the first States to do this, and now the gentleman wants to impose on our appeals process that is working. I do not mind shortening the time. That is not hard for a State to adjust to. But the gentleman wants to impose this language that is very hard to adjust to, and that really throws what is a simple clear system into an unpredictable, and uninsurable liability, I believe, system.

Mr. GANSKE. Reclaiming my time, Mr. Chairman, I want to be clear. The gentlewoman will not support a bill that has medical exigency language in it?

Mrs. JOHNSON of Connecticut. If the gentleman will continue to yield, I will not support the Dingell-Norwood bill because this is one of the passages among many others that create a systemic explosion of litigations.

Mr. GANSKE. Let me point out to the gentlewoman that the bill she is supporting has medical exigency language that she says she does not like, yet she criticizes our bill on, on page 7, on page 11, on page 52, and on page 85. And they all are in the same time frame.

Mrs. JOHNSON of Connecticut. That may be true but it is not in context, if the gentleman will yield.

It is in the context of a totally different ability to sue with all the different definitions. The gentleman talked earlier about the discretion language.

Mr. GANSKE. Here is the language from the bill that the gentlewoman supports. The decision on expedited review must be made according to the medical exigencies of the case. That is in the gentlewoman's bill.

Mrs. JOHNSON of Connecticut. Yes, but in a context that functions very differently than this language does.

Mr. CARDIN. Mr. Chairman, I yield 4 minutes to the gentleman from Washington (Mr. MCDERMOTT), a member of the Committee on Ways and Means and a distinguished member of the Subcommittee on Health.

Mr. MCDERMOTT. Mr. Chairman, I thank the gentleman for yielding me this time.

I first want to say that last year, we passed a bill out of this House that was a terrible bill, absolutely terrible bill, and it rightly died over in the Senate. They never did a thing. But the persistence of two Members of this House, the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) needs to be acknowledged. They knew what was wrong with that bill, and they came back and persisted and put a bill on the floor which makes great sense to anybody involved in the medical profession. That is why hundreds of organizations, of physicians and other health care providers are deeply supportive of this bill. It is because it meets the needs of people who deal on a day-to-day basis in this field.

There are two issues here that I think are really central. We can get into exigencies and all these fancy words, but there are two things that really this bill is about. One is about the question of ERISA. If we allow that Federal law to protect from this bill a whole series of 100 million people in this country, we will not have done a good job.

The reason we need to preempt ERISA is that we have to give everybody, whether they are under a State plan, in Maryland or Washington State or Nevada or working for a major corporation shielded by ERISA, they all ought to have the same protection. There should be no difference. And that, in my view, is what the number of all these other bills are about, is to keep that ERISA protection some way or other that they will be treated differently.

Now, the second issue, and I think this one is more personal. Having recently been a patient and having had open heart surgery, I have been in a hospital and I had my chest opened and they did all this stuff, and within 5 days the doctor came in and patted me on the back and said, ''Jim, you can go home.'' Now, the essence of why we are here on this patient protection act is that everybody, when they are vulnerable, as I felt then, wants to know that that decision was made by my doctor, who knows me and cares about me. I do not want some insurance company person saying, ''Well, let me see. Open heart surgery: 5 days. Home you go.'' I want it to be my doctor that looks at me and listens to my chest and makes the decision.

Now, the gentleman from California says, oh, this is no problem, doctors making the decisions, blah, blah, blah. Is that the reason we had to come in here and pass a bill prohibiting drive-by baby deliveries, as we did 2 years ago? And the next year we came in and we stuck an amendment into a military appropriations bill or something or other, an authorization, saying that we were not going to have drive-by mastectomies. A woman comes to the hospital in the morning; and in the afternoon, she goes home. Who decided that? Did the doctor decide it? No. Insurance companies were throwing people out in the afternoon. And we said, wait a minute, the doctor ought to have something to say about that.

And this whole issue is about whether or not we give the assurance to all the American public that when they are in a vulnerable state after surgery, after cancer treatment, after whatever, that they have the assurance that it is their provider that made the decision about what happened to them. They do not want to sue. I did not want to sue. I simply wanted the assurance that my doctor made the decision.

Mr. THOMAS. Mr. Chairman, I yield 2 minutes to the gentlewoman from Illinois (Mrs. BIGGERT).

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

Mrs. BIGGERT. Mr. Chairman, I rise in opposition to H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act.

Mr. Chairman, I have heard much talk in this chamber about what is wrong in the area of private health insurance. Members from both sides of the aisle have concentrated on what is wrong with HMOs and ignored the many good things that have happened and are happening in private health care.

□ 2030

What I think we are forgetting is that employers are voluntarily providing health insurance coverage for their employees. What we are also forgetting is that our employee-based system of health care has been the best in the world and most employees are pleased with their care.

Mr. Chairman, I fear that what we are doing today will jeopardize millions of employees who are satisfied with both the cost and protection offered by their plans. Employers throughout my district tell me the risk of liability will drive them out of the health care business. They will simply give their employees a check. Who loses then? Employees.

Without the ability to negotiate the lower rates secured by their employers, employees will be forced to pay rates double or triple for the same coverage.

Mr. Chairman, the challenge we face today is encouraging more employers to offer health insurance, not fewer. We need access and accountability, but reform should preserve our ability to offer more cost-effective quality health care, not less.

I am afraid the bill offered by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL) will produce the latter.

I urge my colleagues to oppose H.R. 2723.

Mr. CARDIN. Mr. Chairman, I yield 2 minutes to the gentlewoman from New York (Ms. VELÁZQUEZ).

Ms. VELÁZQUEZ. Mr. Chairman, we are experiencing a health care crisis in our country. Forty-three million Americans are uninsured. Almost 11 million of the insured are children. One in five uninsured adults went without needed health care in the past year. This is unacceptable.

Equally unacceptable are the more than 50 percent of insured Americans who are in HMOs and are denied coverage in emergencies, access to specialists, and recourse if wrongfully denied necessary medical treatment. This bill does something about that.

What matters to Americans is their ability to take care of their families in an emergency. What matters to Americans is that their children will not be turned away from an emergency room because the hospital is not on the family's HMO plan. What matters to Americans is that they will have access to the best treatment by the best doctor when they or their children are sick.

This bill will protect patients. No longer will HMOs deny patients access to specialists and emergency care. No longer will HMOs gag doctors and restrict their freedom to disclose medical treatment options to their patients.

Arguably, the most progressive element of this bill will allow patients to pursue punitive damages in State courts when they have been wrongfully denied necessary treatment by an HMO.

It makes me sick to hear opponents of this bill try to convince the American public that we will pay inflated premiums because of this protection. I have news for them. We do not buy it. We know who will pay the price if we do not demand more accountability in health care. The American public.

I urge everyone here to vote in favor of this bill. By doing so, we will take the first step toward addressing the health care needs of Americans.

Mr. CARDIN. Mr. Chairman, I yield 4 minutes to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Chairman, this really is a historic day for this House. For the first time, Members will have an opportunity to fundamentally change how managed care operates in this Nation.

For far too long, insurance companies have based their treatment decisions not on what is best for their patients but what is best for the companies' stockholders. It is time to put health care providers and patients back into the business of patient care.

We need the Norwood-Dingell bill to ensure that patients have access to emergency care and to specialists. HMOs need to be prohibited from gagging doctors and other providers so that they are prevented from telling their patients of all the treatment options available.

What are the insurance companies afraid of? Are they afraid of their own policies?

Patients also need the right to appeal when they disagree with HMO suggested treatment. The Norwood-Dingell bill grants patients internal and external appeals, a process to ensure that the best possible treatments are made. The bill permits patients or their families who have been injured or die as a result of the HMO's denial of care to sue in State courts.

What is wrong with that? If the insurance companies are confident of their policies, what is wrong with that? This is America.

The Norwood-Dingell bill, however, does not invite frivolous lawsuits. It imposes the number of limitations on lawsuits. These restrictions include those damages only allowable by State law, no punitive damages provided the HMO complied with an external reviewer's decision and no plan would be required to cover services not provided in the contract.

My State of Texas has a patients' bill of rights. This legislation took effect 2 years ago. And while HMOs serve more than 4 million patients in Texas, there have been only five lawsuits resulting from the legislation. That is hardly a flood of lawsuits.

To quote Senator David Sibley, one of my colleagues when I was in the Texas Senate, the bill's Republican sponsor, ''The sky didn't fall'' with its passage.

The number of lawsuits is low because our patients are fully using the external review process, and that is a component of the Norwood-Dingell bill. More than 700 patients have used that external review process in the past 2 years to appeal decisions made by health plans.

Critics of the Norwood-Dingell bill have said it will increase health care costs. Since Texas's bill of rights has been in effect, premiums in our State have been less than the national average, while health care costs rose 3.7 percent nationally in 1998. The Texas health care cost increased only by 1.1 percent. And these are figures done by the Texas Medical Association.

As a former registered, degreed nurse, I strongly understand the relationship between a patient's involvement in his or her treatment and quality health care. We cannot have one without the other.

The Norwood-Dingell bill will create a treatment environment where patients and doctors can work together with insurance companies to produce the best patient care and the best patient outcomes.

I urge all Members to please support this bill. Let us put health care where the patients are.

Mr. THOMAS. Mr. Chairman, I yield myself 3½ minutes.

Mr. Chairman, there was a colloquy just a short time ago on the exigency question. I had said sometime earlier that it was possible to abort the system under Norwood-Dingell and go to jail if they claim that they have been harmed. And it could be denial of medicine for one day, denial of a procedure for one day. That was the point that the gentlewoman from Connecticut was talking about, that although there are numbers stated in the bill, there are ways to short-circuit those numbers and, notwithstanding the internal and external appeal language, go to court.

What was read from the Goss-Coburn-Shadegg provision claiming to be loaded with exigencies is under the section that deals with the emergency 48-hour provision. The 14-day time frame is the ordinary one in which they are required to exhaust the internal and the external. And then based upon the medical exigency, they have a 48-hour capability.

In other words, instead of writing all of the medical conditions that would trigger the 48 hours, they use the phrase ''medical exigency.'' The English word was the same. The location and the usage was entirely different. I will tell my colleagues, that has been the basis for a number of challenges in this debate. Just because a word is there does not mean anything. As most people know, it is the context, the location, and how that word is used.

Let me also point out that although the Clinton administration is pleading for us to move this kind of legislation, and we are talking about in the coalition bill a fast and fixed 14 days in ordinary situations on the internal appeal, 14 days on ordinary situations in the external appeal, and in both situations, depending upon the medical exigencies, 48 hours.

The Clinton administration, with a stroke of a pen, could change the appeals procedure in Medicare. Do my colleagues know what the appeals procedure in Medicare is today? For Part A on a fair hearing, it is 52 days. And if they want to appeal that decision, on average, it is 310 days.

Why are they not making the kinds of changes in Medicare law that they are arguing ought to be imposed on the private sector?

Now, if my colleagues think that is bad, in the Part B appeals provision, currently it is 524 days. It seems to me a fixed 14 days and in serious conditions 48 hours with medical doctors reviewing the appeal, not the rush to judgment, not the claim of harm, not the ability to go to court and let a jury decide whether or not they are harmed, but it seems to me some folks ought to go back and with a stroke of the pen make the changes in Medicare that they are claiming are so necessary to be imposed on the private sector.

Mr. CARDIN. Mr. Chairman, I yield 1 minute to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I appreciate the gentleman yielding the time.

Mr. Chairman, I would point out to the gentleman from California (Mr. THOMAS) that on page 7, lines 25 through 35, are not ''in the expedited care,'' they are ''in the ongoing care.'' And I point out that on page 47, the lines that talk in the Thomas bill are not ''in the expedited area,'' they are ''in the ongoing care'' concurrent review sections.

So I am just glad that my colleague has recognized that there are places in the bill.

Mrs. JOHNSON of Connecticut. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Chairman, the concurrent care, that is what the word ''concurrent'' means, it is during that 48-hour period.

In the longer 14-day period, that language does not appear. It is appropriate when they have only 48 hours and they look at whether the person can stay in the hospital then it ought to be as quick as possible, and it is the same argument the gentleman gave me about why it is important.

Mr. GANSKE. Mr. Chairman, reclaiming my time, I appreciate the comments of the gentlewoman because it conforms with what we have said in these certain areas. We need to have some flexibility in that.

Mr. CARDIN. Mr. Chairman, I yield 2 minutes to the gentlewoman from Florida (Ms. BROWN).

Ms. BROWN of Florida. Mr. Chairman, today we have a chance to do the right thing for millions of Americans who are currently being served by the HMO by holding health care plans accountable when they deny patients the care that they need.

I just suffered through a very painful experience of the death of a very close relative. It was a difficult experience made even more difficult because of the HMO restrictions we face.

For example, a family member is in the hospital for a week and they have to come out and be placed back in because even though the doctor said that the person needs to stay in the hospital or they have to go to a rehab, they cannot go to the one close to their home; they have to go to one miles away.

We know their health care plan should make sense. It should not cause headaches.

Mr. Chairman, this bill brings dignity back to the health care for the 4 million people in my great State of Florida who use HMOs. We did not pass a health care plan in 1993. That did not mean that the problem went away.

Shame on this Congress if we miss this opportunity to provide genuine protection from harm to the citizens that are counting on our leadership. Do the right thing and vote for the Dingell-Norwood bill.

Mr. THOMAS. Mr. Chairman, it is my pleasure to yield 5½ minutes to the gentleman from Florida (Mr. WELDON).

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

Mr. Chairman, I rise to speak in support of the Goss-Coburn-Shadegg-Thomas bill. And let me explain why, should that not pass, I intend to vote for the Norwood-Dingell bill. But first I would like to make a few general comments regarding how we got into the problem that we are in today in the United States with managed care.

A health care plan in the early 1960s, a plan that we all grew up and became used to where there was very little interference in the doctor-patient relationship cost a family of four a few hundred dollars a year. But along came developments like MRI scanners, CT scanners, third-generation cephalosporins, new surgical procedures to treat glaucoma diabetic retinopathy, all good things that prolonged life, improved the quality of life, reduced disability but significantly increased costs.

□ 2045

The pressure of the cost burden on our health care system led many health care economists to look at the perversity in our health care system, where the doctor was not responsible for costs, nor the consumer; the patient was responsible for costs. Both parties were really not regarding costs at all.

Now, what should have been done was exploring alternatives that actually introduced a true marketplace in health care, which is along the lines of some of the reforms we are trying to establish, but instead what was established was managed care, HMOs.

I would like to say, in defense of those entities, while it is true that there are problems in HMOs and people are being injured and are dying, the system that they replaced was a system where people were injured and were being killed, and the body of information on this is out there. It is abundant.

Many economists looked at the issue that there were perverse incentives that caused providers to provide excessive care in some areas such as Cesarian sections, there is abundant data to show that there were too many Cesarian sections; and, yes, there were people who had unnecessary complications; and some people, unfortunately actually, died from it.

Now, I believe it is entirely in order for us to try today to address the problems, the perverse problem in the HMO field, where there is an incentive not to provide care.

Now, I would like to point out to my colleagues that I met with officials from the AMA several months ago; and at that time, they said to me that they thought that a health care reform package that had a good internal and external review, without any litigation language, would be sufficient; and that is because their primary interest was quality of care.

I believe the people at AMA, that is their real interest, in preserving the quality of care. Unfortunately, some of the leaders of the underlying Norwood-Dingell-Ganske bill had come to the conclusion at the same time that I was having that discussion with the AMA that our leadership on this side of the aisle was so determined not to pass any type of reform that they went over to the other side of the aisle and agreed to a proposal that introduces a tremendous amount of new litigation.

If someone asked me what is the real solution to the problem that is at hand, it is to open up insurance companies and HMOs to litigation because they are practicing medicine. Today, when I make rounds at the hospital, third party payers can come in and say, ''No, Dr. Weldon. If you want to send a patient home in 2 days, we do not agree; they have to go home now. No, they cannot go home on that antibiotic, they will go home on this antibiotic.'' That is practicing medicine, and I believe they should be held accountable for that, in all the facets which they are practicing medicine.

There should be reasonable caps and limits on punitive damages and on pain and suffering claims. The other side of the aisle refuses to agree to any of that language, and the President of the United States refuses to agree to any of that language.

The bill we are primarily talking about right now, the substitute with the name of the gentleman from California (Mr. THOMAS) on it, tries to institute some reasonable limits on litigation, reasonable limits on litigation that I feel most of the Republican supporters of the Norwood-Dingell bill actually want to see in place; maybe not this language.

My hope is that as we move from the House to a conference committee, that we will finally have a product that places patients first and the doctor/patient relationship first and that does not open up American courts to more and more litigation.

Mr. CARDIN. Mr. Chairman, I yield 3 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANKSE. Mr. Chairman, I would just like to thank my colleague, the gentleman from Florida (Mr. WELDON), for his support for the Norwood-Dingell bill. He is a family physician. He has been on the front lines. The American Academy of Family Physicians has endorsed the bipartisan bill.

Mr. THOMAS. Mr. Chairman, will the gentleman yield?

Mr. GANKSE. I yield to the gentleman from California.

Mr. THOMAS. I believe the gentleman made a misstatement, and he can take it on my time.

Mr. GANKSE. What was my misstatement?

Mr. THOMAS. The gentleman said he was supporting the Goss-Coburn-Shadegg-Greenwood-Thomas bill and that under the rule, if it passes, I want the gentleman to characterize accurately his statement.

Mr. GANKSE. Mr. Chairman, reclaiming my time, I was accurately stating that the gentleman from Florida (Mr. WELDON) said that he would support the Norwood-Dingell bill.

I hope we get to the Norwood-Dingell bill, to be quite frank. I know the gentleman from California (Mr. THOMAS) will try to prevent that.

I would point out that the American Academy of Family Physicians has endorsed the Norwood-Dingell bill. They are on the front line. My colleague from Florida is on the front line. He understands that we need HMO reform.

I do want to specifically, though, thank the gentlewoman from Connecticut for her remarks because this is about much more than just a debate on liability. The liability provisions that are in this bill are almost verbatim the ones that the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Georgia (Mr. NORWOOD) and I wrote at the behest of the Republican chairman of the Committee on Commerce. Quite frankly, we thought it was a very good faith effort and compromise on the part of the Democrats to agree to a punitive damages liability provision that we have in that bill that would protect employers from any punitive damages liability if they followed the recommendation of that independent panel. I thought that represented a good bipartisan compromise, and I very much appreciate my colleagues from the other side, but this bill is about so much more than that.

It is about emergency services, people getting the care they need. It is about specialty care, people getting the care they need. It is about people who have chronic care problems getting the care they need; women getting the care they need; children getting the care they need, having continuity of care so that the gentleman from Oklahoma (Mr. COBURN) can continue to see his patients and the HMOs cannot yank him around. This is about clinical trials. The American Cancer Society endorses our bill because we have clinical trials in it, as well as numerous other patient advocacy groups.

This is about choice of plans. This is about getting health plan information to beneficiaries. This is about allowing appropriate utilization. It is about allowing internal appeals. It is preventing gag rules that prevent people from getting the information they need. It is about prompt payment of claims. It is about paperwork simplification. These are all things that are in the bipartisan Norwood-Dingell bill. This is about so much more than liability. This is about patients finally having some ground rules that their HMOs have to follow.

Mr. THOMAS. Mr. Chairman, I yield 30 seconds to the gentleman from Oklahoma (Mr. COBURN), one of the central participants in this debate.

Mr. COBURN. Mr. Chairman, I would make two notes. Number one, the American Academy of Family Practice

has endorsed our bill as well, the Goss-Coburn-Shadegg-Thomas bill. Number two is, the gentleman from Florida (Mr. WELDON) is an internist, not a family practice physician. Number three is, we do have cancer clinical trials. And, number four is, we in fact have network adequacy which is not in the consensus bill, which is if there is not an adequate network there is not care.

Mr. CARDIN. Mr. Chairman, I yield 30 seconds to the gentleman from Iowa (Mr. GANSKE).

Mr. GANKSE. Mr. Chairman, my apologies to the gentleman from Florida (Mr. WELDON), who is an internist.

I would point out that the American Society of Internal Medicine has endorsed the bipartisan bill, too.

Mr. CARDIN. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I think the choice here is very clear. There have been many groups and many Members working for many years to get an effective patient bill of rights enacted by this Congress. Three hundred groups have endorsed the Norwood-Dingell-Ganske bill. They understand who has been working to make sure we pass a bill that will be effective, that does the right thing. It is very interesting to see the eleventh hour efforts to try to confuse what we should do.

It is very interesting that the Norwood-Dingell bill has been available. People have looked at it. It has been worked on. It has been given the public airing necessary in order to make sure it is drafted properly.

Now, we saw last year those who did not want to see a Patients' Bill of Rights pass but they did, and bringing out a bill without any real effort made to deal with the issues. Now we see this year an eleventh hour effort in order to confuse the people, but the people are not confused. They know where the advocates are. They know where the people are who have been working on this issue, and it is the Norwood-Dingell bill.

Mr. Chairman, how much time do I have remaining?

The CHAIRMAN. The gentleman from Maryland (Mr. CARDIN) has 1¾ minutes remaining.

Mr. CARDIN. Mr. Chairman, 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. Chairman, I thank the distinguished gentleman from Maryland (Mr. CARDIN) for yielding me this time.

Mr. Chairman, I rise in very strong support of this piece of legislation. On Monday, I met with a constituent of mine, Sharyl Asbra of Waldorf, Maryland. She went to the hospital in June complaining of severe abdominal pains. After diagnosing her condition, the doctors recommended she have a hysterectomy, but her insurance company denied the procedure. After weeks and weeks and weeks and weeks of pain, only after Dr. Scott Kelso repeatedly called the insurer on Sharyl's behalf did the insurer relent and let Sharyl get the necessary treatment. This was after she had to be off work, could not care for her children, her mother had to do so, and after she experienced a long period of pain.

This bill is about real people who have a real problem. It is about people who need medical care, as determined by their doctors and by themselves. It is about ensuring that they have access to the medical care that they need, and that that decision will be made by doctors who are trained to make those decisions and who have sworn an oath of personal responsibility to those patients to ensure that they get the kind of quality health care that is available in this country if it will be paid for.

I rise in strong support of this bipartisan bill to help Sharyl and millions and millions of others like her in America.

Mr. THOMAS. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I would tell my friend from Maryland, he cannot have it both ways. When we were debating the rule, there was plea after plea from the other side of the aisle, do not vote for the rule because they would not let us have an eleventh hour amendment to our bill, and yet they say that they have had their bill without making changes.

They cannot have it both ways. Either they pleaded for an eleventh hour amendment, they did not get it and they voted against the rule, or they have a position they have held for some time.

We can read off hundreds of medical associations. They have endorsed the Coburn-Shadegg bill, just as they have endorsed the other. I can say, we fall by the wayside when we reach about 200 endorsements. The reason we do not reach the level of 300, that the gentleman from Maryland cited, is because we do not have the labor unions and the trial lawyers.

The trial lawyers are endorsing their bill. Why? Because their bill will allow trial lawyers, without medical doctors proving harm, to go to the courtroom and have open-ended penalties imposed by juries. Frankly, we do not think those extra 100 endorsements are the kind of endorsements Americans think should be made in today's health care structure.

Our bill makes sure that medical doctors make the decision, and when the plan is wrong, one can sue.

□ 2100

What I find most egregious is the fact that employers struggling to provide health care to their employees if Norwood-Dingell becomes law, will have to examine the exposure to those same trial lawyers and juries and decide if the risk is worth it. It is a sad statement to make, but I believe a factual one; if Norwood-Dingell becomes law, there will be fewer people covered. On the other hand, if the Goss-Coburn-Shadegg-Greenwood-Thomas bill becomes law, we will have an ordered process, internal and external, reviewed by medical doctors, and if the plan is wrong, they have to provide the coverage. If there has been medical harm, they can go to court, and they can, yes, those now famous phrases, sue their HMO, but it is done in an orderly fashion, and guess what? The trial lawyers do not endorse our proposal. Why? Because it is not open ended, and it is not left up to a jury to determine injury. If we are going to advance medical coverage in this country, it is clear one of the things we have to do is to allow patients to get what they rightfully deserve, and, if harmed, to get proper adjudication. But what we do not need is open-ended trial juries with trial lawyers endorsing the process. They proudly announce they have the trial lawyers on their side. We proudly announce we do not, and that, I think, is the bottom line.

Mr. ARCHER. Mr. Chairman, two principles have forever guided this great nation of ours—freedom and liberty. As a democratic nation whose strength is derived from its people, we have achieved unparalleled success, unsurpassed by any nation on this planet. It's no wonder that people around the globe want to come here and be called Americans. We're the envy of the world.

Our nation's health care system is no different. Americans don't travel abroad to get health care. Visitors come here—to the Mayo Clinic, to Mt. Sinai, to the Texas Medical Center, because we are the best.

And the reason our health care system is the best is because it's based on free-market principles, on choice and on individualism. But we lose that choice when we take it out of the hands of doctors and patients and put it in the laps of trial lawyers. 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.

The best patient protection of all is health insurance, and the number one barrier to access to cost. But this big government approach makes this problem worse by raising the costs of health insurance premiums even higher, pricing thousands of American families out of the market. But Democrats don't stop there.

After they've raised health costs for Americans and made it more expensive for businesses to provide employees with health insurance, they want to pay for it by turning around and sticking it to those same companies under the guise of "closing loopholes." That's why the National Taxpayers Union and Americans for Tax Reform oppose the Democrats' one-two punch, because it slams the very people that create jobs and provide 70 percent of Americans with their health insurance.

Frivolous lawsuits won't promote individual choice. More trial lawyers won't mean better care. And higher punitive damages won't save one American from falling into the ranks of the uninsured.

The best patient protections we can offer to families and individuals is health care coverage. Forty-four million Americans go without that protection every day. Isn't it time we did something for them, and not the special interests? The American people want the choice and freedom to be examined by a doctor in the treatment room, not cross-examined by an attorney in the courtroom.

Finaly, Mr. Chairman, let me point out that the base bill and the amendments made in order under the rule address tax matters under the jurisdiction of the Committee on Ways and Means.

Specifically, section 401 of H.R. 2723, as introduced, contains a single tax code amendment to enforce the legislation's so-called patient protections through the existing tax penalty structure in the tax code. The bill aims to conform to the structure established in the original HIPAA law by including health reforms in both the Public Health Service Act and ERISA, as well as by reference in the tax code. The Houghton substitute includes an identical provision.

Title III of the Boehner substitute and Title III of the Goss substitute include similar provisions necessary to mirror the proposed health reforms in the tax code. However, these two amendments have been drafted to more closely follow the format used in the HIPAA legislation.

Mr. COX. Mr. Chairman, my colleagues today are addressing very real concerns that patients and doctors have raised. The current system of ''managed care'' imposes restrictions on a patient's choice of doctors. It interferes with the doctor-patient relationship. And it requires patients to navigate through a maze of frustrating health care bureaucracy. Indeed, the only dysfunction the current system does not yet suffer from is an epidemic of litigation that drives up health care costs. More lawsuits is not the right prescription for today's health care ailments. Rather, we need more consumer choice. Choice, quality, and competition should be the watchwords of this debate.

In a competitive market, when consumers don't like what they want, they go elsewhere. In today's health care market, where employers often provide only one health care plan to employees, that is often not possible. Workers who are dissatisfied with their HMO care should have real alternatives to choose from, not just a lawsuit against a plan they didn't really want to begin with.

Today, 90 percent of insured Americans are covered through their employers. Fully 30 percent of employers provide only one health plan to their employees. And a whopping 70 percent offer only no more than two choices. The tragic cause of Americans' lack of health care choice is federal regulation. The tax code provides a special break for employer-provided third-party payment plans. It provides a severe disincentive for individuals to shop for their own insurance, fee-for-service medicine, or other health care not preapproved by Uncle Sam. As a result, individuals are left with a Hobson's choice—employer-provided coverage or nothing. When your employer contracts with an HMO provider, what choice do you have?

Today's bill piles on more regulation and litigation on top of this tragic mess. It further regulates how you interact with your HMO. It does not increase individual choice; it only increases the cost of health care for everyone. Increased health care costs, in turn, mean rationing of services, limits on patient choice, shortages of the latest high-tech equipment, and long waiting lists for operations. Consumers will see an increase in premiums, and many will lose their benefits or their insurance altogether as employers are forces to drop coverage due to higher costs.

It's time to give Americans more choice in their health care, and more control over their health care dollars. Instead, however, this bill takes us towards more and more government control.

Until individuals have an alternative to an employer-provided HMO, the fool's gold of ever-increasing litigation and regulation will beckon us toward disaster. The solution is to resist the calls for more lawsuits and more government controls, and to move to a genuinely competitive market that will empower consumers, put patients and doctors back together and cut out the bureaucracy, deliver reduced costs, provide increased access, and guarantee improved health care quality.

Ms. PELOSI. Mr. Chairman, there are few things more important to family security than access to quality health care. People's health must come before the corporate bottom line. We must preserve and protect the doctor-patient relationship, and put health care providers ahead of insurance company accountants. At least 13 million Californians and 122 million Americans are now without enforceable patient protections on their health care plans. To protect them, Congress must act to pass a real Patients' Bill of Rights.

Take, for example, the person who has a painful health condition. Her doctor would like to prescribe a medication with the fewest side effects, but that drug is not on the managed care company's formulary. Or consider a person with a chronic disease who needs frequent access to a specialist, but is required to get a referral from his primary care doctor for each specialty visit.

H.R. 2723, the Norwood-Dingell Patients' Rights Bill, would provide needed protections for these and other health care consumers. The bill would: ensure access to emergency care without prior authorization; allow people to choose their own primary care and specialty providers; and give patients the right to hold HMO's accountable.

The other bills we will consider today fall far short of guaranteeing many important protections. H.R. 2824, introduced by Representatives COBURN and SHADEGG, and H.R. 2926, introduced by Representative BOEHNER, differ from the Consensus bill in important ways. In particular, they would not provide patients with the ability to hold health plans accountable in state courts, which typically handle injury and wrongful death suits, and are less expensive and more accessible than federal courts.

Mr. Chairman, last week we learned that the number of the uninsured in this country has increased to over 44 million. For years, many of my colleagues and I have insisted that we must expand access to health care. But H.R. 2290, the Quality Care for the Uninsured Act, would institute untested or failed health programs and cost at least $48 billion over ten years.

For example, ''Association Health Plans'' authorized in the bill would repeal state-based health care reform initiatives that address the needs of local consumers, and eliminate several consumer protections designed to prevent fraud and abuse. H.R. 2290 would undermine our ability to pass comprehensive and bipartisan patient protection this year. It should be rejected by the House.

The Bipartisan Consensus Managed Care Improvement Act provides a broad range of important protections for health care consumers. The American Medical Association has stated that the bill is ''the only real patients' bill of rights,'' and the Children's Defense Fund feels that the legislation is ''tailored to meet the health care needs of children and their families.'' I urge my colleagues to support real patient protection by voting for H.R. 2723.

Ms. MILLENDER-McDONALD. Mr. Chairman, our day has been consumed with debate on a desperate rule drafted to derail the bipartisan managed care reform train. This disheartens me because the Norwood-Dingell bill is a good bill. It is such a good bill; the three alternatives have used it as their base. Why is that? Whatever the reasons may be, they are all for naught if this good bill has to be joined with the poison pill train that the Rules Committee placed on our tracks.

The Norwood-Dingell bill allows women to obtain routine ob/gyn care for their ob/gyn without prior authorizations or referral. This is a good step in the right direction.

Mr. Chairman, this bill needs a straight up or down vote. When a straight up or down vote—without poison pills is allowed, I urge my colleagues to vote YES on the Norwood-Dingell bill.

Mr. KUCINICH. Mr. Chairman, I rise in favor of this bill. If HMOs are left free to determine the quality and availability of health care in America, they will have an incentive to deny care to those who need it and reward their executives and shareholders with these quote unquote ''savings''. Studies show that HMO enrollees receive ⅓ less home visits after a hospital stay (1994 Health Care Finance Review study). HMO enrollees are three times more likely to report problems getting medical care than publicly owned and managed Medicare beneficiaries (1969 Study by the Physician Payment Review Commission, a Congressional advisory commission). Meanwhile, private HMO executives are richly-compensated. The total cash compensation received by the CEOs of just the 3 largest HMO companies totaled 33.3 million dollars. Three companies: Aetna, Inc.—$888,568, Pacifi Care Health System Inc.—$1.7 million, Oxford Health Plans—$30.7 million.

Now, our job in Congress is to pass laws. But what good is a law that is not enforced? The easiest way for HMOs to limit health care costs is to deny people care to those who need it most. This bill gives citizens the opportunity to hold HMOs accountable for trimming costs at the expense of the sick. If a lawsuit against an HMO corrects the incentives and ensures that the best treatment will be given to a patient rather than the cheapest treatment, then I say, give people their day in court to enforce the law. And what we really need is a national health care system so that every person has health care coverage and has protected rights under the law. Let's pass H.R. 2723, I urge my colleagues to vote ''yes'' on this bill.

Mr. KLECZKA. Mr. Chairman, the need for managed care reform is clear.

According to a study by the non-partisan Kaiser Family Foundation, nearly nine in 10

doctors say their patients had experienced denial of coverage by a health maintenance organization (HMO) over the past two years. The same study found that as many as two in three of those doctors believe that the denial resulted in a serious decline in health for their patients.

To address this problem, the bill before us today, the Managed Care Patients' Bill of Rights, will establish critical patient protections to ensure that consumers get the health care they've been promised and have paid for.

The Patients' Bill of Rights would: prohibit plans from gagging doctors who wish to talk about treatment options; ban arrangements in which doctors receive incentives to limit medically necessary service; prevent plans from retaliating against health care workers who advocated on behalf of their patients; allow women to see their OB/GYN without prior approval; allow patients to select pediatricians as the primary care provider for children; allow patients with special needs to get a standing referral to a specialist; require coverage of emergency care without prior approval; and allow patients with life-threatening conditions access to approved clinical trials.

None of these provisions have any weight unless patients can hold health plans accountable for the medical decisions they make. This bill would allow patients to do so.

Some insurance companies, business groups and their advocates in Congress claim that if you hold health plans accountable in the courts for their actions the whole health care system will collapse. They say there will be a rush to the courthouse and the cost of health care will shoot through the roof. This is just not so.

For those who claim the sky is falling, let me point to an article that appeared in the Washington Post. As this article explains, two years ago, Texas became the first state to give patients the ability to sue their health plan. Since then, there have been only five lawsuits among the over 4 million Texans who belong to HMOs. Moreover, health care premiums have not increased more in Texas than in the rest of the country.

The Dingell-Norwood bill would ensure that all Americans have the protections which have worked to promote better patient care in Texas. The bill would permit patients—or their survivors—to sue their health plans in state courts when they make negligent decisions that result in injury or death.

H.R. 2723 is a responsible approach to make our nation's health plans accountable for their actions. As a cosponsor of the Dingell-Norwood Managed Care Patients' Bill of Rights, I stand in strong support of this needed reform which will finally put patient protections ahead of special interests.

Mr. WELDON of Florida. Mr. Chairman, I rise in support of the Norwood-Dingell bill, H.R. 2723. I am very supportive of the provisions in this bill which strengthen patient protections and restore the doctor-patient relationship.

I am also hopeful that the final bill that we send to a House-Senate conference will include not only the Norwood-Dingell patient protections, but also provisions that will make health insurance more affordable for the growing ranks of the uninsured. Our failure to address both of these issues will leave the job perilously half done.

I fully support the strong patient protection standards included in H.R. 2723, many of which were included in my Access to Specialty Care legislation from the last Congress. Particularly, I am pleased that the bill provides for a strong internal and external review process. This will help reassure patients that medical decisions about their coverage have received full consideration, not only by an internal board of medical experts, but also by an external board of medical experts.

The bill also ensures that patient have access to the care they need in a timely manner. In addition to providing timely internal and external reviews, the bill ensures that patients' emergency room expenses are covered. For a patient to be second guessed by a health plan administrator after an emergency episode is unreasonable. H.R. 2723 ensures that patients have their emergency health care needs taken care of. It also ensures that they have greater access to the specialty care that they need. This is critical for ensuring that patients have access to the type of provider that can care for their special needs.

In addition to these provisions, I am pleased that the bill ensures that women can designate an obstetrician or gynecologist as their primary care provider. Also, I am pleased that we ensure that parents can designate a pediatrician as the primary care provider for their children. These provisions make perfect sense and they will be of significant help in emphasizing preventive care.

The bill will also ensure that health plan enrollees will have access to full, easily understandable language on what medical services are covered and not covered. Information is the key to empowering individuals to make informed decisions on their health care. Consumers should have a right to know before they sign up with a plan exactly what is covered and what is not covered.

I am pleased with provisions that will ensure that no one gets between the physician and the patient. The patient must have the assurance that their physician is not influenced by any third party when making decisions about their health care. Toward this end, the bill eliminates gag rules that in the past have limited the free speech of doctors when talking with their patients. Additionally, the bill ensures that the insurance companies are no longer permitted to offer perverse incentives that would encourage health care providers not to provide care.

Finally, H.R. 2723 includes liability provisions to hold medical decisionmakers accountable. While I agree that the current system in which the people who make medical decisions to deny care are often not held accountable, I am concerned that the provisions in the Norwood-Dingell bill go too far. I fully support provisions to hold health plans accountable for the decisions they make; however, we must ensure that we do not open Padora's Box by turning the Patients' Bill of Rights legislation into a Lawyers Right to Bill. Any liability legislation must impose caps.

We must recognize that allowing trial lawyers and their clients to walk away with multimillion dollar awards will raise everyone's premiums. The costs of multi-million dollar lawsuit awards will be passed along to everyone in higher premiums to health plan enrollees. That is why I believe it is critical that if the final bill includes liability provisions, we must insist on reasonable caps on damages. While caps may not be in the best interest of the trial lawyers, it is important for average American citizens in ensuring that insurance premiums are more affordable.

Mr. UDALL of Colorado. Mr. Chairman, I rise in opposition to H.R. 2990 and in favor of the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act.

At some time in their lives, all Americans will be faced with making tough choices about medical care for themselves or their families. At these times, the last thing anyone wants to think about is whether their health plan will pay for what's necessary. H.R. 2723 is a bipartisan solution to many of the problems Americans face with their health plans. The bill creates new federal standards and requirements on all health insurance plans and would cover 161 million Americans, much more than what is covered in the Senate bill.

I believe H.R. 2723 would protect the doctor-patient reationship. It provides a point of service option if the enrollee otherwise does not have access to non-network alternatives. It provides access to emergency room care, specialists, and clinical trials. It gives women their choices of OB/GYN specialists without referrals from a primary care provider. It allows parents to choose a pediatrician as their child's primary care physician. It provides for continuity of care in cases where a provider or insurer is terminated by a plan.

And finally, it will give consumers uniform grievance and appeals procedures, including the right to sue, if their health plan makes a decision that puts them in harms way.

In short, this legislation will help restore the doctor-patient relationship, give Americans better access to care, greater consumer information, and better protections and benefits. On top of all this, it protects employers by exempting them from legal action if they are not involved in a claim decision.

H.R. 2723 is good legislation. It is good for Americans, and it is good for the future health of our country.

The CHAIRMAN. All time for general debate has expired.

Mr. THOMAS. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. KUYKENDALL) having assumed the chair, Mr. HASTINGS of Washington, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2723) to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, had come to no resolution thereon.

APPOINTMENT TO BOARD OF TRUSTEES OF THE AMERICAN FOLKLIFE CENTER

The SPEAKER pro tempore. Without objection, and pursuant to section 4(b) of Public Law 94–201 (20 U.S.C. 2103(b)), the Chair announces the Speaker's appointment of the following individuals from private life to the Board of Trustees of the American Folklife Center in the Library of Congress on the part of the House:

Ms. Kay Kaufman Sheelmay of Massachusetts to fill the unexpired term of Mr. David W. Robinson; and Mr. John Penn Fix, III, of Washington to a 6-year term.

There was no objection.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. LIPINSKI) is recognized for 5 minutes.

(Mr. LIPINSKI addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana (Mr. BURTON) is recognized for 5 minutes.

(Mr. BURTON of Indiana addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana (Mr. HILL) is recognized for 5 minutes.

(Mr. HILL of Indiana addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan (Mr. SMITH) is recognized for 5 minutes.

(Mr. SMITH of Michigan addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota (Mr. MINGE) is recognized for 5 minutes.

(Mr. MINGE addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

WASTEFUL SPENDING

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Tennessee (Mr. DUNCAN) is recognized for 5 minutes.

Mr. DUNCAN. Mr. Speaker, I want to continue speaking out tonight about very wasteful spending by the Federal Government. One of the most wasteful, extravagant programs in the entire Federal Government is the Job Corps. It is now costing about $26,000 a year to put a student through this program, $26,000 a year. We could give each of these young people a $1,000 a month allowance, send them to some expensive private school and still save money. If we did that, these kids would feel like they had won a lottery, they would be so happy. We are still giving this scandalously wasteful program increases each year. The bill that will be before us next week increases the Job Corps appropriation to $1.4 billion. If this bill or this program was good for children, then it would be worthwhile spending. However, the GAO has reported that only about 12 percent of the young people in this program end up in jobs for which they were trained, and that is after you give the Job Corps every benefit of the doubt and stretch the definition of a Job Corps type job to ludicrous limits. Actually the Job Corps is very harmful to young people. It takes money from parents and families, money that they could be spending on their children, and gives it instead to Federal bureaucrats and fat cat government contractors. That is who really benefits from the Job Corps program, the bureaucrats and the contractors.

Also, there has been a real crime problem in the Job Corps program, including murders and many drug-related and very serious crimes. People who really want to help children would vote to end this very wasteful program or at least make them bring their cost per student down. $26,000 per year per Job Corps student is just ridiculous.

Second, Mr. Speaker, I consider national defense to be one of the most important and legitimate functions of our national government, and the military is continually crying about a shortage of funds. Yet we find that the Air Force has spent $1.5 million to remodel the house of the commandant at the Air Force Academy including $267,000 simply to redo the kitchen. $267,000 should have bought a beautiful new home instead of being just blown on a kitchen. Now we find that the Navy has taken $10,260,000 from operations and family housing accounts to fix up the residences of three admirals. This comes out to more than $3,420,000 per home. These were the houses of the Chief of Naval Operations in Washington, the Commandant of the Naval Academy in Annapolis, and the Commander of the Pacific Fleet in Honolulu.

Let me quickly mention two other examples of very wasteful spending.

A few years ago I read a column by Henry Kissenger which said that the 50 to $60 billion we had sent in aid to Russia over the previous 5 years or so had just been wasted. In 1991, Senator Sam Nunn, the Georgia Democrat, said giving monetary aid to the Soviet Union was like throwing money into a cosmic black hole. But do we ever learn? No. Now we find out many billions more of U.S. taxpayer money to Russia has been put into private accounts that are hidden all over the world, and our wealthy elitist foreign policy establishment will make fun of and sarcastically criticize anyone who opposes sending Russia many billions more.

One final example is the $625,000 taxpayers have been ordered to pay by a Federal judge because Interior Secretary Bruce Babbitt and former Treasury Secretary Robert Rubin illegally withheld documents in a lawsuit over Indian trust funds. The judge regretted that the burden would fall on taxpayers and that he could not fine the Cabinet secretaries themselves.

We see over and over and over again that the Federal Government cannot do anything in an economical, efficient, low-cost manner. We see over and over again that today we have a Federal Government that is of, by and for the bureaucrats instead of one that is of, by and for the people.

Finally, Mr. Speaker, we see over and over again that if you want money to be wasted and spent in ridiculous, lavish ways, just send it to the Federal Government.

MANAGED CARE REFORM

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. DAVIS) is recognized for 5 minutes.

Mr. DAVIS of Illinois. Mr. Speaker, we have had a tremendous debate all evening on managed care, and we will continue to do so even tomorrow.

I received a letter from a physician in my community that I think reflects the position that Americans should take on this issue. It comes from a Dr. Elizabeth Burns, medical doctor, professor and head, College of Medicine, Department of Family Medicine, University of Illinois at Chicago. Doctor BURNS said:

Dear Representative Davis:

As a practicing family physician in your district, I want to ask you to support meaningful management care reform when it is considered in October by the House of Representatives. Your support for the Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, or the Health Care Quality Choice Act of 1999, H.R. 2824, would be responsive to the needs of my patients and your constituents. Meaningful, comprehensive managed care reform is greatly needed right now in your district.

Below are the principles I see as important in any managed care reform proposal:

Reforms need to cover all health care plans, not just self-funded plans. Patient protections should protect all patients.

Gag clause protections need to be extended to all physicians. Physician patient communication must be protected and extended to health insurers' contracts. Unfettered medical communication is undeniably in the best interests of patients, all patients. Any final bill needs specific language stipulating that any provision of a contract between a health plan and a physician that restricts physician-patient communication is null and void.

Physician advocacy must be protected. Managed care reform must include provisions to prevent retaliation

by a health plan towards physicians who advocate on behalf of their patients within the health plan, or before an external review entity. Family physicians, as primary care physicians, play a pivotal role in ensuring that their patients get access to the care they need. Health plans should not have the power to threaten or retaliate against physicians they contract with to provide needed health care services.

Independent external review standards must be truly independent. Managed care reform must contain a fair, independent standard of external review by an outside entity. It makes no sense to pay an outside reviewer to use the same standard of care used by some health plans which may limit care to the lowest cost option that does not endanger the life of the patient. All of our patients deserve better.

Patients need the right to seek enforcement of external review decisions in court. Managed care reform must allow patients to seek enforcement of an independent external review entity decision against the health plan. Without explicit recourse to the courts, the protections of external review are meaningless.

Patients need access to primary care physicians and other specialists. Managed care reform must allow patients to seek care from the appropriate specialist, including both family physician and obstetricians/gynecologists for women's health, as well as both family physicians and pediatricians for children's health. Primary care physicians should provide acute care and preventive care for the entire person, and other specialists should provide ongoing care for conditions or disease.

And so you see, Mr. Speaker, from patient to physician, from consumer to provider, those who want serious reform and serious change know that the Dingell-Norwood bill is the way to go.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Under a previous order of the House, the gentleman from Oklahoma (Mr. ISTOOK) is recognized for 5 minutes.

(Mr. ISTOOK addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana (Mr. SOUDER) is recognized for 5 minutes.

(Mr. SOUDER addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

TWO EXTREMES IN THE HEALTH CARE REFORM DEBATE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Arizona (Mr. SHADEGG) is recognized for 5 minutes.

Mr. SHADEGG. Mr. Speaker, I want to begin by thanking my colleague, the gentleman from Illinois (Mr. DAVIS). He read a letter from a doctor, a constituent of his, who said that he supported two bills, and I think it is very important to note that of the two numbers he read off, the second number that the doctor wrote him about said he supported H.R. 2824.

I think the doctor is right about that. H.R. 2824 is the Coburn-Shadegg bill, the bill that I have cosponsored, and his medical doctor constituent wrote to him to say that he favored either the Norwood-Dingell bill or the Coburn-Shadegg bill. I hope tomorrow the gentleman from Illinois (Mr. DAVIS) will cross the line and do exactly what that doctor said, support the Coburn-Shadegg bill, because it is a reasonable alternative.

I want to talk for a moment about the two extremes in this important health care debate. One extreme says we should do nothing about the faults in the Employee Retirement Income Security Act. One of our colleagues, the gentleman from Mississippi (Mr. PICKERING), his father is a district judge. He has written a number of opinions in this area. I want to quote from those.

I sent around a series of dear colleagues: ''ERISA abuses people. Courts cry out for reform.'' Here is what Judge Pickering wrote: ''It is indeed an anomaly that an act passed for the security of the employees should be used almost exclusively to defeat their security, and to leave them without remedies for fraud and overreaching.''

Second in this series that I want to talk about, ''ERISA abuses people, courts cry out for reform,'' is a decision written by Judge William Young of the Federal District Court in Boston. He writes, ''It is extremely troubling that in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it is designed to protect.''

I want to conclude this series by again reading from another opinion by Judge Pickering in which he says, ''Every single case brought before this court has involved an insurance company using ERISA as a shield to prevent employees from having the legal redress and remedies they would have had under the longstanding State laws existing before the adoption of ERISA.''

Not amending ERISA is an extreme position that will hurt the American people. But I want to point out, there is another extreme position in this debate. That second extreme position is represented by the Norwood-Dingell bill.

The Norwood-Dingell bill is extreme in several regards. First and foremost, it does not protect employers from liability. I want plans held liable. I do not want Mrs. Corcoran's baby to be killed and the plan to be able to walk away, as happened in Corcoran versus United States Health Care. But when that plan is held liable, I do not want the employer held liable. The employer just hired the plan. The employer just wanted to offer health care to his or her employees.

The Coburn-Shadegg proposal, now joined by the gentleman from Florida (Mr. GOSS), the gentleman from Pennsylvania (Mr. GREENWOOD), and the gentleman from California (Mr. THOMAS) protects employers. Employers are not liable unless they directly participate in the final decision. That is the key language.

That means, and here is the debate, and Members will hear this from industry, an employer is not liable, cannot be sued, for merely selecting a plan or for merely deciding what coverage ought to be, or for selecting a third party administrator.

An employer cannot be held liable for selecting or continuing the maintenance of the plan. They cannot be held liable for modifying or terminating the plan. They cannot be held liable for the design of or coverage or the benefits to be included in the plan. They can only be held liable if they make the final decision to deny care. That is the way it should be.

I want to go on to point out that the other extreme position represented by Norwood-Dingell is lawsuits by anyone, as my colleague, the gentleman from California (Mr. THOMAS) pointed out, that let the jury decide injury. Our bill says no, you have to have a panel of doctors to decide injury.

Lawsuits at any time. They do not want you to have to go through internal and external review. They do not want to have to give the plan a chance to make the right decision. They want to just go to court.

Lawsuits over anything. Our legislation says it has to be a covered benefit. Their legislation says you can sue over anything, just get the lawyer and go to court. Their bill says lawsuits even when the plan does everything right. Our legislation says, no, if the plan makes the right decision, you should not be able to throw the book at them in court and drag them and blackmail them into making a settlement.

Their position is lawsuits without limits. They want all kinds of unlimited damages. There are over 100 organizations, not trial lawyers, but over 100 organizations endorsing the Goss-Coburn-Shadegg-Greenwood-Thomas proposal. I urge my colleagues to join us in passing this needed legislation.

A RULE WHICH MAKES PASSING GOOD MANAGED CARE REFORM DIFFICULT

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, in this Republican Congress, the special interests who write the big checks get the last word. The day before the House

began its debate on the Patients' Bill of Rights, the only bill that takes medical decision-making away from insurance company bureaucrats and returns it to doctors and patients, the gentleman from Illinois (Speaker HASTERT) sat down with 15 health care lobbyists who paid $1,000 each for one last chance to make their case.

The health care industry has cultivated the Republican leadership with strong-armed lobbying efforts and well-placed campaign contributions, over $1 million from the Health Benefits Coalition, a group of insurance groups alone.

House Republicans, led by the majority whip, the gentleman from Texas (Mr. DELAY) and the gentleman from Illinois (Speaker HASTERT) are doing everything they can to kill reform to please their contributors in the health insurance industry. Mr. Speaker, that is why they put forward the rule today that was adopted on an almost exclusively partisan vote. Almost every or actually every Republican voted for the rule, and almost every Democrat except for one or a few voted against the rule.

Mr. Speaker, I just want to talk a little bit, if I can, about this rule and why it is making the ultimate question of passage of good managed care reform difficult.

The rule, instead of providing a fair and open rule for considering the Patients' Bill of Rights, basically stacks the deck by insisting on provisions that blend the managed care bill, the Patients' Bill of Rights, with a measure riddled with special interest poison pills designed to kill the Patients' Bill of Rights, the Norwood-Dingell bill, and that denies the gentleman from Michigan (Mr. DINGELL) and the gentleman from Georgia (Mr. NORWOOD) the opportunity to offset any potential revenue losses from the measure.

The Republican bill basically combines a so-called access bill, H.R. 990, and the managed care bill, the Norwood-Dingell bill, together. The measure will combine essentially a meaningful managed care bill with a special interest-laden boondoggle of a bill that masquerades as a health access bill.

There is no question that this rule which was adopted today, I would say again, on almost exclusively a partisan vote, is nothing more than a cynical, desperate, last-minute attempt to stave off a bipartisan Norwood-Dingell managed care bill that was on the verge of passage.

I am very fearful, Mr. Speaker, about what kind of success we are ultimately going to have here tomorrow with regard to the Norwood-Dingell bill because of the way that this rule provides for us to proceed, and because of the stark choices that many Members will have to make; had to make today on the so-called access bill, and will have to make tomorrow on some of the substitutes to Norwood-Dingell.

I wanted to talk about this phony access bill that was voted on today, again, almost exclusively on a bipartisan basis. Most of the Republicans voted for the access bill and most of the Democrats voted against it.

First of all, I would point out that it is designed, according to the Republican leadership, to try to improve access to health insurance for the over 40 million Americans that have no insurance, who are right now uninsured. But the phoniest aspect of this, if you will, is that the bill, this access bill, spends Federal dollars on tax breaks that do more to help the healthy and the wealthy than the uninsured.

According to the General Accounting Office, nearly one-third of all uninsured Americans do not pay income taxes. These families would not be helped at all under the bill that was passed today. Instead, the greatest benefits under the bill would go to the 600,000 uninsured families that make almost $100,000 per year, because the value of shielding income from Federal tax is greater for those in the highest tax bracket.

In addition to not helping the uninsured because so many of them essentially are not paying taxes, or are not paying that much to benefit from this bill, the bill expands medical savings accounts, a special tax break for the healthy and wealthy that threatens to increase health insurance premiums for everyone else.

My point is, Mr. Speaker, that the so-called access bill today, which the Republican leadership claims is trying to get more people into insurance plans and out of the ranks of the uninsured, in fact will make it more difficult for those who are uninsured to buy insurance because the costs will go up. That is accomplished, first of all, by putting in the poison pill of the medical savings accounts, the SMA's, as well as new Federal regulations that would disrupt State health insurance markets.

With the SMA's, and this is nothing new, this is something we have seen over and over again over the last couple years in an effort to try to defeat managed care reform, this poison pill, which was included in the 1996 bill, basically is a tax break for the wealthy.

The new Federal regulations that would disrupt State health insurance markets that are in this bill, the access bill, basically are two proposals called association health plans and HealthMarts, both of which would offer cheaper, less comprehensive policies that bypass State consumer protection, insurance, and benefit requirements.

Like medical savings accounts, these new plans and networks would be able to cherrypick the healthiest out of the State-regulated health insurance market, which could result in higher costs for those still in the State-regulated market.

In addition, like medical savings accounts, the association health plans are supported by big contributors to Republican candidates.

Mr. Speaker, my point is that this access, this so-called access bill that was adopted today, really is mucking up, if you will, the possibility of passing real managed care reform because it will travel now with whatever managed care reform bill that we adopt tomorrow and go over to the Senate together.

It means that whatever managed care reform bill we pass tomorrow will now have these other provisions attached to them, attached to it, that basically are going to make it more difficult to pass in the Senate, more difficult to adopt in conference, if the Senate and the House ever get together to try to come up with a bill that both houses adopt, and undoubtedly will result in a veto by the President, because he could not possibly sign provisions like the SMA's, like the HealthMarts, that basically break the insurance pool and make the costs to buy insurance for those who do not have it even more costly than it is today.

I would like to go on, though, and talk about what is going to happen tomorrow. The access bill is passed, the rule was passed. There is not much we can do about it tomorrow. But tomorrow we have more debate, which began tonight, on the Norwood-Dingell bill, and three substitutes that have been made in order under the rule which really, again, are nothing more than an effort to try to kill and water down the Norwood-Dingell bill.

I have said over and over again on the floor of this House and in this well that the two major advantages and overall goals, if you will, of the Norwood-Dingell bill are fairly simple, fairly easy for the average person to understand.

First of all, the first principle, the first goal of Norwood-Dingell, says that on the one hand, right now most decisions about what kind of medical care we get, what type of operation we get, or what kind of equipment we can use, or how long we stay in the hospital, or all the other things that define adequate health care, the decision as to what type of care we get is essentially now made by the HMO, by the insurance company.

That is not the way it should be. What should be and the way it used to be a few years ago was that the physician, the doctor, our doctor, and us, the patients, would determine what kind of care we were going to get.

We want to turn that around. In the Norwood-Dingell bill, we want to go back to the old days, essentially, when decisions about the type of care that we as Americans receive are basically decisions made by the physician, the doctor, and us, the patient.

The second thing we do in the Norwood-Dingell bill is to say that if we have been denied care that we and our physician think we should have had, then we have to have some adequate way to enforce our rights and overturn that denial of care. That is essentially done in two ways with the Norwood-Dingell bill.

First of all, there is an independent review, so that we do not have to go to

the HMO and appeal their decision, and essentially appeal to them or someone who is within the HMO to decide the appeal. Rather, we go to an external, independent review board not controlled by the HMO, which has the ability to overturn that decision and provide us with the care that our physician and we say we need in a very quick, expedited way.

Failing that, if for some reason this independent external review does not work and we are still denied care that we and the physician think we need, then we have the right to go to court and seek an action to overturn that denial of care. Or if the situation has resolved itself so that we were denied the care and we suffered damages, we were injured, we suffered, or God forbid, died, then we would be able to sue in the courts for damages as a result of that denial of care.

□ 2130

Now, all this makes perfect sense; and, frankly, I do not know what the big deal is. Any time people have a grievance and they suffer damages, they normally can go to some kind of review and take some kind of appeal and ultimately go to the courts.

What we are told by our colleagues who support the Republican leadership on the other side is that that is not acceptable. In fact, the previous speaker made the point that it is not acceptable; that the Norwood-Dingell bill goes too far in providing enforcement actions.

Well, let me just say, if I could, a few things about these substitutes that are going to be considered tomorrow and why they do not establish the two goals, they do not meet the two tests that I have already mentioned; and that is, who is going to decide what kind of care one gets; and, secondly, how one is going to enforce one's rights if one was denied care.

We have three substitutes that will be considered tomorrow. I just want to basically go through some of the key concerns I have with these substitutes and why I ask my colleagues to vote no against them and to let us have, instead, the Norwood-Dingell bill as the base bill that we are voting on.

Let me take first the Boehner amendment in the nature of a substitute. This bill does not include many important patient protections. Now, I have not spent the time this evening going into all the patient protections, all the specific patient protections that the Norwood-Dingell bill provides, and there are many. I have talked about them many times, so I am not going to go through them all this evening.

But I did want to talk about the patients' protections that are in the Norwood-Dingell bill that are not in the Boehner substitute. The Boehner substitute does not apply to all Americans in privately insured plans. It fails to extend protection to millions of Americans who purchase insurance individually.

Now, my colleagues have to understand that, in the other body, a managed care bill was passed in the Senate that basically covered very few people.

The tremendous advantage of the Norwood-Dingell bill is that it covers everybody, anybody who has insurance. Well, if my colleagues were to adopt the Boehner substitute tomorrow instead of the Norwood-Dingell bill, basically millions of Americans who purchase insurance individually would not be covered.

The Boehner substitute also does not include a provision on accountability or liability. It, therefore, provides no meaningful remedies at all for individuals in employer plans. It takes away current remedies by placing restrictions on all health care liability claims, including those in State court.

The bill also does not include access to specialists, an important aspect of the Norwood-Dingell bill, access to non-formulary drug, another important aspect in the Norwood-Dingell bill, protections for patient advocacy or limits on financial incentive arrangements that induce providers to withhold care.

One of the things that is most abusive today and one of the biggest criticisms that I receive from my constituents is that, right now, HMOs provide financial incentives to physicians not to provide care. That is an awful thing. But that is the reality today in the managed care system for many people.

The Boehner bill does not do anything to correct that, whereas the Norwood-Dingell bill does. The Boehner substitute's external appeals provision would require external reviews to use the plan's definition of medical necessity.

When I talked before about how the Norwood-Dingell bill, one of its two major goals is to make sure that the physician and the patient decide what kind of care one gets, that is because, in the Norwood-Dingell bill, the definition of medical necessity, what is medically necessary is made by physicians. It is a standard developed in the particular specialty by the doctors in that specialty area. So that, for example, for cardiology, the Board of Cardiologist standards would hold sway.

Well, the Boehner substitute basically says that, in doing an external review, the plan's definition, the HMO insurance company's definition of medical necessity holds sway. So there again, the HMO is going to decide what kind of care one gets. Reviews would only decide if the plan followed its own guidelines, essentially rubber stamping the HMOs decisions.

The Boehner bill also says that plans control, HMOs control what information patients have to submit to the reviewers. The patient does not have the right to submit his or her own evidence. There is no requirement that reviews be made in accordance with the patient's medical exigencies. A review panel could take up to 30 days.

Again, the problem with these substitutes to the Norwood-Dingell bill is that, if one has been denied care, one is not going to be able to have an effective appeal in a timely manner. That is one of the biggest problems with the Boehner substitute.

Now, let me talk about the Coburn-Shadegg-Thomas substitute. The gentleman from Arizona (Mr. SHADEGG), just a few minutes before I spoke, talked about how wonderful this substitute was. I would point out that the Coburn-Shadegg-Thomas substitute, the second substitute that will be considered tomorrow in lieu of Norwood-Dingell falls short on many important patient protections.

There is a $100 threshold to get to external review. A person who is denied a simple, yet life-saving, test would never get the review. There is no ability for patients to get access to off-formulary drugs when necessary.

The Coburn-Shadegg bill only requires coverage of routine costs of cancer trials, leaving patients with other devastating diseases without any protections. Emergency coverage under the Coburn-Shadegg bill for newborns is judged by a prudent health professional standard. That could mean that plans could deny payment for a larger range of neonatal emergency care.

But let me also talk about the enforcement aspects of the Coburn-Shadegg bill. Again, if one is denied care, how does one enforce one's right to overturn that denial and have the care provided? Well, under the Coburn-Shadegg substitute, there is an entirely new Federal cause of action.

HMOs can require an enrollee, a patient, to go to a certification panel that would decide whether the person was injured and whether this was caused by the HMO. If the panel finds for the HMO, the suit is dismissed.

The bill basically caps the amount of noneconomic damages a person can receive. It also undermines existing remedies because it requires that a person go through the bill's Federal remedy before seeking any State remedies.

What we are seeing here is a series of hoops. I have to be honest. I felt that the gentleman from Arizona (Mr. SHADEGG) was actually being somewhat honest when he was saying that there were major limits on one's ability to sue in the substitute that he has co-authored. Well, why should that be? Why are all these limits placed on one's ability to sue if one has seriously suffered damage? I mean, this is not right.

What we are trying to do here in the Norwood-Dingell bill is to basically make sure that one has a remedy, a right to enforce one's rights, and to make sure that one is not denied care. Any effort to basically water that down, to me, makes no sense and should be defeated.

Mr. Speaker, let me lastly talk about the third substitute that the House will consider tomorrow, and that is the Houghton substitute or Houghton amendment.

It strikes the liability provision from the Norwood-Dingell bill and replaces

it with a weak Federal remedy under ERISA. The Federal remedy would preempt a long history of allowing States to provide appropriate remedies for various harms suffered by their residents.

All we are doing in the Norwood-Dingell bill is saying that one has a right in State court or under State law to sue in the same way that one would for any other damage that one suffered.

Well, why should we go along with the Houghton amendment which basically strikes that liability provision in Norwood-Dingell and creates another Federal remedy under ERISA? ERISA is the Federal law that preempts the State law and then makes it so that, even in States like Texas or New Jersey, where we have patient protections on the State level, that one does not have any right to those protections because one's employer may be self-insured; and, therefore, one falls under the Federal ERISA law.

Well, the Houghton amendment would basically strike the provisions from Norwood-Dingell and give one another Federal ERISA remedy rather than being able to sue under State law. This Federal remedy under the Houghton amendment is full of loopholes and would allow plans, HMOs to escape liability.

The Houghton amendment provides bonding arbitration in place of external review and access to courts with minimal, if any, protections for consumers against bias.

Once again, Mr. Speaker, I urge my colleagues to look carefully at these substitutes tomorrow, and they will find that, in every case, they limit the ability of an American, of our constituents to be able to get quality care and to enforce their rights to make sure that they get their quality care. That is why all those substitutes should be defeated, and we should simply pass the Norwood-Dingell bill.

I wanted to mention a few other things tonight about some of the attacks that we are getting and that I am sure will intensify tomorrow against the Norwood-Dingell bill, which I think have been effectively refuted by those who support the Norwood-Dingell bill, but I want to mention them again because they continue unabated.

We are told, of course, the old thing, that the Norwood-Dingell bill, the Patients' Bill of Rights, is going to allow for numerous lawsuits, and that that is going to increase the costs of premiums, and ultimately employers will drop coverage for their employees because the costs will be too high.

Well, I think that that has been effectively refuted by the fact for the last 2 years that the State of Texas has had on its book a patient protection act very similar to the Norwood-Dingell bill. The reality is there have been only four lawsuits filed during that 2-year period in the State of Texas, and the cost of premiums have gone up less than they have in States that do not have those same kind of patient protections.

I do not think anything more needs to be said on the issue of costs or the issue of suing the HMO and liability and excessive lawsuits than to look at the Texas example.

But the other attack that we are getting again was made by the gentleman from Arizona (Mr. SHADEGG) earlier this evening when he said that the Norwood-Dingell bill would allow for employers to be sued; and because employers would be sued, they would drop coverage because they would not want to be the subject of lawsuits.

Well, again, that is not accurate. The Norwood-Dingell bill has very specific shield language that shields the employer from liability unless they are actually involved in the decision to deny one care.

I would say that even the gentleman from Arizona (Mr. SHADEGG) admitted that, if they are involved in a decision to deny one care, they should be sued.

The bottom line is that it is only the Norwood-Dingell bill that provides this kind of a shield to make sure that employers cannot be sued. To suggest somehow that that shield will not work again is inaccurate.

I just wanted to cite a reference that has been made again by some of my colleagues today and on other occasions, the myth that is being promulgated against Norwood-Dingell on this point is to say that employers would be subject to lawsuits simply because they offer health benefits to their employees under ERISA.

Well, section 302(a) of the Norwood-Dingell bill specifically precludes any cause of action against an employer or other plan sponsor unless the employer or plan sponsor exercises discretionary authority to make a decision on a claim for covered benefits that results in personal injury or wrongful death.

Now, how do we define exercise and discretionary authority? The myth again being promulgated by those against the Norwood-Dingell bill is that employers' decisions to provide health insurance for employees will be considered an exercise of discretionary authority. That is simply not true.

Examples of the types of decisions that health plan administrators make that directly affect the care that patients receive and could be considered medical decisions include inappropriately limiting access to physicians through restricted networks, refusing to cover or delay needed medical services, drawing treatment protocols too narrowly, offering payment incentives, or creating deterrence to discourage the provision of necessary care, and discouraging physicians from fully discussing health plan treatment options, the so-called gag rules. These are not decisions that employers make.

The Norwood-Dingell bill excludes from being construed as the exercise of discretionary authority decisions to, one, include or exclude from the health plan any specific benefit; two, any decision to provide extra contractual benefits; and, three, any decision not to consider the provision of the benefit while its internal or external review is being conducted.

So the bottom line is the employer is shielded from liability. That is the simple truth. That is why the Norwood-Dingell bill should be adopted tomorrow and not some of these substitutes that claim to improve on the law.

Now, let me just say one thing finally if I could, Mr. Speaker. It sounds kind of crazy, but I have heard some of my colleagues say, well, why do we need to pass the Norwood-Dingell bill? Why do we need Federal legislation to address the abuses of managed care, because, after all, the States are doing this, and even the courts are doing it?

I mentioned the Texas law. I mentioned the other day, and some of my colleagues have talked about it, California really recently enacting a law which was signed by Governor Davis just a few days ago.

We have also heard about court cases, a recent decision by the Illinois Supreme Court that ruled last Thursday that HMOs may be sued for medical malpractice.

Just last week as well, the Supreme Court assigned itself an important role in the debate over managed care, the U.S. Supreme Court, by accepting a case on whether an Illinois health maintenance organization breached a legal duty to a patient whose appendix burst during an 8-day wait for a test to diagnose her abdominal pain.

□ 2145

So some of my colleagues are saying to me, we have some States that are passing laws, let them continue to do so. Or we have the court, this case Illinois or maybe even the Supreme Court of the United States, that will ultimately say that an individual has the right to sue the HMO, so why do we need the Norwood-Dingell bill? Well, the fact that many States have decided that they cannot wait for Federal action and have passed these measures to strengthen patient protection should not be an excuse to not have Federal action.

The bottom line is, and if I could just read from an editorial that was in The New York Times the other day, it talks about why State laws are not sufficient, and it says and I quote, ''State initiatives do not replace the need for Federal legislation. For one thing, none of these State protections apply to people in self-insured plans created by large employers, which are exclusively federally regulated. More important, current Federal law has long been interpreted to bar patients covered by private employer-sponsored health plans from suing for damages caused by improper benefit denials, although the Supreme Court this week decided to hear a case that will review this issue. The California legislation tries to get around the legal hurdle by framing the new State-granted right to sue as based on the right to obtain quality care rather than the right to particular benefits. That approach will clearly be

challenged in court and may well be struck down unless Congress closes the loophole in Federal law that now shields health plans from meaningful liability.''

Mr. Speaker, if I am one of the people, one of my constituents out there who has been denied care, I can assure Members that it is not going to make me feel good that I do not come under the patient protections because I happen to be in an ERISA federally-preempted plan, or that I have to wait for the courts, whether it be Federal or State courts, to find a loophole so that I can sue the HMO.

Again, Mr. Speaker, I would say it has been an interesting debate today. I think it is very unfortunate that the rule passed. I think it is unfortunate that this access bill passed now, and that whatever we do pass tomorrow will have to be incorporated in this so-called access bill that I think provides a number of poison pills and will make it difficult for the Norwood-Dingell bill to move in the Senate or to be resolved in conference.

But I would still urge that tomorrow is also an important day, and we want to make sure that the Norwood-Dingell bill passes and is not superceded by some of these other three substitutes that basically will water down the protection and the enforcement rights for our constituents that exist in the Norwood-Dingell bill.

I urge my colleagues tomorrow to support the Norwood-Dingell bill and to vote ''no'' on all the substitutes.

ISSUES OF CONCERN

The SPEAKER pro tempore (Mr. KUYKENDALL). Under the Speaker's announced policy of January 6, 1999, the gentleman from Colorado (Mr. MCINNIS) is recognized for 60 minutes as the designee of the majority leader.

Mr. MCINNIS. Mr. Speaker, this evening I want to address really three subjects. The first two subjects will be quite brief.

One, satellite TV. Many of my colleagues, who like me represent rural districts in this country, have a deep concern about the reception and the need for local access on satellite TV.

The second issue that I intend to address this evening is the Brooklyn Art Museum in New York City. I have gotten a number of phone calls into my office from people who appear somewhat confused on my position in regard to that. I want to make sure this evening that position is clarified.

Then I intend to move on to the third subject, which will consume most of my time this evening as I address my colleagues, and that is the anti-ballistic missile treaty. My comments will be highlighted by the term, and Members have heard it before, the race against time.

What is the anti-ballistic missile treaty and what is the impact that the anti-ballistic missile treaty has on us all as average citizens? What is the threat to this country of continuing to try to comply with the terms of the anti-ballistic missile treaty?

I will go into a definition of what the anti-ballistic missile treaty is, about our national defense against missiles, and I think we will have at least some detail for a somewhat educated exchange this evening on the pros and the cons of the anti-ballistic missile treaty.

Mr. Speaker, let me begin with satellite reception across the country. As I mentioned, my district is the Third Congressional District in the State of Colorado. My district is unique in geographic terms in that this district has the highest elevation of any district in the United States. We have over 54 mountains above 14,000 feet. TV reception in the Third District of the State of Colorado is as important to the people of the Third Congressional District of Colorado as it is to the people in New York City, or as it is to the people in Kansas, or as it is to the people in Los Angeles, or up in Seattle.

TV has become a very important part of our lives. Now, I am not this evening trying to get into the pros and cons of watching television, but I am getting into the ability to have local access through satellite. Many of my constituents, and many of my colleagues' constituents, if they live in rural areas especially in this country, or even if they live in an urban area but have some challenges because of geography or buildings or things like that, are looking to satellite for their TV reception. And I think it is important that these satellite receivers, the users, have an opportunity to have local access, which they have been denied for a period of time.

We have a bill right now that passed out of the House overwhelmingly, passed out of the Senate overwhelmingly, and we have the two bills now in what is known as a conference committee. My good friend, the Senator from the State of Utah, is the chairman of that conference committee, and I am assured that that conference committee is working very hard to come out with some type of compromise so that those constituents of ours who are using satellites will have an opportunity in the not-too-distant future to have the right to local access.

I am confident that we can conclude this in such a manner that it will not be damaging to the other competitors out there but will allow satellite to be at least at the same level as cable TV.

Now, Mr. Speaker, let me move to the second subject, the subject that some of my colleagues who have been on the floor when I have spoken before know I feel very strongly about.

I will precede my comments by telling my colleagues that at times in the past I have supported government involvement in certain art projects. I think art is fundamentally important in our country. I think there are a lot of things about art that help our society become more civilized and so on. But that said, I, like all Americans, have limitations. And those limitations, of course, were tested, intentionally tested, recently by the Brooklyn Art Museum in New York City.

Let me explain what is happening at that museum. That museum, which is funded in part, in large part, by taxpayer dollars, by taxpayer dollars, decided to put on a show, an art show, an exhibit, that displayed, amongst other things, the Virgin Mary, which is a very significant symbol of the christian religion, but to exhibit a portrait of the Virgin Mary with, for lack of a better word, although they say dung in my country they understand it as crap, with crap thrown on the portrait. It is disgusting. The artist knows it is disgusting, the Brooklyn Art Museum knows it is disgusting, and the directors of the Brooklyn Art Museum know it is disgusting.

But they have decided to defy what I think is common sense, and they have decided to stand up and say it is their right, trying to paint it under the constitutional right of freedom of speech, it is their right to use taxpayer dollars, taxpayer dollars, it is their right to use those dollars to pay for this exhibit. I disagree with that.

Now, let me say at the very outset, so that I am perfectly clear, this is not, this is not an argument about the first amendment of the Constitution, freedom of speech. No one that I have heard, no one that I know has said that this exhibit, as sick as it is, should be prohibited from being shown somewhere in the country by any individual. We believe very strongly in this country about the freedom of speech and about that first amendment in our constitution. That is not the issue here. They have tried to paint the issue as a first amendment issue. It is not a first amendment issue.

The issue here is very clear. Number one, should taxpayer dollars be used to pay for this exhibit? Now, some people say, well, how do we decide what is offensive? How do we decide when taxpayer dollars should be used or should not be used? The decision, to me, is pretty easy, and I am sure the decision to a number of my colleagues is pretty easy. It is called a gut feeling. I wonder how many of my colleagues out there would take a look at the portrait of the Virgin Mary with dung, or crap, thrown all over it and their gut would not tell them that something is wrong; that this is not right; that this should not be happening.

Now, to me, that decision would be no more difficult than looking at a portrait of Martin Luther King with crap thrown all over it. That is not right. It should not be exhibited with taxpayer dollars. And whoever would do that is sick, in my opinion. It is not a display of art. But there is that right of freedom of speech.

I can tell my colleagues what has happened in the Brooklyn Art Museum is they have decided to put that exhibit up and they have decided to test it and

use taxpayer dollars. Well, what have they done and why is a congressman from the State of Colorado and the mountains of Colorado worried about an art exhibit in New York City? Well, number one, I am a Catholic and I am personally offended by what has occurred here.

But that is not the primary issue. The primary issue is that I am a supporter of the arts. But I think by these prima donnas in New York City at the Brooklyn Art Museum deciding to display this portrait of the Virgin Mary with crap thrown all over it that these prima donnas have damaged the art community throughout the United States, including in the Third Congressional District in the State of Colorado.

I am sure my colleagues can understand how hard it is sometimes to go to our constituents and to defend the fact that we have voted for government funding of some type of art project, no matter how worthwhile it is. These prima donnas at the Brooklyn Art Museum, do they take that into consideration? Do they take into consideration that they are offending the christian communities out there?

I can tell my colleagues right now that the Brooklyn Art Museum and those prima donnas would no more think about putting a Nazi symbol in the museum and pay for it with taxpayer dollars, they would not think of doing it with a Martin Luther King portrait, they would not do it with an AIDS quilt, those beautiful quilts that are made in memory of the people that have suffered that horrible tragedy, and then have crap thrown on that blanket. They would not think about it. In fact, they would probably join in a protest to take down the building or destroy the building. But when it comes to Christianity, they think it is okay.

And then, beyond that, look what these prima donna directors at this museum, and the director of the museum, are doing to the art community. Do they need to harm the programs that we now have in place where we have legitimate worthwhile art projects that are paid for in part with taxpayer dollars? Do they need to put those in threat of extinction? Do they need to do that? They do not need to do that. They have a lot of money there at the Brooklyn Art Museum. They can pick up a phone and call one of their benefactors, they have a lot of wealthy benefactors at that museum, and they can ask for them to pay for the exhibit. They do not need to use taxpayer dollars. The only reason that they are using taxpayer dollars is because at that museum they want to put their thumb in the face of the American citizen.

Now, I have gotten some calls in the office, as many of my colleagues do when we talk about a controversial subject. I have gotten some threats about my future in politics because of my philosophy that we should not be using taxpayer dollars here. But those people that call me with those threats, those people that think they are justified in displaying art like the Virgin Mary with crap thrown all over her, at taxpayers' expense, those people that call me on the phone, in my opinion, colleagues, have a very difficult time. In reality, when they are by themselves, they have a very difficult time when they get up in the morning looking at that mirror and saying to themselves that what they did today and what they are going to do tomorrow is justified; that it makes a lot of sense to go ahead and use taxpayer dollars to fund this kind of garbage.

Now, some people have called my office saying, ''How dare you call any kind of art garbage. How dare you act so offended by this piece of art. This is an artist's right of expression.'' Of course, they do not answer the question, they usually hang up on me, when I ask them about some of these other examples I have cited earlier. But I am telling my colleagues that there are limitations.

First of all, I think the average person, just their gut reaction is deep offense, deep offense at a portrait of the Virgin Mary or a portrait of a Jewish leader or a Buddhist leader that would have crap thrown on it. There is an inherent standard of character with the American citizen that says there is not a place for that. Do not put that in our society, especially with taxpayer dollars.

□ 2200

So, my colleagues, those of your constituents who disagree with me, let me make it very clear. I think they are a minority. I think that the average American out there wants character standards in this country and says there is no place for this type of art.

Let me now move on to the subject of which I intend to spend most of my time and which is entirely separated from either the satellite issue that I just spoke about or the fight we are having over the Brooklyn Art Museum.

By the way, let me include one other thing. Mayor Giuliani in New York City has come under criticism because he yanked the taxpayer dollars. Well, I will tell you something, Mayor, you are doing the right thing.

The second thing I should point out is some of my colleagues, I heard it well, what the Republicans are trying to do is exercise censorship on the art community. What a bunch of bogus baloney. What do you mean exercise censorship? Those are taxpayer dollars, Democrats. And for you to come out in the press and say the Republicans are trying to exercise censorship is ridiculous and you know it is ridiculous.

Do not evade the issue. Do not try to push it off under the first amendment. It has nothing to do with the first amendment. It has to do entirely with, number one, should you be doing that in a public institution, but number 2, should you be allowed to use taxpayer dollars for those kind of expressions.

Mr. Speaker, let us move on to my other subject, the race against time.

Many of us in this country assume that if this country were to come under attack by missiles of another country that we would have a defense.

I live in the State of Colorado. Just outside of my district and the district of my good colleague the gentleman from Colorado (Mr. HEFLEY) who represents the community of Colorado Springs, the County of El Paso, there is a mountain called Cheyenne Mountain. That mountain has been bored out. In fact, a small community is now within that mountain that is called the NORAD Defense System inside Cheyenne Mountain.

Within seconds, and I do not know the exact details because it is classified or the details I do know are classified, but, generally, within a very short period of time, if any country in the world launches a missile, NORAD in Colorado Springs, through its detection devices, can pick up, one, that a launch has occurred; two, the direction of the missile; three, the speed of the missile; and a lot of other things; and, of course, they can pick up the target of the missile.

Well, we have known this for a long time. NORAD is one of our proud accomplishments at providing a defense for the United States of America against our enemies. In the past we really only had one country capable of delivering that type of missile attack against the United States. It was Russia. But what a lot of people mistakenly assume is that once we detect within a very short period of time that a missile has been launched against the United States of America, then we somehow can defend against that missile.

Well, the bad news that I bring my colleagues this evening is that we have no defense. We have the technology. We are even gaining more technical capability to defend this country against a missile attack. But we do not have a defense system in place to stop those missiles.

I want to say at the beginning of these comments that a lot of the information that I have gathered over the years on the Anti-Ballistic Missile Treaty has been gathered from some of the experts at the Wall Street Journal. I want to commend to my colleagues, I hope you have an opportunity to read any of the articles that the Wall Street Journal has on the Anti-Ballistic Missile Treaty.

But let us go over a few facts about our military defense. One, as I just told you, we can detect a launch, we can determine when that missile is coming, where it is coming from, and where it is going to hit. But then all we can do is call up the target and say, you have got an incoming ICBM and we will say a prayer for you because there is not much else we can do for you.

That is wrong. Henry Kissinger once said, ''It is morally irresponsible not to provide for the people of your country

a missile defense system.'' ''It is morally irresponsible not to provide the people of your country a missile defense system.'' I was at the World Forum about 3 years ago in Vail, Colorado, and there Margaret Thatcher said exactly the same thing. These people are people of intellect. They are people who have had many experiences through their lives and they realize the importance of having a defense system in place.

Let me go through a few facts for my colleagues. The Cox report. Remember what the Cox report was about? The Cox report was a bipartisan, not a Democrat, not a Republican, a combination of Republican and Democrat congressmen, and I say that generically, who investigated the Chinese espionage.

It is said, and from what I have read and the briefings I have gotten I believe it to be true, that the Chinese espionage was the worst and most devastating espionage we have had in American history. The Cox report reveals that Communist China has moved almost overnight from a 1950s nuclear capability to the most modern technology in the American nuclear arsenal.

In the opinion of many of the experts, as I just said, this could be the most damaging failure in American intelligence history.

Fact number 2: The ABM Treaty, the Anti-Ballistic Missile Treaty, is over 27 years old. It has not been amended. It is a treaty that exists only between two countries, between Russia and the United States. Remember earlier in my comments I mentioned that at the time this treaty was put together and in the early days of the missiles, the only country really capable of delivering a significant and severe blow to the United States was Russia.

This is a very important fact and one we have got to remember: Today over two dozen countries have the capability to deliver a missile into the United States. Many of these countries are in the process of building even more sophisticated delivery systems.

We know, for example, what the North Koreans are doing. The answer, by the way, of the administration to the North Koreans is, buy them off, get them to promise that they will abandon their nuclear program and we will give them more aid. We give them a lot of aid right now, I think 500,000 barrels of oil a year and money that the North Koreans promised us they will not put into the military, they will put into food for their citizens.

What kind of fools are we? These people do not have our interests in mind. They do not care about the United States of America. They do not care about our future.

Now, that is not to say we need to go to war with them. I am not advocating that at all. My position is, however, if somebody picks a fight with us, we ought to be in shape to handle it, because at some point in the future it is going to happen.

Do my colleagues not think that we have an obligation to the generation behind us, if not our own generation, to be ready when that day comes? It is a race against time.

We need a missile defense system. We need a defense system that, as stated by the Heritage Foundation, is a defense based on land, sea, and space. Here it goes, space.

Remember when Ronald Reagan was President and he got ridiculed, frankly, he got an awful lot of ridicule from the Democrats, he got a lot of ridicule for his proposed missile defense system in space? Well, you know, the day is coming when we are going to look back at Ronald Reagan and say he knew what he was talking about on that missile defense system.

In fact, we must put into place a missile defense system based on land, based on sea, and yes, based on space. Having a missile defense system in space gives us many, many more options. In other words, instead of waiting for the incoming missile to come into our country where we try and intercept it with a one-shot opportunity, we can then, through satellite detection and so on, hit the missile in several different stages as it arcs over to our country. We can actually hit it on the launching pad.

There are lot of options out there and we should not eliminate any of them and we should not allow our hands to be tied by this Anti-Ballistic Missile Treaty. I am going to explain a little more on the Treaty and what the Treaty means. But the world has changed a great deal since the ABM Treaty was first ratified, over 27 years ago. The U.S. faces a lot of new challenges and there are a lot of different types of threats that are coming at us today.

Take a look at China and take a look at what China has gotten into their espionage and take a look at the capabilities. The Chinese are very bright people and they know and they want a future, not only a future as a giant in economics, they want to be the leading country in the world in military.

As many of you know, and some of you may hate to admit it, but the fact is you cannot be the second strongest kid on block. You cannot do it, especially if you have something else that the strongest kid on the block wants. You have got to be the strongest.

That is not to suggest that you got to be a bully and you got to go out and pick fights. But it is to say that if you are not the strongest, you are going to be in a lot of fights.

It is interesting. Let me tell you, I have been very blessed over the years with many high school students coming into my office, very bright. That generation has got a lot of things going for it. There are a lot more things going right for this generation than going wrong. But once in a while when these classes come in and I have an opportunity to speak with some of these fine young people, someone brings up the question, why do we spend so much money on military defense? Why do we worry about a missile defense system in this country?

I say to them, if you were a black belt in karate and everybody in your class knew that you were a black belt in karate and everybody in that class knew that if they decided to take your lunch or pick on your friend or pick on you that you would exercise the knowledge you have as a result of your black belt in karate and you break their nose or break their neck, how many fights do you think you would be in? How many people do you think would pick a fight? Not very many.

I forget who I should attribute this saying to, but there is a quote and it should be attributed, but I cannot remember who it was, but the quote goes something like this: The best way to stay out of a war is to always be prepared for a war. That is the best way to stay out of it.

Well, let us talk about another fact, the Rumsfield report.

Former Defense Secretary Donald Rumsfield and his team of defense experts, now remember, this is bipartisan, this is not a Republican deal, not a Democrat deal, it is a bipartisan team, the Rumsfield report, and we have real experts on that. We do not have some congressmen. We are real experts on missile defense that are on this panel. Here are their conclusions, and they are important conclusions to remember. Lock them in because it impacts our generation and every generation to go forward.

Former Defense Secretary Donald Rumsfield and his team of defense experts issued a report to the United States Congress in the summer of 1988 that said ballistic missiles from rogue nations could strike American cities with little or no warning. Ballistic missiles from rogue nations could strike American cities with little or no warning; that North Korea has been said to be building missiles with a 6,200 mile range that could reach Arizona or even Wisconsin; that Iran is working on missiles with the capability to hit Pennsylvania or Montana or Minnesota; that there is a fear that Russian missiles may be bought by one of these nations or a terrorist like Bin Laden, that when dealing with terrorists arms control negotiations do not work.

Well, let us talk about the Anti-Ballistic Missile Treaty. I am going to read this. And let me again attribute a lot of this information right here to the Wall Street Journal. I think they are very accurate in their description. And my colleagues, I would ask that you be patient but listen to the words as I read through.

''Anti-Ballistic Missile Treaty meant to hold the populations of the United States and Soviet Union hostage to nuclear attack.''

Now, what do they mean by that? What the Anti-Ballistic Missile Treaty does. The essence of it, very simplified, is that Russia and the United States agreed over 27 years ago, look, one way to deter war is to not have the ability to defend against it. In other words, one way to make sure you never pick

on anybody is to be sure that you never get a black belt in karate.

□ 2215

So they come up with the Anti-Ballistic Missile treaty, which in essence says that Russia cannot build a defense against incoming missile attack and the United States cannot build a defense against an incoming missile attack. The theory of this is that the United States would never then go to war with Russia because we have no way to defend ourselves and, vice versa, Russia would never go to war with the United States because Russia has no way to defend itself.

The language of the Anti-Ballistic Missile treaty expressly forbids the development of a national missile defense, allowing each side to deploy just 100 land-based anti-missile interceptors, capable of shielding only a small region. The United States observed the treaty and still does. Yet, from the onset there were troubling signs that the Soviets were not.

Now a new book provides disquieting evidence that the treaty has proved to be a gigantic sham and an enormous deterrent to the security of the United States of America. In the book, the ABM Treaty Charade, a Study in Elite Illusion and Delusion, William T. Lee, a retired officer with the Defense Intelligence Agency sets down a devastating twofold case against the treaty.

First, it increased the risk of nuclear war during the Cold War. Second, there is conclusive proof of violations on a massive scale, both by the Soviet Union and post-Communist Russia. Champions of the treaty argue that it reassured the Soviets, dampened the armed race and brought stability to the United States-Soviet Union relations.

In reality, by leaving itself defenseless against missiles, the United States had encouraged Moscow to prepare to win a nuclear war. Soviet annual defense expenditure climbed steady to about 30 percent of gross domestic product in 1988, from about 15 percent in 1968. So 15 percent in 1968 to 30 percent in 1988. In 1981 through 1984, although it was not widely understood at the time, the Soviet Union had nearly launched a full scale attack against the United States and its NATO allies. Had America deployed a missile defense around 1970, which by the way it could have done with technology at that time, the Soviets would probably have found the quest for nuclear supremacy prohibitive from the start and would have never, ever considered or come as close as they did to launching a nuclear attack against our Nation.

To make matters worse, in utter contempt of the treaty the Soviets conceived, tested, deployed and refined a missile defense. Not only did the USSR, unlike the United States, deploy the one missile defense permitted by the treaty, leaving Moscow with 100 intercepters, sanctioned by the law, but Moscow also littered about the Soviet territory with another 10,000 to 12,000 intercepters and 18 battle management radars. So, in other words, we signed the treaty with Russia and contained within that treaty, and we will go over a few parts of that treaty here in a minute, contained within the treaty was a clause that said each side could have 100 intercept defense missiles.

The United States had 100 intercept defense missiles. The Russians had 12,100 under the mask of secrecy, and under the mask of compliance of the anti-ballistic Missile treaty they did not build just 100 intercepters they built 12,100 intercepters. We are such fools sometimes in this country. We owe it to ourselves to become alert about this issue.

Together, the Moscow defense and the vast homeland defense formed an interlocking system, nearly all of it not allowed by the treaty. How could the U.S. intelligence system overlook such an astounding violation? To answer this question is to comprehend another awful part of the treaty legacy. Those in this country who promoted the treaty succeeded in elevating it to theology and they prevailed upon virtually everyone in authority to accept no evidence that spoke to the existence of Soviet missile defense. We just intentionally, these arms control fanatics intentionally put a shield in front of their eyes and said, do not tell me about any Soviet missile defenses. I do not hear it. I do not want to see it. I do not want to talk about it. It is not happening.

In the meantime, 12,000 Russian intercepter missiles are put out there, and we comply with this treaty and we build 100. Washington knew about the 10,000 to 12,000 intercepters; in 1967 and 1968 had concluded that the intercepters that were not part of the Moscow system were anti-aircraft systems and that each of the radars was for early warning of a missile attack. No violations.

In 1991, however, a U.S. team visited one of the radars and found that the passing of data was not only for early warning but also for battle management. Violation.

This discovery, combined with earlier evidence which had been dismissed by the Central Intelligence Agency, leads to the clear conclusion that the 12,000 interceptors were dual use, lethal against ballistic missiles as well as aircraft. Several former top Soviet officials have confirmed the dual use in memoirs published this decade, but Washington has continued to ignore this massive violation of the treaty.

Today with the Cold War over, the ABM treaty is as dangerous as ever to the United States. Long gone, and this is so important, this is so important, long gone are the days where the only threat to the United States in the form of a capacity of a missile was from Russia. How foolish to forsake missile defense in the face of rising missile powers such as China, such as Iran, such as India, such as Iraq, such as North Korea, such as Pakistan.

Remember, the treaty is not between the United States and Iran. It is not between the United States and North Korea. It is between the United States and Russia and prevents the United States from defending itself against any other country, not just Russia but against North Korea, against Iran. So we cannot build a missile defense system because we are locked in under this treaty.

It is foolish. It is crazy.

Let us talk for a minute about what we have, what the Anti-Ballistic Missile treaty is and some of the articles that are important. I have to my left here, Mr. Speaker, a display board and I will go over a couple of things. Article number one, my red dot is there, this is the Anti-Ballistic Missile treaty. These are parts of it taken out. By the way, the treaty is not complicated. I would be happy to provide any of my colleagues a copy of it. It is three or four pages long. This is not a study in complexity. It is fairly simply written. It is easy to understand, and it is devastating in its contents.

Each party undertakes to limit Anti-Ballistic Missile systems and to adopt other measures in accordance with provisions of the treaty. Each party, again speaking only of the United States and of Russia, but it is applicable as to the defense against any other country, against the United States of America, each party agrees not to deploy Anti-Ballistic Missile defense systems for the defense of its territory. Each party undertakes not to deploy ABM systems for defense of the territory of its country, and not to provide a base for such defense and not to deploy ABM systems for defense of an individual region except as provided in article three of the treaty.

Right there, that paragraph right there, we are saying 27 years ago we will not provide any kind of missile defense system in this country.

Well, I cannot figure out the logic of it 27 years ago. I cannot figure out the logic of it 15 years ago and today I sure as heck cannot figure out the logic of this treaty, especially when we have numerous other countries that are developing this ballistic missile capability, over two dozen of them.

Let us skip here just for a minute. Each party undertakes not to develop, test or deploy ABM systems or components which are sea-based, air-based, space-based or mobile-land based. This treaty, in my opinion, is a complete lock-out of any opportunity of the citizens of the United States of America to defend themselves.

Each party undertakes not to develop, test or deploy ABM launchers for launching more than one ABM intercepter missile at a time from each launcher, not to modify deployed launchers, et cetera, et cetera. You can see as this goes on, to enhance the assurance of effectiveness on the ABM systems and their components, each

party undertakes not to give missiles, launchers or radars, other than ABM intercepter missiles, ABM launchers or ABM radars capabilities to counter strategic basic missiles or their elements in flight trajectory and not to test them in an ABM mode. To assure the viability and effectiveness of this treaty, each party undertakes not to transfer to other states and not to deploy outside of its national territory ABM systems of the components limited by this treaty.

What I have brought out of the treaty here is the language that is fairly simple, easy to understand and the concept is clear. The concept is that the United States of America, based on the word of Russia, would not build a defensive missile system for itself. Know what? In America, we like to keep our word. We kept our word. In America, the United States did not deploy a missile defense system. We are here today, 1999, just a few short weeks away from the turn of the century, facing over two dozen countries with sophisticated missiles and the opportunity to increase the technology and the sophistication of their missiles, and we still continue to put a blindfold in front of our eyes.

As Henry Kissinger said, it is immoral, it is immoral, not to provide a defense system for our citizens.

Well, now some people say, all right, SCOTT, you have convinced us, this treaty is not a good idea. It prevents the United States from defending its own territory.

But are we locked into it? Well, the treaty is perpetual, meaning that it goes on as long as the parties agree, but the treaty also has language that allows us to abrogate the treaty, to get out of the treaty, legitimately. It is in the contract.

Again, language from the contract, article 15 of the Anti-Ballistic Missile treaty, ABM, this treaty shall be of unlimited duration. I spoke about that a moment ago. Each party shall, in exercising its national sovereignty, have the right to withdraw from this treaty if it decides that extraordinary events related to the subject matter of this treaty have jeopardized its supreme interest.

Let us talk for a minute about extraordinary events. What are some extraordinary events? Well, there are several out there that we can look at. First of all, the other party that we made the agreement with, the Soviet Union, is no longer in existence. Now we have independent countries over there. So one party of the agreement is not even in existence as it was at the time we signed the agreement over 27 years ago.

Number two, the countries that have the missile capability 27 years ago, 20 years ago, even 15 years ago, the only country that was capable of bringing and delivering those missiles to Minnesota or to Montana or to New York or Los Angeles was Russia. So extraordinary event, now we have over two dozen countries that are building or are capable of delivering those missiles into the inside of the United States of America. That is a pretty extraordinary event, and that is exactly what that term is intended to mean in that treaty.

We ought to get out of this treaty. We ought to abrogate the treaty.

It shall give notice of its decision to the other party 6 months prior to withdrawal from this treaty. Such notice shall include a statement of the extraordinary events the notifying party regards as having jeopardized its supreme interests.

Supreme interests; think of the wording, supreme interests. Above all else, what should the United States of America be concerned about, above all else when it comes to this military? It is the defense of our people. We are not warmongers. Our country has lost many, many of our citizens and lives to protect other countries, some of them in recent years, and we know that in the future we will have another fight. But what are our supreme interests? It is an inherent supreme interest to protect yourself. Even individually, we have the concept of self-defense. That is what this is. It is self-defense for an entire nation, for the territory of the United States. That is a supreme interest and that is why we should, in this country, abrogate this treaty under the terms of the agreement and build a missile defense system for the United States.

□ 2230

Now what are some people thinking about this? You are not going to believe it, you are not going to believe it.

There are still, of course, supporters out there for this treaty, including the President.

Colleagues, we have an opportunity in another year and a half to have new leadership down there, and regardless of which party it comes from, although obviously I have some preference in that regards, whichever party it comes from, that new President, our new President, should seriously consider the terms of this and how it has handcuffed the United States in its own self-defense.

But I want you to know there are other people on the other side of this issue. What are their thoughts?

They want to go a step further. They actually do not think that the anti ballistic missile treaty is enough. They think we ought to do something called, and get ahold of this, and any of my colleagues out there that have constituents with any type of military conscience, get ahold of this:

They call it de-alerting, de-alerting, D-E-hyphen-A-L-E-R-T-I-N-G, de-alerting. Let me describe what de-alerting is. You are not going to believe it.

Now, having lulled the country to sleep on defenses against missiles, the same group of old-time arms controllers have come up with another idea called de-alerting which would take our nuclear forces off alert status. The aim would be to increase the amount of time necessary to launch a nuclear weapon from minutes to hours to even days.

De-alerting, a word so awkward only arms control bureaucrats could have thought of it, could take a number of forms, and suggestions being put forward are somewhat concerning. They include removing the integrated circuit boards from the ballistic missiles that we have and storing them hundreds of miles away.

What? As my colleagues know, what you do is you take the computer brains of the missiles we have, and you take them, and you store them several hundred miles away so that if, all of a sudden, we come under attack by another country and we decide to retaliate, we have got to go get the parts several hundred miles away, bring them to the missile and install them. Makes a lot of sense; does it not? Taking the warheads off the missiles or possibly the Minutemen ICBMs, welding shut, and get ahold of this, welding shut the missile hatches on some submarines and doubling the number of orders a hard-to-communicate-with submarine would have to receive before it can launch a missile.

Any one of these measures is the nuclear equivalent of giving a beat cop an unloaded gun and requiring he radio back to headquarters for bullets when he wants to use them. That is a pretty good example. I want to credit the Wall Street Journal for that example. What they are saying is what the new arms control people are aiming for is the essence of giving a police officer out on the street in a dangerous situation an unloaded gun and that if he wanted the bullets for his gun, he would have to call headquarters and request headquarters to get them out of the lockbox. He can run back, get the bullets and then come back to the scene.

That is what they are asking us to do with our military defense. We have got to change the direction that some of these people are going, and I think the majority of people in the United States believe, one, very strongly that we should not initiate a war unnecessarily; two, that our country has a fundamental obligation to its citizens, a fiduciary obligation to its citizens, and not only a fiduciary and fundamental obligation to its citizens, but a fiduciary and fundamental obligation to the future generations to provide a defense, a missile defense, for this country.

That is where we have to go with this. That is where we need to take it, and that is the direction we need to go. And can we do it with the anti ballistic missile treaty? We cannot do it. We need to get rid of it. It is not serving our best interests. It does not help us. It does us as much good on the floor as it does in action. I mean it is not helping. It hurts us. We should be entitled to defend ourselves with defensive missiles.

Let me wrap up just very briefly about the conclusion that I think we should all look at.

Number One, remember the facts, that there are over two dozen countries currently with the capability or building the capability to deliver missiles into the heart of the United States of America.

Number Two, that when this treaty was drafted, it was 27, over 27 years ago, and it was drafted between two countries, Russia and the United States. It was applicable. Even though the United States now faces multiple threats, this treaty prevents the United States not only from defending itself from the country of Russia, but defending itself from any of the other threats like they may have from North Korea, or Iran, or Iraq, or Pakistan, or India, et cetera, et cetera. Mr. Speaker, we could go through two dozen of those kinds of countries.

Number Three, we have the sophistication today to build an effective missile defensive system. We have the money today, and it should be a high priority. We have the money today to develop even better technology.

Now is the technology complicated? It is very complicated. Imagine a bullet coming several thousand miles per hour, and you have got to take it down with another bullet going several thousand miles per hour.

Now many of you may recall over the last couple of weeks we had a successful test where the bullet hit the bullet. It is a preliminary test, but the technology there is promising.

The next fact that I think is important is do not automatically, colleagues, do not automatically dismiss a space defense system.

Now in the days of Reagan when the Democrats ridiculed him, it was amazing, it was amazing in my opinion the shortsightedness that was allowed to continue with that ridicule. But today those days are passed. I am willing to go past that. But today we need to sit down as a team. We need to sit down and develop the kind of technology, not to start a war, not to pick on somebody, but to defend the supreme interests, and I use that as a quote out of the anti ballistic missile treaty, supreme interests, to defend the supreme interests of the United States of America. It is a race against time.

I have said several times during my comments this evening I have quoted Henry Kissinger. It is immoral, it is immoral not to provide the citizens of your country with a defensive missile system.

To my colleagues, when you leave the chambers tonight, you may not remember the facts. I hope you remember a little about this treaty and how and what it does to us. But more than anything else, I hope you remember those four or five words:

A race against time.

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. PALLONE) to revise and extend their remarks and include extraneous material:)

Mr. LIPINSKI, for 5 minutes, today.

Mr. HILL of Indiana, for 5 minutes, today.

Mr. MINGE, for 5 minutes, today.

Mr. DAVIS of Illinois, for 5 minutes, today.

(The following Members (at the request of Mr. DUNCAN) to revise and extend their remarks and include extraneous material:)

Mr. BURTON of Indiana, for 5 minutes, October 13.

Mr. BRYANT, for 5 minutes, October 6.

Mr. DUNCAN, for 5 minutes, today.

Mr. ISTOOK, for 5 minutes, today.

Mr. MILLER of Florida, for 5 minutes, October 12.

Mr. JONES of North Carolina, for 5 minutes, October 7.

Mr. SOUDER, for 5 minutes, today.

Mr. SHADEGG, for 5 minutes, today.

ENROLLED BILL SIGNED

Mr. THOMAS, from the Committee on House Administration, reported that that committee had examined and found truly enrolled a bill of the House of the following title, which was thereupon signed by the Speaker.

H.R. 2606. An act making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes.

SENATE ENROLLED BILL SIGNED

The SPEAKER announced his signature to an enrolled bill of the Senate of the following title:

S. 559. An act to designate the Federal building located at 300 East 8th Street in Austin, Texas, as the ''J.J. 'Jake' Pickle Federal Building.''

BILLS AND JOINT RESOLUTION PRESENTED TO THE PRESIDENT

Mr. THOMAS, from the Committee on House Administration, reported that that committee did on the following dates present to the President, for his approval, bills and a joint resolution of the House of the following titles:

On September 29, 1999:

H.J. Res. 34. Congratulating and commending the Veterans of Foreign Wars.

On October 5, 1999:

H.R. 2084. Making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

On October 6, 1999:

H.R. 2606. Making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes.

ADJOURNMENT

Mr. McINNIS. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 10 o'clock and 38 minutes p.m.), the House adjourned until tomorrow, Thursday, October 7, 1999, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

4665. A letter from the Director, Office of Regulatory Mangement and Information, Environmental Protection Agency, transmitting the Agency's final rule—Imazapic-Ammonium; Pesticide Tolerances for Emergency Exemptions [FRL–6382–3] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4666. A letter from the Secretary of Defense, transmitting the approved retirement of Lieutenant General David K. Heeber, United States Army, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.

4667. A letter from the General Counsel, Federal Emergency Management Agency, transmitting the Agency's final rule—National Flood Insurance Programs; Procedures and Fees for Processing Map Changes (RIN: 3067–AC88) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Banking and Financial Services.

4668. A letter from the Acting Inspector General, Department of Defense, transmitting the FY 1998 Department of Defense Superfund Financial Transactions; to the Committee on Commerce.

4669. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Implementation Plans; Indiana [IN96–2; FRL–6452–6] received October 1, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4670. A letter from the Secretary of Energy, transmitting a legislative proposal to amend certain provisions of the Weather Assistance Program for Low-Incomed Persons; to the Committee on Commerce.

4671. A letter from the Auditor, District of Columbia, transmitting A copy of a report entitled, ''Audit of the People's Counsel Agency Fund for Fiscal Year 1998,'' pursuant to D.C. Code section 47–117(d); to the Committee on Government Reform.

4672. A letter from the Executive Director, Committee For Purchase From People Who Are Blind Or Severely Disabled, transmitting the Committee's final rule—Additions to and Deletions from the Procurement List—received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform.

4673. A letter from the Comptroller General of the United States, General Accounting Office, transmitting the Research Notification System through September 7, 1999; to the Committee on Government Reform.

4674. A letter from the Office of the District of Columbia Auditor, transmitting a report entitled ''Observed Weakness in the District's Early Out Retirement Incentive Program''; to the Committee on Government Reform.

4675. A letter from the Office of the District of Columbia Auditor, transmitting a report entitled ''Auditor's Review of Unauthorized Transactions Pertaining to ANC 1A''; to the Committee on Government Reform.

4676. A letter from the Office of the District of Columbia, Auditor, transmitting a

copy of a report entitled, ''Examination of the People's Counsel Agency for Fiscal Year 1997''; to the Committee on Government Reform.

4677. A letter from the Assistant Secretary for Fish and Wildlife and Parks, Department of the Interior, transmitting the Department's final rule—Amendment by Mexico to Appendix III Listing of Bigleaf Mahogany under the Convention on International Trade in Endangered Species of Wild Fauna and Flora (RIN: 1018–AF58) received June 9, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4678. A letter from the Commissioner, Department of the Interior, transmitting draft legislation to authorize not new feasibility investigations for three water resource development projects within the Pacific Northwest; to the Committee on Resources.

4679. A letter from the Commissioner, Department of the Interior, transmitting a draft bill ''To authorize the Secretary of the Interior to refund certain collections received pursuant to the Reclamation Reform Act of 1982''; to the Committee on Resources.

4680. A letter from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 630 of the Gulf of Alaska [Docket No. 990304062–9062–01; I.D. 092499J] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4681. A letter from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Fisheries of the Exclusive Economic Zone Off Alaska; Atka MACKerel in the Central Aleutian Islands [Docket No. 990304063–9063–01; I.D. 092399E] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4682. A letter from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 610 of the Gulf of Alaska [Docket No. 990304062–9062–01; I.D. 091799B] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4683. A letter from the Assistant Administrator for Fisheries, National Marine Fisheries Service, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Pacific Halibut Fisheries; Local Area Mangement Plan for the Halibut Fishery in Sitka Sound [Docket No. 990416100–9256–02; I.D. 031999C] (RIN: 0648–AL18) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4684. A letter from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 610 of the Gulf of Alaska [Docket No. 990304062–9062–01; I.D. 092399A] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4685. A letter from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Fisheries off West Coast States and in the Western Pacific; Pacific Coast Groundfish Fishery; Fixed Gear Sablefish Mop-Up [DOcket No. 981231333–8333–01; I.D. 091399D] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4686. A letter from the Acting Director, Office of Sustainable Fisheries, National Oceanic And Atmospheric Administration, transmitting the Administration's final rule—Fisheries of the Exclusive Economic Zone Off Alaska; Pollock by Vessels Catching Pollock for Processing by the Mothership Component in the Bering Sea Subarea [Docket No. 990304063–9063–01; I.D. 092499N] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4687. A letter from the Deputy General Counsel, FBI, Department of Justice, transmitting the Department's final rule—Federal Bureau of Investigation, Criminal Justice Information Services Division Systems and Procedures [AG Order No. 2258–99] (RIN: 1105–AA63) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

4688. A letter from the Chief, Office of Regulations and Administrative Law, USCG, Department of Transportation, transmitting the Department's final rule—Technical Amendments; Organizational Changes; Miscellaneous Editorial Changes and Conforming Amendments [USCG–1999–6216] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4689. A letter from the Chief, Office of Regulations and Administrative Law, Department of Transportation, transmitting the Department's final rule—Safety Zone Regulations; Mile 94.0 to Mile 96.0, Lower Mississippi River, Above Head of Passes [COTP New Orleans, LA Regulation 99–022] (RIN: 2115–AA97) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4690. A letter from the Chief, Office of Regualtions and Administrative Law, USCG, Department of Transportation, transmitting the Department's final rule—Special Local Regulations; Tall Stacks 1999 Ohio River Mile 467.0–475.0, Cincinnati, OH [CGD08–99–052] (RIN: 2115–AE46) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4691. A letter from the Chief, Office of Regulations and Administrative Law, USCG, Department of Transportation, transmitting the Department's final rule—Safety Zone: Wedding on the Lady Windridge Fireworks, New York Harbor, Upper Bay [CGD01–99–163] (RIN: 2115–AA97) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4692. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Noise Transition Regulations; Approach of Final Compliance Date—received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4693. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; Pratt & Whitney PW2000 Series Turbofan Engines [Docket No. 99–NE–02–AD; Amendment 39–11333; AD 99–20–03] (RIN: 2120–AA64) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4694. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; Pratt & Whittney JT9D–7R4 Series Turbofan Engines [Docket No. 99–NE–06–AD; Amendment 39–11334; AD 99–20–04] (RIN: 2120–AA64) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4695. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; Airbus Model A319, A320, and A321 Series Airplanes [Docket No. 98–NM–270–AD; Amendment 39–11335; AD 99–20–05] (RIN: 2120–AA64) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4696. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; Airbus Industrie Model A320 Series Airplanes [Docket No. 99–NM–48–AD; Amendment 39–11336; AD 99–20–06] (RIN: 2120–AA64) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4697. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Establishment of Class E Airspace; Pikeville, KY [Airspace Docket No. 99–ASO–13] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4698. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Revision of Class E Airspace; Center TX [Airspace Docket No. 99–ASW–14] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4699. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—High Density Airports; Allocation of Slots [Docket No. FAA–1999–4971, Amendment No. 93–78] (RIN: 2120–AG50) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4700. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; McDonnell Douglas Model MD–11 Series Airplanes (RIN: 2120–AA64) received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4701. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Standard Instrument Approach Procedures; Miscellaneous Amendments [Docket No. 29753; Amdt. No. 1950] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4702. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—Standard Instrument Approach; Miscellaneous Amendments [Docket No. 29754; Amt. No. 1951] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4703. A letter from the Admiral, U.S. Coast Guard Commandant, Department of Transportation, transmitting a report on the Coast Guard's findings the Chicago area search and rescue standards and procedures; to the Committee on Transportation and Infrastructure.

4704. A letter from the Principal Deputy Assistant Secretary for Congressional Affairs, Department of Veterans Affairs, transmitting a draft bill to authorize major facility projects and lease programs for Fiscal Year 2000; to the Committee on Veterans' Affairs.

4705. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule—Section 846 Discount Factors for 1999 [Revenue Procedure 99–36] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4706. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule—Section 832 Discount Factors for 1999 [Revenue Procedure 99–37] received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4707. A letter from the Chief, Regulations Service, Internal Revenue Service, transmitting the Service's final rule—Mutual Insurance, Inc. v. Commissioner—received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4708. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule—Medical Savings Accounts—Number—received October 4, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4709. A letter from the Secretary of Health and Human Services, transmitting the notification you that Department of Health and Human Services is alloting emergency funds to be made available to the State of North Carolina; jointly to the Committees on Commerce and Education and the Workforce.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. BURTON: Committee on Government Reform. H.R. 1788. A bill to deny Federal public benefits to individuals who participated in Nazi persecution; with an amendment (Rept. 106–321, Pt. 2). Referred to the Committee of the Whole House on the State of the Union.

BILLS PLACED ON THE CORRECTIONS CALENDAR

Under clause 4 of rule XIII, the Speaker filed with the Clerk a notice requesting that the following bill be placed upon the Corrections Calendar:

H.R. 576. A bill to amend title 4, United States Code, to add the Martin Luther King, Jr. holiday to the list of days on which the flag should especially be displayed.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. ROGAN (for himself, Mr. BOUCHER, Mr. COBLE, and Mr. GOODLATTE):

H.R. 3028. A bill to amend certain trademark laws to prevent the misappropriation of marks; to the Committee on the Judiciary.

By Ms. DUNN (for herself and Mr. MCDERMOTT):

H.R. 3029. A bill to amend title XVIII of the Social Security Act to increase Medicare payment to skilled nursing facilities that have a significant proportion of residents with AIDS; to the Committee on Ways and Means, and in addition to the Committee on Commerce, 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. HINCHEY:

H.R. 3030. A bill to designate the facility of the United States Postal Service located at 757 Warren Road in Ithaca, New York, as the ''Matthew F. McHugh Post Office''; to the Committee on Government Reform.

By Mr. LEWIS of Georgia (for himself, Mr. HILLIARD, Mr. FROST, Mr. RUSH, Mr. PAYNE, Mr. ENGEL, Mr. THOMPSON of Mississippi, Ms. KILPATRICK, Mr. DAVIS of Illinois, Mr. TOWNS, Mr. CLYBURN, Mr. CLAY, Mr. BISHOP, Ms. EDDIE BERNICE JOHNSON of Texas, Ms. BROWN of Florida, and Mrs. MEEK of Florida):

H.R. 3031. A bill to redesignate the Federal building located at 935 Pennsylvania Avenue, NW, in Washington, DC, as the ''Frank M. JOHNSON Federal Building''; to the Committee on Transportation and Infrastructure.

By Mr. MARKEY (for himself, Mr. GEORGE MILLER of California, Mr. HOEFFEL, Mr. WEXLER, Mr. KUCINICH, Mrs. MALONEY of New York, Mr. WEINER, Ms. DELAURO, Mr. NEAL of Massachusetts, Mr. LIPINSKI, and Mr. WAXMAN):

H.R. 3032. A bill to restore the jurisdiction of the Consumer Product Safety Commission over amusement park rides which are at a fixed site, and for other purposes; to the Committee on Commerce.

By Ms. ROS-LEHTINEN (for herself, Mrs. MEEK of Florida, Mr. SHAW, Mr. DIAZ-BALART, and Mr. HASTINGS of Florida):

H.R. 3033. A bill to direct the Secretary of the Interior to make certain adjustments to the boundaries of Biscayne National Park in the State of Florida, and for other purposes; to the Committee on Resources.

By Mr. ROYCE (for himself and Mr. DUNCAN):

H.R. 3034. A bill to amend the Internal Revenue Code of 1986 to allow unused benefits from cafeteria plans to be carried over into later years and used for health care reimbursement rollover accounts and certain other plans, arrangements, or accounts; to the Committee on Ways and Means.

By Mr. MILLER of Florida (for himself and Mrs. MALONEY of New York):

H. Con. Res. 193. Concurrent resolution expressing the support of Congress for activities to increase public participation in the decennial census; to the Committee on Government Reform.

MEMORIALS

Under clause 3 of rule XII, memorials were presented and referred as follows:

259. The SPEAKER presented a memorial of the House of Representatives of the Commonwealth of The Mariana Islands, relative to House Resolution No. 11–183 memorializing the U.S. House Speaker, Chairman Young, U.S. House Committee on Resources, the President, Senator MURKOWSKI, Secretary of the Interior, CNMI Governor and CNMI Senate President to permit the U.S. House Committee on Resources to bring to justice all those who may have taken part in any illegal political activities aimed against the CNMI's ability to control its own immigration and minimum wage policies as provided under the Convenant; to the Committee on Resources.

260. Also, a memorial of the Legislature of the State of California, relative to Assembly Joint Resolution 16 memorializing the President and Congress of the United States to maintain the existing restrictions on trucks from Mexico and other foreign nations entering California and to continue efforts to ensure full compliance by the owners and drivers of those trucks with all the highway safety, environmental, and drug enforcement laws; to the Committee on Transportation and Infrastructure.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 126: Mrs. MALONEY of New York and Mr. FORBES.
H.R. 274: Mr. MALONEY of Connecticut.
H.R. 325: Mr. BISHOP and Mr. HOYER.
H.R. 353: Mr. WU, Mr. ETHERIDGE, Mr. UDALL of Colorado, Mr. BURR of North Carolina, Mr. COLLINS, and Mrs. LOWEY.
H.R. 355: Mr. TALENT and Mr. SANFORD.
H.R. 372: Mr. COYNE, Mr. MORAN of Virginia, and Mr. HOLT.
H.R. 405: Ms. WOOLSEY.
H.R. 460: Mr. EVANS.
H.R. 488: Mr. MORAN of Virginia.
H.R. 637: Mr. STRICKLAND.
H.R. 742: Mr. HOLDEN.
H.R. 773: Mr. GUTIERREZ and Mr. HINOJOSA.
H.R. 780: Mr. LAFALCE.
H.R. 802: Mr. TOOMEY and Mr. GOODE.
H.R. 872: Mr. HASTINGS of Washington.
H.R. 1057: Mr. BERMAN.
H.R. 1095: Mr. SANDLIN, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. GREENWOOD, Mr. PASTOR, Mr. SHAYS, and Ms. ROS-LEHTINEN.
H.R. 1195: Mr. SOUDER, Mr. VITTER, Mr. RYUN of Kansas, and Mr. KENNEDY of Rhode Island.
H.R. 1248: Mr. PRICE of North Carolina.
H.R. 1322: Ms. ESHOO.
H.R. 1344: Mr. SWEENEY.
H.R. 1456: Mr. BILBRAY.
H.R. 1459: Mr. WHITFIELD.
H.R. 1485: Mr. EVANS.
H.R. 1532: Mr. LUTHER.
H.R. 1598: Mr. ISTOOK, Mr. SMITH of New Jersey, and Mr. HILL of Montana.
H.R. 1835: Mr. MCHUGH, Mr. BURTON of Indiana, Mr. GOODLING, Mr. DELAY, and Mr. TANCREDO.
H.R. 1887: Mr. BILBRAY.
H.R. 1910: Mrs. WILSON.
H.R. 1977: Mr. BENTSEN.
H.R. 2059: Mr. TRAFICANT.
H.R. 2244: Mr. TIAHRT and Mr. VITTER.
H.R. 2260: Mr. REYNOLDS.
H.R. 2325: Mr. DAVIS of Florida.
H.R. 2362: Mr. NEY, Mr. HAYES, and Mr. PEASE.
H.R. 2372: Mrs. NORTHUP, Mr. BRADY of Texas, Mr. PETERSON of Pennsylvania, Mr. CALVERT, Mr. FRANKS of New Jersey, Mr. LOBIONDO, Mr. BOEHNER, and Mr. HAYES.
H.R. 2418: Mr. TANNER, Mr. ROGERS, and Mr. FRELINGHUYSEN.
H.R. 2446: Mr. MARTINEZ and Mr. NADLER.
H.R. 2492: Mr. THOMPSON of Mississippi, Mr. GILMAN, and Mrs. LOWEY.
H.R. 2494: Mr. HILL of Montana and Mr. LEWIS of Kentucky.
H.R. 2554: Mr. PAYNE and Mr. HEFLEY.
H.R. 2571: Mr. GARY MILLER of California.
H.R. 2631: Mr. SISISKY.
H.R. 2673: Mrs. LOWEY.
H.R. 2726: Mr. SCHAFFER.
H.R. 2733: Mr. BURTON of Indiana.
H.R. 2745: Mr. FORBES.
H.R. 2746: Mr. HOUGHTON and Mr. MCNULTY.
H.R. 2757: Mr. CANADY of Florida, Mr. RADANOVICH, Mr. EHLERS, and Mr. LAHOOD.
H.R. 2776: Ms. ROYBAL-ALLARD, Mr. HINOJOSA, and Mr. PALLONE.
H.R. 2785: Mr. FRANKS of New Jersey.
H.R. 2790: Mr. GEKAS.
H.R. 2807: Mr. THOMPSON of Mississippi and Ms. NORTON.
H.R. 2814: Mr. GALLEGLY and Mr. CUNNINGHAM.
H.R. 2825: Mr. NEY.
H.R. 2882: Mr. DEFAZIO.
H.R. 2892: Mrs. MORELLA, Ms. STABENOW, Mrs. KELLY, and Ms. ESHOO.
H.R. 2909: Mr. WAMP, Mr. DEFAZIO, Ms. PRYCE of Ohio, Mr. WU, and Mr. WEXLER.
H.R. 2911: Mr. PHELPS and Mrs. EMERSON.

H.R. 2915: Ms. PELOSI, Mrs. THURMAN, Mr. FROST, Mr. LUTHER, Mr. TIERNEY, and Ms. NORTON.

H.R. 2971: Mr. WELDON of Florida.

H.R. 2980: Mr. THOMPSON of Mississippi and Mrs. NAPOLITANO.

H.R. 2993: Mr. JOHN.

H.R. 3012: Mr. ROHRABACHER, Mr. SUNUNU, and Mr. METCALF.

H.J. Res. 25: Mr. VITTER.

H.J. Res. 53: Mr. KASICH, Mr. LOBIONDO, Mr. MILLER of Florida, Mr. RYUN of Kansas, and Mr. SIMPSON.

H.J. Res. 55: Mr. SWEENEY.

H. Con. Res. 51: Mr. TANCREDO and Mr. ROYCE.

H. Con. Res. 133: Mrs. LOWEY.

H. Con. Res. 188: Mr. HOLDEN, Mr. BROWN of Ohio, Ms. PELOSI, Mr. CUNNINGHAM, Mr. ENGEL, Mr. HORN, Mr. PAYNE, Mr. MCGOVERN, Mr. GUTIERREZ, Mr. BEREUTER, Mr. WYNN, Mr. BAIRD, Mr. HINCHEY, Mr. TOWNS, Ms. KAPTUR, Mr. MCDERMOTT, Mr. SANDLIN, Ms. ROS-LEHTINEN, Mr. ANDREWS, Mr. MCNULTY, Mr. CAPUANO, Mr. MALONEY of Connecticut, Mrs. KELLY, Mr. ROYCE, Ms. NORTON, Mr. ENGLISH, and Mr. GILMAN.

H. Res. 224: Mr. HILL of Montana.

H. Res. 298: Mrs. MCCARTHY of New York, Mr. CROWLEY, Mr. GEORGE MILLER of California, Mr. SHERWOOD, Mr. RADANOVICH, Mr. CLAY, Mr. TOWNS, Mr. PASTOR, Mr. KLECZKA, and Mr. NADLER.

H. Res. 303: Mr. SMITH of Michigan and Mr. WELDON of Florida.

PETITIONS, ETC.

Under clause 3 of rule XII, petitions and papers were laid on the clerk's desk and referred as follows:

62. The SPEAKER presented a petition of Omaha City Council, relative to Resolution No. 2507 petitioning the President of the United States, Secretary of State, Majority Leader of the United States Senate, Speaker of the United States Senate, Speaker of the United States House of Representatives, the Ambassador of Indonesia to the United States, and the U.S. Ambassador to the United Nations to support independence of East Timor; to the Committee on International Relations.

63. Also, a petition of Township of Freehold, New Jersey, relative to Resolution 99–100 petitioning the the Congress to support the Protection of Religious Liberty and to oppose H.R. 1691; to the Committee on the Judiciary.