

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

NAYS—209

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

NOT VOTING—4

Delahunt	Scarborough
McKinney	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 policies 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 allow-

ance 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 NON-DISCRIMINATORY.—

“(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 connec-

tion 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 re-

quire 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 Sec-

retary 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 rule-making.

“(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 “(I) 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 rule-making 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 multi-employer 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 oper-

ation, 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 an 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.

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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 pre-existing 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 managed 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 deduction 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.

□ 1430

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 gentleman 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 pay-

ing 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 gentleman 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 gentleman 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.

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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 reimbursement, 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 an 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 precepts 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.

Also, 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 California¹ 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

¹California 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 explore 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 out-years 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 bu-

reaucrats, 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 smoke-screen, 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. Nine-

ty-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 mil-

lion 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 gentleman 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 rural 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.

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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 out 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 deductible 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 underserved 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 per-

sona 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 inappropri-

ately 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 cov-

erage, 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 managed 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 deduction 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 con-

sistent 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 ef-

fect, 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 Doggett LaFalce
Ackerman Dooley Lampson
Allen Doyle Lantos
Andrews Edwards Larson
Baird Engel Lee
Baldacci Eshoo Levin
Baldwin Etheridge Lewis (GA)
Barcia Evans Lipinski
Barrett (WI) Farr Lofgren
Becerra Fattah Lowey
Bentsen Filner Lucas (KY)
Berkley Forbes Luther
Berman Ford Maloney (CT)
Berry Frank (MA) Maloney (NY)
Bishop Frost Markey
Blagojevich Gejdenson Martinez
Blumenauer Gephardt Mascara
Bonior Gonzalez Matsui
Borski Goode McCarthy (MO)
Boswell Gordon McCarthy (NY)
Boucher Green (TX) McDermott
Boyd Gutierrez McGovern
Brady (PA) Hall (OH) McIntyre
Brown (FL) Hall (TX) McNulty
Brown (OH) Hastings (FL) Meehan
Capps Hill (IN) Meek (FL)
Capuano Hilliard Meeks (NY)
Cardin Hinchev Menendez
Carson Hinojosa Millender-
Clay Hoeffel McDonald
Clayton Holden Miller, George
Clement Holt Minge
Clyburn Hooley Mink
Condit Hoyer Moakley
Conyers Inslee Mollohan
Costello Jackson (IL) Moore
Coyne Jackson-Lee Moran (VA)
Cramer (TX) Murtha
Crowley Jefferson Nadler
Cummings John Napolitano
Danner Johnson, E. B.
Davis (FL) Jones (OH) Oberstar
Davis (IL) Kanjorski Obey
DeFazio Kaptur Olver
DeGette Kennedy Ortiz
Delahunt Kildee Owens
DeLauro Kilpatrick Pallone
Deutsch Kind (WI) Pascrell
Dicks Kleczka Pastor
Dingell Klink Payne
Dixon Kucinich Pelosi

Peterson (MN) Scott
Phelps Serrano
Pickett Sherman
Pomeroy Shows
Price (NC) Sisisky
Rahall Skelton
Rangel Slaughter
Reyes Smith (WA)
Rivers Snyder
Rodriguez Spratt
Roemer Stabenow
Rothman Stark
Roybal-Allard Stenholm
Rush Strickland
Sabo Stupak
Sanchez Tanner
Sanchez Tauscher
Sandlin Taylor (MS)
Sawyer Thompson (CA)
Schakowsky Thompson (MS)

NOES—220

Aderholt Gillmor
Archer Gilman
Armey Goodlatte
Bachus Goodling
Baker Pitts
Ballenger Graham
Barr Granger
Barrett (NE) Green (WI)
Bartlett Greenwood
Barton Gutknecht
Bass Hansen
Bateman Hastings (WA)
Bereuter Hayes
Biggett Hayworth
Bilbray Hefley
Bilirakis Herger
Bliley Hill (MT)
Blunt Hilleary
Boehlert Hobson
Boehner Hoekstra
Bonilla Horn
Bono Hostettler
Brady (TX) Houghton
Bryant Hulshof
Burr Hunter
Burton Hutchinson
Buyer Hyde
Callahan Isakson
Calvert Istook
Camp Jenkins
Campbell Johnson (CT)
Canady Johnson, Sam
Cannon Jones (NC)
Castle Kasich
Chabot Kelly
Chambliss King (NY)
Chenoweth-Hage Kingston
Coble Knollenberg
Coburn Kolbe
Collins Kuykendall
Combust LaHood
Cook Largent
Cooksey Latham
Cox LaTourette
Crane Lazio
Cubin Leach
Cunningham Lewis (CA)
Davis (VA) Lewis (KY)
Deal Linder
DeLay LoBiondo
DeMint Lucas (OK)
Diaz-Balart Manzullo
Dickey McCollum
Doolittle McCrery
Dreier McHugh
Duncan McInnis
Dunn McIntosh
Ehlers McKeon
Ehrlich Metcalf
Emerson Mica
English Miller (FL)
Everett Miller, Gary
Ewing Moran (KS)
Fletcher Morella
Foley Myrick
Fossella Nethercutt
Fowler Ney
Franks (NJ) Northup
Frelinghuysen Norwood
Gallely Nussle
Ganske Ose
Gibbons Oxley
Gilchrest Packard
Paul

NOT VOTING—2

Scarborough

Thurman
Tierney
Townes
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

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
Terry
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

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

Souder	Thomas	Watts (OK)
Spence	Thornberry	Weldon (FL)
Stearns	Thune	Weldon (PA)
Stump	Tiahrt	Weller
Sununu	Toomey	Whitfield
Sweeney	Upton	Wicker
Talent	Vitter	Wilson
Tancredo	Walden	Wolf
Tauzin	Walsh	Young (AK)
Taylor (NC)	Wamp	Young (FL)
Terry	Watkins	

NAYS—205

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

NOT VOTING—2

McKinney	Scarborough
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□ 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 equipment, 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.