

cians, although the legislation it amended was never considered on the House floor. House Resolution 30, which has the same goal, now has the bipartisan support of 115 Members of Congress. I urge my colleagues to join with us in expressing our support for designating ob-gyns as primary care physicians.

TARGETED INDIVIDUAL HEALTH INSURANCE REFORM ACT

HON. HARRIS W. FAWELL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mr. FAWELL. Mr. Speaker, yesterday, I introduced H.R. 996, the Targeted Individual Health Insurance Reform Act of 1995, under which access to coverage will be expanded for individuals. Joining me as original cosponsors were Representatives BILL GOODLING, TOM PETRI, MARGE ROUKEMA, CASS BALLENGER, PETE HOEKSTRA, BUCK MCKEON, JAN MEYERS, JIM TALENT, JAMES GREENWOOD, TIM HUTCHINSON, JOE KNOLLENBERG, LINDSEY GRAHAM, DAVE WELDON, and DAVID MCINTOSH.

A section-by-section analysis of H.R. 996 follows:

TARGETED HEALTH INSURANCE REFORM IN THE INDIVIDUAL MARKET SUMMARY

This legislation providing individual market reforms presents a well-targeted and workable framework within which incremental health insurance reform can be enacted this year.

The bill contains targeted but important elements of health insurance reform in the individual market including non-discrimination, portability, renewability, utilization review, and fair rating standards.

WHAT THE TARGETED HEALTH INSURANCE REFORM BILL DOES

New protections and freedoms for workers in a mobile workforce

Portability and limits on preexisting conditions under health plans helps eliminate job-lock (e.g. if an employee once chooses insurance coverage they do not have to again satisfy a preexisting condition as long as some form of coverage is continued, whether obtained in the individual market or otherwise).

Insurers and multiple employer plans must guarantee the renewal of health coverage.

Let the market roar: Increased health plan competition means more affordable choice of coverage

State benefit mandates are limited.

State anti-managed-care laws are restructured and, instead, uniform standards are encouraged.

Buyer cost awareness is encouraged through Medisave plans.

Access to fully-insured coverage expanded for individuals

Insurers must open their individual markets to all eligible buyers.

then purchase health insurance coverage, nor does it restrict their choice of coverage (in fact, it will help expand their choice).

It does not impose mandates that result in lost wages and lost jobs.

It does not require any new federal spending or new taxes.

It does not have unfunded state or local mandates.

It does not have price controls or impose government-prescribed health care budgets that would lead to rationing or lower quality of care.

It does not establish a government-run health care system, nor does it create a massive bureaucracy.

It does not impose a single, one-size-fits-all, national benefits package determined by the government.

Title II

Subtitle A—Increased availability and continuity of health coverage for individuals

The purpose of this subtitle is to expand access to affordable health coverage for individuals and their families and to help eliminate job-lock and the exclusion of such individuals from coverage due to preexisting condition restrictions.

Part I—Nondiscrimination, Portability, Renewability, and Plan Participation Standards

Sec. 2001.—Nondiscrimination and limitations on preexisting condition exclusions.

Sec. 2002.—Portability.

These sections limit preexisting condition restrictions under all general health insurance coverage offered in the individual market. This section provides that a child who is covered at birth or adoption and remains covered shall not be considered to have a preexisting condition at the time of birth or adoption.

The provisions will help end job-lock and help assure continuous availability of health coverage for both the employed who lack access to employer coverage as well as non-employed individuals by prohibiting preexisting condition restrictions for those who are continuously covered. Coverage is considered “continuous” as long as any lapse in coverage is not longer than 3 months. Generally, plans may not have more than a 6/12 preexisting exclusion (i.e. treatments or diagnoses in the 6 months prior to coverage could be excluded from coverage for up to 12 months). Insurers in the small group market can also offer 12/12 coverage.

Sec. 2003.—Requirements for renewability of coverage.

This section prohibits health insurance coverage offered by insurers from being canceled or denied renewability except for reasons of: (a) nonpayment of premiums, (b) fraud or misrepresentation, (c) noncompliance with plan provisions, and (d) certain other conditions.

Part 2—Encouragement of Private Standards Setting Organizations for Provider Networks and Utilization Review

Sec. 2011.—Encouragement of private standards setting organizations for provider networks.

Sec. 2011.—Encouragement of private standards setting organizations for utilization review.

notification and review regarding the termination of providers from a network, and (4) conditions relating to utilization review, including timely review and provider participation in such decisions.

Part 3—Requirements for Insurers Providing Health Insurance Coverage in the Individual Market

In general, the purpose of this Part is to expand access to health insurance by making private health insurance coverage marketed to individuals more affordable and available.

Sec. 2021.—Requirements for insurers to offer general, catastrophic, and Medisave coverage in the individual market.

This section provides for the availability of health insurance coverage to eligible individuals from those insurers who sell health insurance in the individual health insurance market. Insurers would be required to open their general coverage market to individuals and to offer a catastrophic plan with higher cost-sharing provisions (unless the insurer is an HMO or does not otherwise offer fee-for-service coverage). Insurers may also offer a Medisave plan that includes catastrophic coverage with an integrated family medical savings account. Among the general policies offered must be a fee-for-service option, a managed care option, and point-of-service option, but only if these are made available by the insurer under other policies of insurance.

The extent to which an insurer may offer or deny coverage with respect to an individual who would be expected to incur disproportionately high health care costs is contingent on the establishment of risk adjustment mechanisms, high-risk pools, or other mechanisms. The suggestions of the NAIC, actuaries, insurers, and other experts are solicited so that a workable framework can be developed in this complex area.

Sec. 2022.—Use of fair rating, uniform marketing materials, and miscellaneous consumer protections.

Under this section, insurers must use fair rating standards in setting initial and renewal premiums in the individual market. In general, premiums may vary for age, geographic area, family class, and administrative category for a particular benefit design.

When the fair rating standards are first effective, the premiums of two individuals having similar demographic characteristics cannot vary by more than 100% based on initial underwriting factors. Other rules apply in subsequent years. This rule and the permitted one year surcharge for coverage containing the less restrictive 6/12 preexisting condition clause will help insulate the currently insured from the premium “sticker shock” which could otherwise result from more restrictive rules. Suggestions as to the extent to which this 100% variation may be reduced over time without reducing coverage are solicited from the NAIC and other interested parties.

Subtitle B—Establishment of standards; enforcement

Sec. 2101.—Establishment of standards applicable to insurers offering health insurance coverage in the individual market.

NAIC. States that voluntarily elect to implement such standards have the exclusive authority to enforce such standards as they apply to insurers.

Pursuant to the preemption provisions under Section 2103, a state may not establish or enforce standards applicable to insurers which are different than the nationally uniform standards under this subpart. Certain state benefit mandates and anti-managed care laws are also preempted under the bill.

Sec. 2104. Effective date.

In general the requirements of the bill apply on January 1, 1998 with regard to insurers offering health insurance coverage in the individual market.

UNITED NEGRO COLLEGE FUND
[UNCF]

HON. CARDISS COLLINS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mrs. COLLINS of Illinois. Mr. Speaker, a week ago I delivered the keynote speech at the Second Annual United Negro College Fund Banquet Fundraiser given by the Alliance of Telecommunication Employees' metro area chapter, where this year's theme was "The Future Is Yours * * * Black History Evolves Through Education and Diversity."

This theme underscores what I believe to be the mission for all colleges and universities, not just our heritage-rich historically Black colleges and universities, and that is providing deserving, qualified students an opportunity for a quality education at a reasonable price.

However, during the month of February, Black History Month, this occasion allowed me a moment to highlight just some of the many accomplishments—or miracles, if you will—of the United Negro College Fund.

For example, in just 50 short years, the United Negro College Fund [UNCF] is responsible for: Graduating 33 percent of the African-American students who attend college; helping to fund 41 historically Black colleges and universities; graduating in real numbers over 250,000 predominantly African-American students; and raising over \$1 billion to help deserving students further their education.

UNCF distinguishes itself from all others because UNCF provides a hand and not a hand-out.

UNCF plays a critical role for persons with low income and socioeconomic level and those otherwise financially disadvantaged.

We are battling a noncaring, do-it-yourself, and an I-don't-care Government. This is exemplified by passage of the so-called Contract With America legislation by House Republicans and conservative Democrats bent on killing such things as education grants and loans at decent interest rates, and eliminating funding for Medicare, Medicaid, and so on.

There are efforts under way designed to have a negative effect on the quality of life

TON: RETURN CRIME FIGHTING
TO CRIME FIGHTERS

HON. DONALD A. MANZULLO

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mr. MANZULLO. Mr. Speaker, this week, the House restored maximum crime fighting power to the people who best know how to use it—the men and women who make up the ranks of our local law enforcement. Broken down into six parts, the cornerstone of the GOP crime bill is the Local Law Enforcement Block Grants Act of 1995. This measure directly grants money to local communities based upon a formula which takes into consideration population and violent crime rate. Once the community receives the grant, it can decide how it wants to allocate the funds; for more cops, court personnel, prevention programs, etc. If it chooses to do so, it can spend all the money on cops or on prevention. The point being that the needs of the communities in McHenry County are different than the needs of New York, Los Angeles, or Detroit.

The second major provision of the Republican crime bill is the Violent Criminal Incarceration Act. This legislation allocates \$10.5 billion in prison construction funds to States that enact or make significant progress toward truth in sentencing in their corrections programs. Truth in sentencing will require violent criminals to serve 85 percent of their sentences. This measure is about protecting the American people. In Illinois, 46 percent of inmates released from prison are back in prison within 3 years.

In 1980, Illinois released 21,000 prisoners 3 months before the completion of their sentences, solely for the purpose of saving money. The State saved \$60 million; however, those prisoners committed 23 murders, 32 rapes, 262 acts of arson, 681 robberies, 2,472 burglaries, 2,571 assaults, and 8,000 other crimes in 3 months following their release. By requiring inmates to serve more of their sentence, fewer will be able to revictimize society.

When a judge sentences a criminal to 20, 30, or 40 years, that sentence should be carried out. What will it cost to keep criminals locked up? In 1992, the U.S. Department of Justice reported that the average criminal, if not detained, costs society \$171,566 per year in direct injuries to victims and direct costs such as lost jobs, sales taxes, and educational opportunities. Some of the costs associated with reincarcerating criminals include \$26,000 for treatment of a gunshot wound, \$2,711 to cover the cost of each criminal investigation, \$700 for pretrial detention, and \$1,205 for prosecution, defense, and court cost for each felony case.

The annual cost of keeping a criminal in prison is \$16,000.

The GOP crime bills also included the Effective Death Penalty Act which will dramatically

used to reimburse the victim for necessary child care, transportation, and other expenses incurred while participating in the investigation or court proceedings. This law will also allow, but not require, the courts to order restitution of any person who was harmed physically, emotionally, or financially by the unlawful conduct of the defendant.

Last year, the Democratic-controlled 103d Congress passed a crime bill that told local law enforcement agencies that Washington knows best when it comes to their needs in fighting crime. The House of Representatives in the 104th Congress has reversed this arrogance. These amendments to last year's crime bill put crime fighting power back in the local agencies and tells Washington to get out of the way. It is time that victims of crimes are served. It is time criminals are punished swiftly and serve out their sentences.

Mr. Speaker, it is time that bureaucrats in Washington realize that they are not crime fighters.

TRIBUTE TO DR. HERBERT L.
CARTER

HON. JULIAN C. DIXON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mr. DIXON. Mr. Speaker, I am privileged to have this opportunity to salute my good friend Dr. Herbert L. Carter on the occasion of his retirement as president and chief executive officer of the United Way of Greater Los Angeles. Herb's retirement, effective February 27, 1995, will be short-lived. In fact, he is only reshifting his energies and focus. He will return to the California State University system as a trustee professor on the campus of Los Angeles State University at Dominguez Hills.

As head of the United Way of Greater Los Angeles, Dr. Carter provided leadership and management direction at a time when philanthropy to the organization was sorely tested. He directed a staff of approximately 200 individuals and managed a budget in excess of \$60 million.

Dr. Carter guided the organization through two especially difficult periods. First to occur were the civil disturbances of 1992 and second, the Northridge/Los Angeles earthquake of 1994. Both of these catastrophes placed severe strains on the many organizations that depend on the United Way for funding. Through his tenacity and fund-raising acumen, however, the United Way of Greater Los Angeles not only confronted the disasters, but prospered in its efforts to continue providing funding for its member organizations.

Five years ago, I had the pleasure of introducing my colleagues to Dr. Herbert L. Carter. The occasion was a history-making one as Herb stood poised to become the first African-American chairman of the board of directors of