

1981. During this time, it has become routine for agencies to address the issues covered in those Executive Orders; however, the public rulemaking notices published in the Federal Register often do not reflect clearly the agency's rationale for the rulemaking action, and the agency discussions of proposed and final rules, contained in the Federal Register "Preamble" to the substance of the rule, are highly inconsistent in format and depth of information, making it difficult for the public to understand the basis for the rule and how particular issues were addressed. Often, such information might exist, but it is not summarized in the Federal Register notice, but is contained in an agency docket or other files, where it is generally inaccessible to all but the most knowledgeable and Washington-based individuals. In other words, the current rulemaking information presentation system is not "user-friendly" for the public.

The proposed bill would address this matter by requiring the Office of the Federal Register to establish a uniform format for Federal agency rulemaking that would make clear how an agency addressed certain issues that are commonly addressed in rulemaking and which are covered in the regulatory Executive Order. If a particular issue was not relevant for an individual rulemaking, presumably the agency would simply put "not applicable" under that subject heading in the Federal Register notice.

This should not make more work for agencies; in fact, it should reduce effort for all concerned, particularly our citizens.

One provision would call for some additional effort, but it would be minimal. The "Public Notice" section of the proposed legislation (Sec. 4) would establish certain reporting requirements for agencies regarding number of rules promulgated and reviewed by OMB each year. The purpose of this is to allow Congress to track the level of regulatory activity from year to year.

I urge my colleagues and the American public to support this legislation.

TRIBUTE TO CARL S. SMITH

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 31, 1998

Mr. GREEN. Mr. Speaker, I rise today to reflect on the passing of an outstanding man, a legendary Houstonian, and a great Texan, Carl S. Smith, who died this week at the age of 89. Carl served 51 years as Harris County's Tax Assessor and Collector. Mr. Smith served the citizens of Harris County with distinction and honor.

Carl was a legend in Harris County politics. He was first appointed to the office by the Harris County Commissioners Court in 1947. The next year, he won election to the office and was re-elected 12 times.

Well liked and respected, Mr. Smith was revered by many of his employees. He was always known for insisting, from his staff, on unwavering courtesy to the public. He expected much of this staff, but he treated them kindly and with respect.

Carl had a real interest in helping all people. In 1952, he was the first Harris County official to promote an African-American employee to an important government position, a deputy

clerkship. In addition, he wrote the statewide property tax exemption for citizens over 65 that was later adopted as a constitutional amendment.

Carl's wife of 59 years, Dorothy DeArman Smith, died in 1991. They were parents of two daughters, Nancy Stewart and Pam Robinson, both of Houston.

Mr. Speaker, I ask all the Members of the House to join me in offering their gratitude for the hard work and dedication of Carl S. Smith.

AUTHORIZING VA HEALTH CARE FOR VETERANS EXPOSED TO NASOPHARYNGEAL RADIUM IRRADIATION THERAPY—H.R. 4367

HON. LANE EVANS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 31, 1998

Mr. EVANS. Mr. Speaker, today I am introducing legislation to authorize the Department of Veterans Affairs to provide health care treatment to veterans exposed to Nasopharyngeal Radium Irradiation Therapy (NRIT) and to include these veterans in its Ionizing Radiation Registry (IRR) Program. Joining me as original co-sponsors of the bill in the House are Representatives BOB FILNER, COLLIN PETERSON, CORRINE BROWN, FRANK MASCARA, BARBARA LEE, LUIS GUTIERREZ, CIRO RODRIGUEZ, JULIA CARSON, NEIL ABERCROMBIE, and JOSEPH KENNEDY. The measure I am introducing today is similar to legislation submitted to Congress by the Administration and closely reflects S. 1822, as introduced by Senator SPECTER and cosponsored by most of the members of the Senate Veterans Affairs' Committee: Senators THURMOND, JEFFORDS, MURKOWSKI, ROCKEFELLER, AKAKA, WELLSTONE, LIEBERMAN, and MURRAY.

During the 1940's to the 1960's, many submariners and air crew members were occupationally exposed to NRIT to prevent ear injury. The Centers for Disease Control has estimated that as many as 20,000 service members may have received this treatment. Treatment was not limited to service members. This therapy was prevalent among civilians and was even used to treat children. Studies have found statistically significant associations between exposure to this therapy as a child and development of certain head and neck cancers. Associations between health outcomes and adult exposure to therapy are less clear, but poor recordkeeping on the use of this treatment may not allow new studies to determine definitive associations within the veteran population and previous studies have been flawed.

VA has noted that the high levels of exposure among treated individuals may call for special consideration of this population. Exposure to radiation during nasopharyngeal treatments was greater than the exposure of many of the veterans who already populate VA's IRR. Given the high incidence of exposure to this therapy for occupational purposes among the veteran population, the relatively high levels of exposure these individuals were subjected to, and the scientific evidence that exists, the Administration requested that Congress authorize these veterans' treatment in VA medical facilities. It is time to give the veterans who received NRIT treatments—many

of whom did so involuntarily—the benefit of the doubt. It is time to allow VA to treat them and the conditions it believes may be linked to this exposure and add them, along with other veterans who were exposed to far lower levels of radiation, to its registry. This is a responsible bill—and it's the right thing to do.

I urge my colleagues to sign on as a cosponsor to this important legislation.

PATIENT PROTECTION ACT OF 1998

SPEECH OF

HON. HARRIS W. FAWELL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 24, 1998

Mr. FAWELL. Mr. Speaker, I would like to take some time to talk about some "good news" in the area of private health care. So often, the news media and Congress will tend to center on what's wrong with private health care and ignore the many good things that have happened, and are happening in private health care.

For instance, let us recognize that about 132 million people in America are getting their health care in the private market via employer provided health care under the ERISA statute! About 80 million of these people are receiving their health care from their employers under self-insured health plans, that is, where the employer is acting as their own insurance company, so to speak. Here, we are talking about fee for service plans, PPOs and variations of managed care. But under these self-insured plans, in general the employer does not pay "premiums" or transfer the obligation to pay benefits to an insurance company or HMO. Instead, the employer takes the place of the insurance company and may even contract directly with hospitals, doctors, other providers and health care networks. The market dynamics of these arrangements help to bring the price of health care down. Most of the large corporations in the United States use this method to supply health coverage to their employees. The remainder of the 132 million people who receive their employer provided health insurance from their employers do so under standard indemnity insurance policies, HMO contracts or other forms of fully-insured health insurance coverage purchased by their employers. With the exception of governmental plans, all private employer provided health coverage plans are under ERISA, although indemnity health insurance policies and HMO policies (referred to as "fully insured" coverage, as opposed to "self-insured" coverage) are subject to regulation by the states. That is, while the employer provided plan (i.e. the employer benefit plan consisting of medical care) is always under ERISA, in those instances where an employer buys an indemnity or HMO policy for his employees, the states control the issuance, make up and conditions of the policies themselves.

The important point, however is that the employers of America, under the ERISA statute are voluntarily providing health insurance coverage for their employees. There is no law requiring employers to finance health care, fully or partially, for their employees. ERISA, insofar as health care is concerned, has functioned over the years—especially in the area of self-insurance—with relatively little interference from either federal or state laws. It is

a rare oasis of freedom, representative of neither federal or state power. It is, rather, a relatively unique example of "people power", because it is the employer and the employees and unions, who collectively determine what kind of health care coverage should be provided for the employees, and how the plan will operate. The employer makes no profit from his involvement in health insurance as does the indemnity insurance company or HMO. It is a not-for-profit health insurance obligation that is assumed voluntarily by the employer. And, yes, state law is pre-empted, in general, insofar as the administration of an employee health benefit plan by an employer is concerned and that, I think, reflects the genius of the drafters of ERISA. As a result, employers have, over the years, been able to create lower cost and high quality health plans for their employees without having to readjust to the laws and regulations of the various states in which the employer's business may be involved or in which an employee may reside. Business people, of course, must be involved wherever the flow of their commerce may take them. They cannot very well be expected, in setting up health or pension programs for their employees, to readjust these programs to meet the laws, mandates, regulations price controls and standards of the various states which the flow of their commerce mat take them. Indeed, it was this recognition which, in 1974, resulted in the creation of ERISA and the necessity for the uniformity of federal law relative to employee benefit program.

As a result, the administration of employer health benefit plans, under ERISA, was able to flower in a unique area of relative freedom, unimpeded by the regulation of the 50 states (with the exception of the states' regulations of health insurance policies per se). And, over the years after ERISA, the Congress has also restrained itself from micromanaging ERISA employer provided health care, although I will admit there are increasing signals that this era of enlightenment may be changing. Indeed in this environment employer provided health care—especially self-insured plans—have been eminently successful. The result has been the 132 million people who now secure private employer provided health care under ERISA. In addition, an estimated 33 million people also receive employer provided health care, outside of ERISA, from state and local governments as well as under the Federal Employee Health Benefit Act.

I find it troublesome, therefore, to hear so many of my colleagues talk with levity and disapproval of ERISA preemption, as though it stands as a mortal threat to states' rights. They seem totally unaware of the tremendous success of ERISA in motivating employers to provide health care and pensions for their employees. Rather than decry an alleged loss of "states' rights", I prefer to recognize that a major cause for the creation of our Nation's Constitution was the need for commerce to flow between the various states unimpeded by conflicting state taxes, laws, regulations and requirements. If Congress should now become hostile to ERISA and its preemption clause at this late date, and if employers are told that their employee benefit plans, including health care plans, can no longer flow with their commerce without meeting hundreds and thousands of conflicting state laws, taxes and regulations, then multiple millions of workers and their families will be in for a rude surprise as

employers began to opt out of their sponsorship of employee health care plans. That, indeed, would invite a political upheaval that would make the Medicare Catastrophic Health Insurance debate of a few years ago look like a passing inconvenience.

The need for broad preemption is clearly explained in testimony by Mr. Frank Cummings, then Senate Labor Committee Minority Counsel and an adviser to Senator Javits, who helped fashion a predecessor of the ERISA law. Speaking of the law prior to ERISA, he stated "The inherent limits of state jurisdiction made the system unworkable, and often did more harm than good. Technical problems in enforcing benefit rights were often unsurmountable under state laws. Those hurdles included: inability to achieve service of process on necessary parties outside the boundaries of a single state; choice-of-law uncertainty; insufficiency of the law of equity since the real decisions were made by persons who were not defined as 'fiduciaries' (other than the trustee). Interstate businesses could not comply with these laws separately, and yet benefit plans were most effective and efficient if they were company-wide in scope."

ERISA, in my view, was one of finest acts passed by the Congress. It was a law born ahead of its time! It is 21st Century thinking! It gave employers, employees and their representatives the freedom to self-insure and create not-for-profit health care plans for their workers and their families without being subjected to the endless varieties of state micro-management, mandates, price controls, and remedies which otherwise drive up the price of health insurance. And it has worked miraculously well for large and mid-sized employers who had the economies of size to opt for self-insurance. It allowed employers to break away from the monopoly of the regular indemnity insurance companies and HMOs and, on behalf of their employees, to bargain and discount the price of health care directly with both health care providers, including their networks, and insurance companies. Employers and employees were thus allowed to determine for themselves what the price, cost and terms of their health insurance would be, what would be covered, whether preventive care would be emphasized, ad infinitum. In short, they were given the right to operate their own health care plan free from domination of the states and their for-profit allies, the insurance companies and HMOs, and to do so by simply having the employers act as their own insurer or, if they got the right price, to contract with a regular indemnity insurance company after bartering down the price of insurance. Insurance companies and HMOs no longer ruled the roost! The market evolved!

The ERISA statute was born back in 1974 when Congress was blessed with a lot of forward thinking people like Senator Jacob Javits of New York and Congressman John Erlenborn, of Illinois, and a host of others who realized that employers cannot very well sponsor health and/or pension plans or other employee benefit plans if they had to readjust their rules and operations with each of the 50 states. Obviously, commerce needs to flow generally unimpeded over state lines and that surely includes employee health insurance programs operated by employers. The creators of ERISA were well aware of all this. Thus, the concept of pre-empting state laws which "related to" employer provided employee benefit

programs was born! Ahead of its time! Rep. John Dent (D-PA), the House floor manager of the ERISA bill, declared that the broad preemption provision was the "cornerstone" of the legislation.

Mr. Speaker, the ERISA statute has served the nation well in allowing employers to provide health insurance for their employees—especially for large and mid-sized employers! Professor of Law Sallyanne Payton says it well in her presentation to the Conference on Patient-Centered Health Care Reform at the University of Michigan Health Policy Forum held November 21, 1997. "These large employee benefit plans have been the driving forces behind most of the recent innovations in medical service delivery because, being unregulated, they have the power to create their own benefit packages and medical care delivery mechanisms. For example, despite the health policy community's enthusiasm for full-integrated closed-panel HMOs, the employee benefit plans responded to patient dissatisfaction and resistance by inventing the Preferred Provider Organization and have created a market for network-style managed care organizations of many different types. Self-insured employers have been aggressive in the current effort, through, for example, the National Council on Quality Assurance, to develop quality standards and measures and to redesign the quality oversight function."

However, as indicated, small employers who do not have the economies of size and who therefore cannot as easily "self insure", have never had the ability to take advantage of the ERISA statute in providing health insurance for their employees. These small employers, in order to secure health insurance for themselves and their employees, have to go into the small group insurance markets, controlled by health insurance companies or HMOs, who of course do not want new competition in this market. They didn't want it in the large employer insurance market either and were reluctant suitors of ERISA in 1974.

But anyone who has to go out into the small business group health insurance market or even the individual market—alone—knows that affordable health insurance can be difficult to find and even more difficult to hold onto if any chronic illness develops in the family.

Mr. Speaker, the existing "system" of health insurance relative to small employers and the self-employed, controlled by indemnity insurance companies and HMOs which are basically under state jurisdiction, has, in effect, anti-selected its purchasers of health care to the tune of 43 million people who cannot find accessible and affordable health care. It is the disgrace of the private health care system in America and it must change. And it can change by simply allowing small business employers and the self-employed to finally have precisely the same advantages long possessed by large and mid-sized employers. There is nothing so powerful as an idea whose time has come. The idea that small employers and the self-employed should be able to band together in bona fide professional, trade and business associations to give them the economies of scale of large businesses is an idea whose time has come. It

has been held off by fierce opposition of insurers and HMOs who simply fear the same competition they must daily face in the large business group health insurance market. The Association Health Plan provisions are an important and positive answer to the problems challenging the private health insurance market. Millions of the uninsured are hoping that AHPs will become law as a part of the Patient Protection Act of 1988.

I would now like to explain in more detail the rules governing association health plans included under Title I, Subtitle D, the Small Business Affordable Health Coverage Act of 1998.

In effect, the proposal implements a current law provision, which the Administration has failed to invoke, allowing legitimate association health plans (AHPs) to be treated under ERISA preemption in a manner similar to single employer health plans. Only ERISA "group health plans"—sponsored by legitimate associations, franchise networks, church plans, etc. are eligible to voluntarily apply for certification.

Association must be bona-fide. An association sponsor must demonstrate that it is established as a permanent entity with substantial purposes other than sponsoring an AHP, has the active support of its members, and collects dues from its members without conditioning such on the basis of the health status or claims experience of plan participants or on the basis of the member's participation in a group health plan.

AHPs will expand choice of coverage. To be certified, AHPs must allow plan participants to choose at least one option of fully-insured "health insurance coverage" offered by a health insurance issuer and may also offer non-fully-insured options—such as those found under the plans of large employers like CBS, Inc, the New York Times, the Washington Post Co., Gannett, Dow Jones Co., etc.—only if the plan meets strict solvency provisions.

AHPs will expand portability. Employees would be more likely to have true portability of coverage, since employees and the self-employed tend to stay in the same occupation or industry.

AHPs improve affordability. AHPs can better reach small businesses and the uninsured with more affordable and accessible health benefit options by removing regulatory barriers—plans are freed from costly state mandated benefits and given flexibility to offer coverage that employees want and employers can afford, including uniform benefits across state lines; plans can achieve administrative economies-of-scale and join with coalitions of other ERISA plans to negotiate more cost-effective and high quality services from providers and insurers; costs of coverage can be allocated to employers in a nondiscriminatory manner based on plan experience (an employer cannot be singled out for higher contributions just because they are in a particular type of business or have higher claims experience); in general, AHPs are nonprofit entities that can deliver more benefits for the contribution dollar by also improving cash flow and earning investment income on reserves.

AHPs are subject to consumer protections. AHPs are subject to strict sponsor eligibility, nondiscrimination, fiduciary, financial, reporting, disclosure, solvency and plan termination standards. Also, AHPs are already subject to the portability, preexisting condition, non-

discrimination, special enrollment, and renewability rules added to ERISA under HIPAA. AHPs offering options that are not fully-insured are subject to actuarial reporting, reserve, mandatory stop-loss insurance and mandatory solvency indemnification standards to ensure participants against loss of promised benefits. The standards are enforced by the states with a federal backup.

AHPs offer guaranteed coverage. AHPs must offer coverage to all employer and self-employed members and cannot condition coverage on the basis of employee health status, claims experience, or the risk of the employer's business. AHP sponsors must be established for at least 3 years for substantial purposes other than offering health insurance.

Subtitle D stops insurance fraud. The Department of Labor Inspector General testified that the enforcement provisions will help stop health insurance fraud perpetrated by "bogus unions" and other illegitimate operators by making legitimate association plans accountable and adding new civil and criminal tools to end fraudulent schemes.

Under Subtitle D, bona-fide Association Health Plans offering benefit options that do not consist solely of fully-insured health insurance coverage (i.e. self-insured options are available) will be subject to strict new solvency protections as follows.

An AHP must remain a qualified actuary on behalf of plan participants.

AHPs must maintain cash reserves sufficient for unearned contributions, benefit liabilities incurred but not yet satisfied and for which risk of loss has not been transferred, expected administrative costs, any other obligations and a margin for error recommended by the plan's qualified actuary. The reserves must be invested prudently and be liquid.

In addition to the cash reserves, AHPs must maintain capital surplus in an amount at least equal to \$2,000,000 reduced in accordance with a scale, to not less than \$500,000, based on the level of aggregate and specific stop loss insurance coverage provided under the plan.

AHPs must secure coverage from an insurer consisting of aggregate stop-loss insurance with an attachment point not greater than 125% of expected gross annual claims and specific stop-loss insurance with an attachment point of up to \$200,000 as recommended by the qualified actuary.

AHPs must also obtain non-cancelable and guaranteed renewable indemnification insurance. To prevent insolvency, the indemnification insurance would pay for any claims that a plan is unable to satisfy by reason of a termination of the plan.

To ensure that the indemnification insurance will always be available to pay all unpaid claims upon plan termination, AHPs are required to make annual payments to an AHP Account which would be used only in the unlikely event that a terminating plan is in need of funds to avoid a lapse of the required indemnification insurance. These solvency protections apply to AHPs in every state, whereas the solvency guaranty fund protection for fully-insured options by HMOs and Blue-Cross/Blue-Shield organizations are only available in six states and 25 states respectively.

To ensure that the solvency standards are uniform, negotiated rulemaking is used to receive the advice of the National Association of Insurance Commissioners, the American

Academy of Actuaries, and other interested parties.

States would enforce the AHP solvency and other standards with a federal backup if the state of domicile of an AHP does not choose to enforce such standards. States will have more authority to put an end of health insurance fraud. If an entity cannot show that it is either licensed by the state or is certified as an APH, then the state can shut down the entity. To the extent the entity flees a state's border, the Department of Labor is directed to assist the state to shut the entity down through new "cease and desist" authority. Illegal entities become subject to criminal penalties if they try to hide their operations.

IN TRIBUTE

SPEECH OF

HON. CHARLES H. TAYLOR

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 28, 1998

Mr. TAYLOR of North Carolina. Mr. Speaker, it's said that tragedy can bring us together and result in stronger bonds than existed before. The tragic deaths of Officers Chestnut and Gibson have brought a most heartfelt expression of the appreciate we all have for the heroic efforts of not just Officers Chestnut and Gibson, but all of our law enforcement officers throughout the nation.

Sue Stover Gaither, a volunteer chaplain with the Asheville, North Carolina Police Department was asked to sing at the Department's Annual Awards Banquet. Sue asked her brother, Jim to write a song meaningful 'just for them.' Sue made a special effort through my office to share a recording of "Heroes in Blue," with the Chestnut and Gibson families; noting in her letter to the families, that while the title of the song is "Heroes in Blue," it was written and is performed in appreciation of all law enforcement officers, no matter what color their uniform or department in which they serve.

Mr. Speaker, I am proud to share the lyrics of "Heroes in Blue," by Jim Stover.

HEROES IN BLUE

To the footsoldier faithfully pounding the beat

The one in the blue and one cruising the street

Laying your life on the line, protecting mine
There's always somebody who's breaking the rules

Thugs in the alley and drugs in the schools
In a war that never ends, you hold the line

Chorus: To every hero dressed in blue
Thank you all for everything you do
Each and everyday you risk your lives
And that makes you a hero in my eyes
And when we fail to acknowledge the good deeds you do

It may be that many are known to only a few
You keep the faith, you fight the fight
You teach the kids that right is right
Into the dark, you bring some light

Footsoldiers pounding, blue and whites
cruising

Good guys are winning, bad guys are losing
Almighty God is on your side!

Chorus: To every hero dressed in blue
Thank you all for everything you do
Each and everyday you risk your lives
And that makes you a hero . . .