

Now, USDA's final rule proposes Class I differentials that would be "flatter." Across all orders, differentials would average 29 cents a hundredweight less than existing levels.

The so-called make allowances would be raised for plants making butter and cheese under federal order jurisdiction. The intent is to make federal order plants more competitive with those in California which operate under higher make allowances. But there is only so much value in a hundredweight of milk. Boosting margins for plants leaves less money to pay producers.

The National Milk Producers Federation estimates that dairy farmer income in federal orders would have averaged \$196 million a year less during the past five years had USDA's final rule been in effect. That figure may be inflated somewhat as it does not include overorder and other premiums that would be paid. Still, we're talking about less money in dairy farmers' bank accounts.

Having said this, let's remember that much has changed during the past two years since the Farm Bill was passed. Feed grain and wheat prices have been in the pits. The pork picture needs no explanation. Beef prices are stagnant, at best. And our milk prices soared to record highs, followed by the lowest level in eight years. In short, today's ag policy environment is much different than it was just two years ago.

Accordingly, the medical motto "First, do no harm" comes to mind. Federal milk orders are put in place for dairy farmers, to be approved by dairy farmers. While the order proposal addresses some pricing aberrations, we can't be expected to embrace a plan that reduces income for this high-capital, low-margin, physically-demanding business of producing milk.

Rather than market orientation, we should be concerned about the nearly 8,000 families that sold their cows during 1998, many because they couldn't make ends meet. Rather than global competitiveness, we should be concerned that the highest milk prices ever (1998's average mailbox price was \$15.05) were well under the total economic cost of production in five of six regions of the country, according to USDA analysis.

Congress is to react to the reform plan by early summer. There will be heated debates on divisive issues, such as differentials and make allowances, both within and beyond the Beltway. Dairy farmer leaders from across the country need to put aside regional differences and bring to Washington a unified voice that asks for best possible price for all dairy farmers.

#### SUPPORT THE DEMOCRATIC PATIENTS' BILL OF RIGHTS

The SPEAKER pro tempore (Mrs. NORTHUP). Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Madam Speaker, this evening I would like to talk about two significant health care issues that the Democrats have made a major thrust, if you will, of their agenda for this Congress. One is the Patients' Bill of Rights, which is our HMO reform, our patient protection reform; and the second one is the effort that was announced today by President Clinton at the White House to modernize and

strengthen Medicare and, most importantly, to provide a prescription drug benefit for all Medicare recipients for the first time.

As Members know, when Medicare began in the 1960s under President Johnson, there was not a prescription drug benefit. As part of the effort to modernize Medicare and strengthen Medicare, the President today went far towards coming up with a prescription drug benefit that I think is a wonderful way for this Congress to show that it really does care about our senior citizens.

Let me start this evening by talking a little bit about the Patients' Bill of Rights. I have said over and over again on the floor of the House of Representatives, both this session and previous sessions, that the most important issue, the issue that I hear the most from my constituents about and the issue that I think our constituents feel we should address immediately, is reforming HMOs. Because so often Americans who have managed care, whose insurance policy is essentially a managed care or HMO type of policy, find that there is not adequate protection under the law for them to receive quality care when they need it.

The horror stories have been recounted many times about Americans who need a particular operation and are told that the HMO will not pay for it or need a particular type of equipment and are told that the HMO does not cover that or who need to go to an emergency room and want to go to the closest one nearby to where they live or where they happen to be hurt and are told that they cannot go to that emergency room because that particular hospital does not come under the HMO plan. All we are seeking to do with the Patients' Bill of Rights is to provide sufficient protections, what I call common-sense protections under the law, under Federal law, that get rid of these horror stories.

Essentially, the Patients' Bill of Rights has two focuses. One is to make sure that the decision of what kind of medical care you receive is made by the doctor and the patient, not by the insurance company; and the second focus is that there be an opportunity, if you are denied care by the HMO, that you have some sort of appeal, external appeal, as well as the right to bring suit in court to make sure that your grievance is heard and that that incorrect decision can be overturned if it should be. Those are the two focuses of our legislation.

But there are a number of other things that come up in the context of the Patients' Bill of Rights. I would like to go into a little bit some of the objectives tonight. I say that there are four central objectives of the bill: Patients should have access to needed care, doctors should be free to practice medicine without improper inter-

ference from HMOs and insurance companies, the health plan's decision to deny care can be appealed by patients to an independent entity, and health plans are held accountable for their medical decisions that lead to harm.

Let me get into some of the specifics, because I think that they are important. As I mentioned, patients today face numerous obstacles as they seek access to doctors and needed health care services in the context of managed care. These barriers to quality health care range from managed care companies' refusal to pay for emergency room services without prior authorization to restricting patients' access to specialists.

These are the most important provisions that I am going to go through in the Patients' Bill of Rights that will provide patients with access to the care that they need when they need it.

First, access to emergency room care. The Patients' Bill of Rights allows patients to go to any emergency room during a medical emergency without having to call a health plan first for permission. Emergency room physicians can stabilize patients and begin to plan for poststabilization care without fear that health plans will later deny coverage.

Access to needed specialists. We hear many times about the fact that, under HMOs, patients have been told, "Well, you can't go to a particular specialist." The Patients' Bill of Rights ensures that patients who suffer from a chronic condition or a disease that requires care by a specialist will have access to a qualified specialist. If the HMO network does not include specialists qualified to treat a condition, such as a pediatric cardiologist to treat a child's heart defect, it would have to allow the patient to see a qualified doctor outside its network at no extra cost. And the Patients' Bill of Rights also allows patients with serious ongoing conditions to choose a specialist to coordinate care or to see their doctor without having to ask their HMO for permission before every visit.

Another important provision in our Patients' Bill of Rights is access to an OB/GYN. The Patients' Bill of Rights allows a woman to have direct access to OB/GYN care without having to get a referral from her HMO. Women also would have the option to designate their OB/GYN as their primary care physician.

The other thing, because, as I mentioned earlier, one of the major concerns right now is access to prescription drugs, well, under the Patients' Bill of Rights, it requires that needed prescription drugs be available to patients. Currently, many HMOs refuse to pay for prescription drugs that are not on their preapproved list of medications. As a result, patients may not

get the most effective medication needed to treat their condition. The Patients' Bill of Rights ensures that patients with drug coverage will be able to obtain needed medications even if they are not on the HMO's approved list.

Now, before I go on and talk a little more about the Patients' Bill of Rights, let me stress that what the Democrats have faced in this Congress is the fact that the Republican leadership refuses to bring up the Patients' Bill of Rights. They refuse to have a hearing in committee, they refuse to mark it up in committee, they refuse to bring it to the floor of the House of Representatives. This has been going on now since the beginning of this session, and we faced the same problem in the previous session of Congress.

So what do we do? Well, what we did last week is we started a petition process. There is such a thing as a discharge petition which Members can sign on the floor of the House of Representatives; and if a majority of Members of this House sign the discharge petition, then that forces the Republican leadership to bring the bill to the floor to have a debate, to have a vote, to have the American people see us have the opportunity to vote on this bill.

What we started last week was this petition drive. As of Friday, we had 180 signatures to our discharge petition, all Democrats. We are hoping, though, that we can eventually get some Republicans to join us; and we went through the same process last year in an effort to get the Patients' Bill of Rights to the floor.

I assure my colleagues that over the next few weeks we will do our best to get to that magic number of 218 which will bring the Patients' Bill of Rights to the floor, if we can get that number, and I think we can, because I think there is a huge groundswell, if you will, of public opinion that wants to see this legislation brought to the floor.

Let me just say a few more things about the Patients' Bill of Rights, what the legislation does. I stressed in the beginning this notion that doctors need to be free to practice medicine. Accountants, insurance companies, insurance company bureaucrats, should not be making medical decisions and deciding what type of care you receive. Yet some managed care organizations interfere with doctors' medical decisions and even go so far as restrict open communication between patients and doctors.

I think that most people are surprised to find out that if the HMO does not cover the particular type of procedure or operation that your doctor thinks you need, that the HMO can actually tell the doctor that he or she is not allowed to tell you what that procedure is. It is called a gag rule, because, essentially, the doctor is denied

his or her freedom of speech, their first amendment rights. That is just the most egregious example, and one of the things that the Patients' Bill of Rights does is to prohibit insurers, HMOs, from gagging doctors. But even more important is the idea that the decision about what is medically necessary, what is defined under the insurance policy to be medically necessary, is defined by standards within that particular specialty of care. In other words, right now if you have an HMO and the HMO decides that a particular procedure or a length of stay in the hospital, for example, is not what they want to cover, they will simply say that what is medically necessary for you does not include that.

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They will define what is medically necessary.

What we do in the Patients' Bill of Rights is we say no, the decision about whether a particular cardiac procedure is medically necessary is defined, is made by the board of specialists for cardiology. The decision about whether a child should stay in the hospital, as my colleagues know, a certain number of days or the mother should stay in the hospital a certain number of days after the baby is born is not defined by the HMO, the insurance company, but defined by the specialist for pediatric care or for obstetrics, whatever happens to be that specialty defines what the level of care, what the treatment, what the equipment, what the number of days in the hospital should be.

And that is very important because right now even if your HMO allows you to appeal the denial of care in a particular circumstance, that usually goes to a review board either within or outside the HMO that limits its review to whether or not the insurance policy is allowing you a procedure that they would normally allow. In other words, they allow what is medically necessary themselves, and all that the appeals process can do is to review whether they stood within the confines of their own definition of what is medically necessary.

That is not the way it should be. It should be that those standards are defined by the doctors, by the specialist in that particular area and that that is what is reviewed when it goes to an external review board or when it goes to a court of law, and it is a very important part of all this.

All we want to do is make the HMOs accountable for their actions. Some people have said to me, well, as my colleagues know, if you let an external review take place of whether or not someone should have been denied that particular procedure or if you let that person go to court and have the court decide, as my colleagues know, whether or not that denial of care was appropriate, you are going to have, as my

colleagues know, endless lawsuits and the costs are going to go up and all this kind of thing. Well, none of that is true.

I see my colleague from Texas has joined me tonight, and he has pointed over and over again how Texas has enacted a Patients' Bill of Rights, and none of those concerns about extraordinary costs or a lot of litigation have come true. But what we are really saying is that there has to be accountability, that the HMOs, just like anyone else has to be accountable for their actions, and, if you have an external review process that is independent, that does not have people from the HMO making those decisions, or if you allow someone to go to court to overturn a denial of care or to have someone recover because the care was not provided and they suffered damages, then in the long run the HMO will be more accountable. They will do the right thing from the beginning because they will be fearful that their decision, their wrong decision, will be overturned or that they have to pay damages in a court of law.

So we are not really trying to do anything I think that most people do not already think should be the case, but, unfortunately, it is not the case. And I would point out that what we are seeing now on the Republican side, because I think they understand that this is a major issue and that they cannot keep denying us the opportunity to consider the Patients' Bill of Rights on the floor or in committee is that they have come up with their alternatives, what I call a piecemeal approach.

They have introduced eight different bills to cover some aspects of the Patients' Bill of Rights, but those eight bills are woefully inadequate in terms of the kinds of protections that are needed, they do not look at this problem in a comprehensive way, and most importantly, the Republican bills that are put out there, these eight bills, do not define medical, what is medically necessary in a way that leaves it up to the physician and the patients to make that decision. They essentially leave it up to the HMO, and they do not have any kind of accountability because they do not have an external independent review process and they do not allow you to sue in a court of law.

So we are going to go through this process, we are going to see the Republican leadership trying to say that they are going to do HMO reform, but hopefully our discharge petition will eventually force the Republican leadership to bring the Patients' Bill of Rights to the floor, and then we will have a full debate and a vote on the bill.

I wanted to tonight also go into what happened today at the White House where the President unveiled his plan to modernize and expand Medicare and, of course, the prescription drug benefit that is so important as part of that.

I think my colleague from Texas may have already discussed that to some extent tonight, but maybe what we can do, if I can yield to him, is we can talk somewhat about the Patients' Bill of Rights, and then we can go into the Medicare prescription drug benefit as well because I think it is so important, and I yield to the gentleman from Texas.

Mr. GREEN of Texas. Madam Speaker, I thank my friend from New Jersey for one, requesting this special hour this evening, but also for the announcement yesterday that you are going to continue to serve with us in the House, we hope, and not make that jump over to the other Senate side, and because of your leadership both in our health task force but also on this issue. I think we can use that experience here on this side of the aisle. The air is so rarified over in the Senate anyway, you have to have oxygen over there.

But, Madam Speaker, for months all we have heard is that we cannot pass a Patients' Bill of Rights because it will increase the cost and open employers to unfair lawsuits, both of which will supposedly force employers to drop insurance coverage from their employees. Essentially they are trying to kill meaningful managed care reform with half truths and scare tactics.

The insurance industry, managed care organizations, HMOs and oftentimes even some of the big businesses have repeatedly tried to scare the American people by saying the bill would dramatically raise premiums and force employers to drop health insurance for their employees. Obviously, that is not the furthest thing I would ever want to do and I know every Member of the House would not want to do that.

Some of these special interest groups even suggest that the increase could go as high as a 40 percent increase in premiums, and once they are done spreading that inaccurate number, maybe we really ought to talk about what the bill may cost and even use some real life experience, what has happened in the State of Texas. But even on the Federal level our nonpartisan Congressional Budget Office after thoroughly analyzing each section of the Patients' Bill of Rights determined that the bill would cost beneficiaries only \$2 a month; that is right, the cost of a happy meal at McDonalds. Patients and managed care could have what they really need as fairness and protection in accountability and for \$2 a month. But the news is even better than they want to hear because in my home State of Texas, which passed a Patients Protections in 1997, the State of Texas Patient Bill of Rights included external appeals and accountability and liability sections, and you know the only premium increase that can be attributed is to the higher cost for prescription medication.

There have been increases, but it has been the standard increase whether it is in Dallas or Houston, it has been in San Francisco or Denver or in Washington or New York, anywhere else in the country. There has been no noticeable increase in premiums in the State of Texas since 1997 because of the managed care reform bills. So even the Congressional Budget Office at \$2 a month may be over exaggerating, but again maybe we can afford a happy meal to make sure we get the health care we need.

In fact, in the State of Texas in the outside appeals 50 percent of those appeals are being found in the patients benefit; so in other words, 50 percent of the time if an HMO tells you that is not covered or we are not covering it, they are wrong, and that is what happened in the State of Texas. So again, for \$2 a month or even less I would be more than happy to have an outside appeals process that is really an appeals process. Plus, there has been no mass exodus in the State of Texas for employers that drop health insurance in Texas. What Texas residents do have now is health care protections that they need and they deserve. Provisions included in the Patients' Bill of Rights in the State of Texas should be extended to all Americans and, most importantly, to the 8 million Texans who have insurance policies that come under federal law.

Again, we have many policies in our country that come under State law or Federal law, and no matter if all 50 States pass their own patient protections or the Patients' Bill of Rights, we still have to pass it on the Federal level because of the Federal law and ERISA. These include eliminating gag clauses so that the physicians will be able to communicate freely with their patients. That should not cost a dime except letting the doctors talk to their patients. Open access to specialists for women, children in the chronically ill of patients who will not need to have a referral every time they see a physician. They have to go back to their primary care doctor, and we understand this. A woman, for example, may pick a primary care doctor that is not her OB/GYN, and she should not have to go back to that primary care doctor every time she needs to go to her obstetrician. Same way a person who may be diagnosed with cancer. They should not have to go back to that primary care doctor every time they need a cancer treatment. They should be able to go to their oncologist that is on their list. External and binding appeals process that guarantees patients timely review of questionable decisions.

Again, in the State of Texas 50 percent of the time the appeals have been found for the patient, and 50 percent for the insurance company, and that is great; 50 percent of the time they are wrong, and before this law passed in

Texas, 100 percent of the time they were wrong. It is just that we have found out that half the time they were right. Coverage for emergency care so families will not be required to stop at a pay phone to get pre-authorization because they could go to the nearest emergency care unit that they have and medical necessity for those decisions.

But also, and we heard it last week and we have heard testimony not only in our Committee on Commerce hearing we had, but also in our task force hearing we had last week: If you hold the medical decision maker accountable, if you hold that doctor or that provider accountable, then the person who is telling that doctor how to practice medicine ought to also be accountable, and in the State of Texas again; I hate to keep using Texas as an example, but that is where this has been tried and tested and proven.

There have been no more than three lawsuits anybody knows of filed since 1997; one because the appeals process is working. Patients only want to have the health care that they pay for, and so if they get it and then plus if they are ruled against half the time, then they are probably not going to go hire them a lawyer because the facts are already out there, and they know what reason was made for not having the health care that they expected they should have.

Instead they recognize the affordability and the value of the Patients' Bill of Rights. I am sorry to hear that our Republican leadership continues to push with sometimes half fixes and even loopholes. To be honest, I am not so sure I have been convinced that the leadership seriously wants to pass a managed care reform bill that truly protects patients with some of the things I have heard the last few weeks.

Certainly their actions to date have not given us any reason that they will, but I do think they would have compassion to bring a bill up on the floor so we can debate it here on the floor just like we are doing tonight. If our ideas do not have the majority vote, then so be it. That is the democracy and the American system. But we need to have, the American families need to have, the protections, and we ought to debate it openly here on the floor of the House, and whether it takes, as my colleagues know, 1 hour or 10 hours we ought to have that time here for the most important health care bills that will come along maybe in our lifetime.

Unfortunately that is not the case. Last year's floor consideration, as Members of the Committee on Commerce, we did not even have, were unable to consider the bill that came up here on the floor, was actually drafted in the Speaker's office, and we had one chance to mend it, one chance. And we all, we lacked five votes in coming up with a real strong Patients' Bill of

Rights. Ours failed by 5 votes. What passed the House was not even seriously considered by the U.S. Senate because it actually weakened the law that had already been passed in a lot of our States.

And so that is why tonight I am happy to be here with you again and in talking about how important a comprehensive Patients' Bill of Rights, and let us stop stonewalling, let us go ahead and get this bill out here on the floor. Sure, we can have all the committee hearings we want, but we really need to get a comprehensive bill here on the floor of the House. It is a fair bill, but it rules that we can debate our ideas, and that way we can vote out here in public for everyone.

With that I would be glad the gentleman requested this time this evening, and again I know you wanted to talk about the President's plan today. And let me just say that a few minutes ago I spoke, and the President's plan may not go as far as I would like it to go, but it moves us down that road. In football terminology we may be on the one yard line now, he may move us to the 40 or 50. Of course, I would rather have a touch-down, but at least he moves us down the road on really prescription medication for our senior citizens.

And so I am glad the President announced that today. Hopefully we will go from here and go forward with it.

Mr. PALLONE. I want to thank the gentleman for his comments.

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Madam Speaker, I just wanted to comment on some of the remarks that my friend, the gentleman from Texas (Mr. GREEN), made because I think they are so significant.

First of all, with regard to the Patients' Bill of Rights, the gentleman has set forth not only tonight but on many occasions, including last week when we had our Democratic Health Care Task Force hearing, on the fact that there is no question that under the Texas law, which is very similar to what we have, that some of the concerns that have been expressed about HMO reform legislation, like the Patients' Bill of Rights, have just not materialized. The fact that there have been almost no lawsuits, the fact that the cost increases have been really a few pennies, really, per month, and I think that is important because as much as we realize a lot of these criticisms are not justified, many of the insurance companies, many of the HMOs continue to make these criticisms and in many cases spend a lot of money trying to advertise potential problems that might exist with the Patients' Bill of Rights; and the Texas legislation, which has been in force now for about 2 years, shows rather dramatically that those criticisms are not legitimate.

The problem, of course, is that this Texas law and the New Jersey law,

which we have in my State, and all the State laws do not apply to the majority of the people who fall under a Federal preemption because their insurance is essentially Federal because their employer is self-insured or some other things that might bring them under Federal preemption. So we do need the Federal law, and I think we will get the Federal law if we keep pressing.

I did want to switch because I did not hear the gentleman this evening but I knew that he was talking about the announcement that the President made today, and I think that we are going to see that his proposal for Medicare reform and expansion, albeit modest, is something that the majority of the people will become very supportive of. And we hopefully will not have to press the Republican leadership to bring that up for the vote; but if we have to, we will.

If I could just talk briefly about the prescription drug benefit, I guess the hallmark of it, from what I understand, is that it will pay for half the cost of prescription drugs up to a total cost annually of \$5,000 when it is fully in force, which I guess is in the year 2008. But initially when it goes into force, it will at least cover up to \$2,000 annually, and we are talking about a premium which I think is about \$24 a month beginning in the year 2002.

So if this went into place the first time in 2002, one would be paying \$24 a month; and this would apply to anybody who wanted to. It is a voluntary system, a new part B benefit, that anybody who wants to could pay the \$24 a month, and they would be guaranteed in that year up to \$2,000 of prescription drugs that they might incur. A thousand of that, half of that, would be paid for by Medicare. Then that premium would eventually go up, I guess, to \$44 a month when fully phased in at 2008, but at that point it would cover up to \$5,000 in costs.

Now I say it is modest because I am sure some people will say, well, why is it not paying the whole cost? Why is it we only get 50 percent and we still have to put up the other 50 percent?

I think we have to look at the realities of the situation. We know that everything costs money and that the Federal budget is not infinite. The President is basically saying that he is going to put 15 percent of the surplus into Medicare, and this will be one of the benefits of that. When I think of most of the seniors that I know, they would be very glad to pay that \$24 a month and to have half of their drug costs subsidized by Medicare.

The other thing which I do not think was heralded so much today but I am sure will be brought out as this unfolds is for beneficiaries with low incomes, below 135 percent of poverty, which I guess is defined as \$11,000 for a single person or \$17,000 for a couple, they

would not pay premiums or cost sharing. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well, in the same way that we do with part B that covers the doctors' bills. I guess it is called the QMB. I have forgotten what QMB stands for, but these are people with low income who do not have to pay the premium. So between that and this \$24 cost that anyone else wants to pay on a voluntary basis, I think it is a pretty good deal.

I would like to see it go further, but I think it is a very good beginning and something that hopefully we can get bipartisan support for.

I would yield to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Madam Speaker, earlier, in a 5-minute special order, I talked about a constituent of mine that pays \$260 a month for her prescription medication. That comes out to a little over \$3,000 a year, \$260 a month.

Basically, under the President's plan, and again we will all see how this applies to our own constituents but now she pays a little over \$3,000 a year. Under the President's plan, she would pay \$25 a month so that would be times 12. She would pay 200-and-something dollars. Let me see. I have to go back to my math but probably around \$300 a year. And then she would get half of that so she would be paying \$1,500 if her medication costs stay the same, \$3,000. She would pay half under the President's plan and then the other half would be paid for by Medicare part B. So she would actually come out saving money.

Again, that is like I said, she still has to come up with her amount. She is paying this \$260 a month now, and at \$25 it just seems like it would save her money. It is not as far as I want but, like I said, it moves us down the field a little bit.

Again, I do not have all the numbers. We serve on the Committee on Commerce, not the Committee on Appropriation and the Committee on the Budget. We identify the problems. Then we have to figure out how to do it. If we cannot completely solve them, let us at least go part of the way to do it.

The President's plan goes \$3,000 for the first few years, and then it goes up to \$5,000 after that. I have constituents that have been to my townhall meetings literally for years and said that a husband or wife, oftentimes the wife has minimum benefits on Social Security because the wife worked traditionally at a lower wage job. Her whole check, every month, goes to their prescription medication. Their fear is that what happens when one of them passes away?

Now, sure, their prescription medication may be cut in half, but they are losing that income, and they are also going to lose some of their Social Security. So they cannot afford for one of

them to pass away because of the high cost of their prescriptions.

It is just a shame in our country. I have seniors who have told me their blood pressure medicine that they have to take once a day, I really cannot afford it because it is really so expensive so I take it every other day. That should not be for that senior to have to do it or decide I am not going to have dinner tonight or I am not going to have breakfast or go to lunch because I need to take my medication. Those choices should not have to be made in a country as wealthy and as great as ours and who has a tradition, at least since the 1930s, of taking care of our seniors, first by a Social Security system that literally was the first welfare bill because people paid into Social Security so when they are retired they get something back on it, and then in 1965 with the Medicare bill and now in 1999 to expand it to include prescription medication.

The other thing the President talked about in his Medicare proposal was to correct some of the inequities in the Balanced Budget Act of 1997 where a lot of our hospitals and even our home health care providers, the cuts were so dramatic that they are not being able to provide some of the services. I know I get letters in my office from senior citizens but also hospitals. So by dedicating 15 percent of the budget surplus over and above the Social Security amount that we will need for Medicare, it shows that that will help us and not only with prescription medications.

So I congratulate the President. Again, I hope that we will have the chance on the floor of the House to debate prescription medication provisions for our senior citizens. Again, it may not go as far as I want to, but again let us show some progress in the legislative side. Instead of just saying no, we are not recognizing the problem, let us show we recognize the problem and do the best we can with the resources we have to do it.

Again, I thank the gentleman for taking this time tonight and also letting us talk a little bit about prescription medication because that is important to all of our constituents. Whether they live in Houston or Texas or New Jersey or California or whether they are Democrat or Republican, it is important for us to address that.

Mr. PALLONE. Madam Speaker, I want to thank the gentleman from Texas (Mr. GREEN) for his remarks. I know that we just heard about the details of this proposal today, but I am sure that over the next few weeks or few months we will be going into the details a lot more and basically pointing out the good points of the program.

I just wanted to mention, it is estimated that about 31 million Medicare beneficiaries would actually benefit from the coverage that the President outlined today. The reason there are so

many is because so many older and disabled Americans rely so heavily on medication. In other words, somebody who is younger might say, well, will I even incur \$25 worth of prescription drug costs per month? But for people who are over 65 or the disabled that are covered by Medicare, most of them incur prescription drug costs that are well over the \$24 premium per month.

As I said, about 31 million people would benefit if they took advantage and opted into this new part B prescription drug benefit that the President has outlined.

The other thing I would say about it is that the way the President is structuring this Medicare prescription drug benefit, it ensures beneficiaries discounts similar to that offered by many employer-sponsored plans estimated to be, on average, over 10 percent for each prescription purchased. That has nothing to do with the limit. In other words, it has built into the prescription drug program these kinds of discounts; and, of course, the Medicare subsidy to pay half the cost is beyond the discount that one would also get. So I think that is another very significant aspect to it.

The other thing, there were a number of other things that the President mentioned today as part of the Medicare expansion that he unveiled, and I just wanted to mention a few of these because I think they are significant.

Very significant is that his proposal eliminates all cost sharing for preventive benefits in Medicare and institutes a major health promotion education campaign. Let me just talk a little bit about that preventive aspect.

One of the biggest criticisms that we have had over the years, not only of Medicare and Medicaid but just health care in general, is that we do not encourage prevention. Prescription drugs essentially are prevention. It used to be 30 years ago when Medicare was started that prescription drugs were not important because the emphasis on health care then was if one was in the hospital and if they had to have an operation they had the operation, and that was the way to cure them.

Prescription drugs have become more available and more prevalent over the last 30 years since the 1960s when Medicare began because it was a preventive measure. One takes the prescription drugs to prevent getting further sick or having to be hospitalized or having the operation, but there are other preventive benefits in Medicare that are just as important.

By eliminating existing copayments and deductibles for these kind of preventive services, I think the President goes far, combined with the prescription drug program, in stressing prevention as part of the Medicare program which is so important.

He said today, just to give an idea of the kind of preventive services that

would no longer have those copayments and deductibles, just to give some examples of the cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self-management benefits, mammograms, these are the kinds of preventive measures that I think should not have the copayment deductible because we want everybody to take advantage of them, a significant part of his proposal today.

The other thing is he reiterated as part of his Medicare proposal today the Medicare buy-in for the near elderly. The plan includes the President's proposal to offer any American between the ages of 62 and 65 the choice to buy into the Medicare program for approximately \$300 per month; displaced workers even at a lower age. Displaced workers between 55 and 62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium, approximately \$400 per month.

So what we are seeing here is an effort by the President to expand Medicare to the near elderly at no additional cost because this would be the cost of having those people enter into the Medicare program. I think that is also significant.

The last thing I wanted to mention on the President's Medicare proposal today, I think my colleague, the gentleman from Texas (Mr. GREEN) already touched on it, but I wanted to reiterate that his proposal extends the life of the trust fund, the Medicare Trust Fund, until at least 2027.

A lot of my constituents come up to me and say, is Medicare going to be there in a few years? Well, the answer is that if the President's plan is adopted, it will be. It will be there at least until 2027. He does that by dedicating 15 percent of the surplus, which is \$794 billion over 15 years, to Medicare, to insure the financial health of the trust fund through at least the year 2027.

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We will go into this more, Mr. Speaker, as we get a chance to look at his proposal in more detail over the next few weeks.

ON TURKISH INTRANSIGENCE AND CONCERNS REGARDING THE ENTITIES LIST AGAINST TURKEY AND PAKISTAN.

Mr. PALLONE. Mr. Speaker, what I would like to do now, if I could, and I will not take up the whole time, but I wanted to sort of change the subject and talk about two foreign policy areas which I am very concerned about.

The first one involves U.S. relations with India, which I often speak about as a member of our bipartisan India Caucus. It references legislation that I am introducing today with regard to the so-called "entities list" against both India and Pakistan.

The legislation I am introducing, Mr. Speaker, is a concurrent resolution

aimed at getting the administration to review its so-called "entities list" with regard to India and Pakistan.

The Bureau of Export Administration has created a blacklist of private and public entities in the two countries, subjecting them to a near complete prohibition on all exports, including paperclips and paper cups, without regard to their specific use or whether these items contribute in any way to nuclear weapons or missiles.

In effect, the entities list imposes a trade embargo against nearly 300 companies and agencies with little or no direct connection to nuclear weapons programs. In practice, this is an essentially punitive list. Besides punishing the Indian and Pakistani entities, the list also ends up hurting U.S. firms and U.S. research organizations that have ties with them.

Mr. Speaker, the administration, I believe, has cast too wide a net in listing entities, including private companies and research institutions, that do not threaten U.S. security interests. There are a total of 196 entities from India and 92 from Pakistan on the list. This compares with a total of only 13 named entities from China and 13 from Russia.

There are some truly absurd examples of entities that have been included in this list. For example, medical equipment cannot be supplied to a cancer unit that comes under the administrative jurisdiction of an atomic research center. The trade restrictions are actually more permissive with regard to military than civilian entities. It is indicative of policies that I think have lost touch with the spirit of the laws that they were meant to implement.

Thus, I have introduced today my sense of the Congress resolution, similar to a provision approved in the other body, the Senate, as part of the fiscal year 2000 defense appropriation legislation.

It states that export controls should be applied only to those Indian and Pakistani entities that make direct and material contributions to weapons of mass destruction and missile programs, and only those items that can contribute to such programs.

The entities list was adopted, I think I mentioned, by the Bureau of Export Administration last year in the wake of the imposition of unilateral U.S. sanctions pursuant to the Glenn Amendment to the Arms Export Control Act.

The sanctions were invoked automatically, pursuant to the Glenn Amendment. However, the naming of the Indian entities on the list is not a mandatory Glenn Amendment sanction. I would say that the list goes way beyond the intent of Congress when it enacted the Glenn Amendment in an effort to prevent nuclear detonations by what were termed nonnuclear pow-

ers by the Nuclear Non-Proliferation Treaty. Furthermore, the entities list is not subject to suspension or waiver.

Mr. Speaker, in the Omnibus Appropriations Act of the last fiscal year, there was a provision granting the President the authority to waive certain Glenn Amendment sanctions. This year both houses of Congress, both the House and Senate, are moving legislation to further waive or to suspend the sanctions, but the entities list would not be affected by these efforts. It is a discretionary measure imposed by the administration above and beyond what the Glenn Amendment provides for.

Mr. Speaker, I have repeatedly made the point that I have concerns about this discretionary approach in general. Personally, I would like to see the sanctions permanently repealed. I would at least favor suspension of the sanctions for some period of time, 5 years is provided for in the Senate language, rather than continuing to use the sanctions in a carrot and stick strategy to force concessions.

With the entities list, we have seen this discretionary approach taken to its logical extreme. Instead of controlling exports that have a direct bearing on nuclear or missile programs, the list is simply a broad technological embargo against non-weapons related private and commercial activities.

Mr. Speaker, I made the point that this list is punitive, but the real question is, whom does it punish? The named entities can generally find alternative suppliers from other countries. The real victims are the American companies, their employees, and suppliers.

Furthermore, the list is open-ended. The named entities from India and Pakistan are not accused of violating any law or commitment. There is nothing the entities can do to get delisted, since there was nothing really they did to get put on the list in the first place.

I have come to this floor on many occasions in the last year to express my concern that the sanctions regime against India has severely damaged the burgeoning economic relations that have been opened up since India undertook historic market reforms in the early 1990s.

The sanctions have forced the U.S. to oppose major projects funded by the World Bank and other international financial institutions. We have had to abandon nonhumanitarian aid, including technical assistance programs that were helping India establish the kind of viable financial institutions that it would allow for much-needed infrastructure and other development projects. The sanctions not only deprive the people of India of important opportunities, they also serve to cut the U.S. private sector out of one of the world's major emerging markets.

I am glad to see Congress is working on a bilateral and bicameral basis to

lift the sanctions. Mr. Speaker, these efforts would not affect the Administration's entities list. It is up to Congress, working with the American private sector entities that have been hurt by this counterproductive policy, to speak out and urge the administration to reconsider.

I hope we can enact this legislation that I am introducing today, Mr. Speaker, and that the administration will respond in a meaningful way by removing entities from this list that simply do not belong there.

Mr. Speaker, I also wanted to take a few minutes, about at the most 5 minutes, to talk about something that I read about over the weekend in the New York Times that again indicated very strongly the Turkish government's intransigence with regard to the continued occupation of Cyprus.

I have a number of Cypriot constituents. I know the Cypriot Americans as a community have been to many Members of Congress, both Democrats and Republicans, many times to express their concern over the lack of progress in resolving the continued Turkish occupation of Cyprus. This year, actually July 20 of this year, next month, will mark the 25th anniversary of this illegal Turkish invasion and occupation of Cyprus.

The problem is that the Turkish side continues to refuse to come to the negotiating table with the intention of negotiating in good faith. Hundreds of attempts to solve this problem have been made, yet to date the islands is divided and remains one of the most militarized places on the face of the Earth.

Mr. Speaker, to its credit, following the leading role it played in bringing NATO's role with Serbia to an end, the group of eight major industrialized nations, the G-8, agreed to press for a new round of negotiations recently on the Cyprus issue.

The Secretary General of the U.N. endorsed the G-8's plan and subsequently announced he was prepared to invite the Greek and Turkish Cypriots to hold comprehensive peace negotiations. The Turkish side, however, did not waste a second in reaffirming its disrespect for the will of the international community.

Turkish president Rauf Denktash, he is the President of the Turkish occupied part of Cyprus, quickly dismissed the U.N.'s proposal for a new round of peace talks as nonsense.

After nearly 25 years of Turkish belligerence and intransigence over the Cyprus issue, this latest refusal to allow the peace process to move forward is hardly a surprise. I am certainly not surprised. But I nonetheless wanted to come down here to discuss this particular example on the House floor because, frankly, the U.S. Government is simply not doing enough to help bring Turkey to the negotiating table.

In my view, pressure by Members of Congress who support a just resolution to the Cyprus problem must be turned up. The justification the Turkish leader provided to Reuters News Agency for rejecting a new round of peace negotiations is absolute garbage. Denktash told Reuters he would not attend any negotiations at which the democratically-elected president of Cyprus, Mr. Clerides, represented the Cyprus government.

According to Denktash and his patrons in Ankara, the Cypriot government does not have any official jurisdiction or authority over the portion of the island that has been illegally occupied by Turkish troops for almost 25 years.

Adding to this absurdity, the Reuters report also noted that Denktash and Turkey claimed that "decades of talks on an inter-communal basis have failed to acknowledge the existence, in effect, of two separate governments on the island."

Mr. Speaker, these ridiculous claims were made by Denktash for the sole purpose of killing a new round of negotiations before they have a chance to succeed. That is what he is up to. Clerides, President Clerides, is recognized internationally as the President of Cyprus, and Turkey is alone in its recognition of the so-called Turkish Republic of Northern Cyprus. No other country in the world recognizes the portion of Cyprus that the Turks have illegally occupied for 25 years as an independent state.

The Turkish suggestion that peace negotiations must be between leaders of independent nations from the same island is way outside the realm of reality.

Mr. Speaker, the international community recently reaffirmed its position on the Cyprus issue. In December of last year, the U.N. Security Council passed a number of resolutions on the Cyprus situation, including Resolution 1217 which reiterates all previous resolutions on the Cyprus problem.

Those resolutions state that any solution to the Cyprus problem must be based on a State of Cyprus with a single sovereignty and international personality and a single citizenship, in a bi-communal and bi-zonal federation, with its independence and territorial integrity safeguarded.

So on the one hand we have the international community taking steps to reaffirm its commitment to a peaceful and just settlement to the Cyprus problem, and on the other hand, the Turks are only hardening their position and thumbing their nose at whatever the international community suggests.

Their claim that a new basis for negotiations is needed because the negotiations over the last 2½ decades, which they have worked systematically to undermine, have failed to

produce any results essentially says it all. Rejecting all reasonable and peaceful overtures and substituting unreasonable and unworkable conditions in their place is not an approach that will move the peace process forward.

Sadly, that is precisely why they make the suggestions. If the Turks were truly interested in moving the peace process forward, they would come to the table and abandon their belligerent and unreasonable conditions for negotiations.

They could also accept the standing offer from the Cypriot government to demilitarize the islands in an effort to reduce tensions, as well as the Cypriot government's offer to pay for the costs of the peacekeeping force following any such demilitarization.

The fact of the matter is that the Turkish side could do any of a number of things to reduce tensions and put the peace process back on track if Ankara, where the real decisions about Cyprus are made, allowed it to happen. History has shown we should not expect that to happen any time soon, and that is why the U.S. has to do more to make it happen.

Mr. Speaker, I just wanted to say that in my view, it is long past time to stop focusing public and private efforts on the Turkish Cypriots and intensify American efforts to move the peace process forward on the Turkish military, which has real and substantial influence on decision-making in the Turkish government.

To that end I would reiterate what I and many other Members of Congress have said publicly and privately to the administration. The United States government must stop spinning its wheels and convey to Ankara in forceful and unequivocal terms that there will be direct consequences in U.S.-Turkish relations if Ankara does not prevail upon the Turks to come to the negotiating table in good faith.

Almost 25 years have passed since Turkey invaded Cyprus. The recent comments by Denktash, who is now taking his orders from the very same Prime Minister in Ankara who presided over Turks 1974 invasion, suggest it might as well have been yesterday.

Mr. Speaker, finally, I think it is clear that the people of Cyprus have waited far, far too long for their freedom. It is my unshakable belief that the U.S. should immediately take the appropriate course of action against the Turkish government to help the Cypriot people attain their independence and their freedom and the cause of a united Cyprus without further delay. I do think these international issues are important.

CONFERENCE REPORT ON H.R. 775,  
Y2K ACT

Mr. GOODLATTE (during Special Order of the gentleman from New Jer-

sey, Mr. PALLONE) submitted the following conference report and statement on the bill (H.R. 775) to establish certain procedures for civil actions brought for damages relating to the failure of any device or system to process or otherwise deal with the transition from the year 1999 to the year 2000, and for other purposes:

CONFERENCE REPORT (H. REPT. 106-212)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 775), to establish certain procedures for civil actions brought for damages relating to the failure of any device or system to process or otherwise deal with the transition from the year 1999 to the year 2000, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

**SECTION 1. SHORT TITLE; TABLE OF SECTIONS.**

(a) *SHORT TITLE.*—This Act may be cited as the "Y2K Act".

(b) *TABLE OF SECTIONS.*—The table of sections for this Act is as follows:

Sec. 1. Short title; table of sections.

Sec. 2. Findings and purposes.

Sec. 3. Definitions.

Sec. 4. Application of Act.

Sec. 5. Punitive damages limitations.

Sec. 6. Proportionate liability.

Sec. 7. Prelitigation notice.

Sec. 8. Pleading requirements.

Sec. 9. Duty to mitigate.

Sec. 10. Application of existing impossibility or commercial impracticability doctrines.

Sec. 11. Damages limitation by contract.

Sec. 12. Damages in tort claims.

Sec. 13. State of mind; bystander liability; control.

Sec. 14. Appointment of special masters or magistrate judges for Y2K actions.

Sec. 15. Y2K actions as class actions.

Sec. 16. Applicability of State law.

Sec. 17. Admissible evidence ultimate issue in State courts.

Sec. 18. Suspension of penalties for certain year 2000 failures by small business concerns.

**SEC. 2. FINDINGS AND PURPOSES.**

(a) *FINDINGS.*—The Congress finds the following:

(1)(A) Many information technology systems, devices, and programs are not capable of recognizing certain dates in 1999 and after December 31, 1999, and will read dates in the year 2000 and thereafter as if those dates represent the year 1900 or thereafter or will fail to process dates after December 31, 1999.

(B) If not corrected, the problem described in subparagraph (A) and resulting failures could incapacitate systems that are essential to the functioning of markets, commerce, consumer products, utilities, Government, and safety and defense systems, in the United States and throughout the world.

(2) It is in the national interest that producers and users of technology products concentrate their attention and resources in the time remaining before January 1, 2000, on assessing, fixing, testing, and developing contingency plans to address any and all outstanding year 2000 computer date-change problems, so as to minimize