

Griffin's "Bill of Rights." It is important to understand the foundations of union democracy before one can discuss necessary changes.

Today, Landrum-Griffin covers some 13.5 million members, in more than 30,000 unions having more than \$15 billion in assets. Congress passed the LMRDA as a response to public outcry resulting from revelations of corruption and racketeering in the labor movement. This corruption came to light in the late 1950s, during three years of hearings in the Senate Select Committee on Improper Activities in the Labor and Management Field, chaired by Senator John L. McClellan. The authors of the LMRDA believed that promoting democracy within unions would reduce corruption and strengthen the labor movement by providing union members more control over their own union affairs.

Clyde Summers, Jefferson B. Fordham Professor of Law Emeritus at the University of Pennsylvania Law School, who sat on a panel of experts convened by then-Senator John F. Kennedy to draft a union members' Bill of Rights (the basis for Title I of Landrum-Griffin), eloquently summarized the intent of the law in testimony before the EER Subcommittee on March 17, 1999:

The whole focus of the Landrum-Griffin Act was to protect the democratic rights of members as an instrument of collective bargaining. There was a guiding principle to limit governmental intervention to the minimum, to limit intervention in terms of union decision-making, to leave unions free to make their own decisions. But this was to be accomplished by guaranteeing the democratic process inside the union on the logic, the philosophy, that if the union members made these decisions on their own, that if these were democratically made, this gave a legitimacy to these decisions.

Landrum-Griffin contains six titles. The first title, the foundation upon which the rest of the legislation is constructed, contains a union member Bill of Rights mandating various rights: to information, to free speech, to free association, and to protection from undue discipline. Title II governs reporting and record-keeping by labor organizations. Title III provides a framework for trusteeships. Title IV lays out requirements for elections of union officers, including specific time frames within which elections must be held. Title V outlines the fiduciary duties of union officers. Title VI provides a variety of additional requirements, and grants general investigatory powers to the Department of Labor.

#### THE AMENDMENTS

The bill I introduce today includes several amendments to Landrum-Griffin. Each of these changes will have a positive impact on the everyday lives of union members. Those unions that treat their members fairly will not be affected at all. The legislation introduced today is not an exhaustive list of reforms. There are other changes that Congress may want to consider in the future, but the DRUM Act represents a very productive starting point.

My bill provides: enhanced notification to union members of their rights under the LMRDA; increased authority for the Department of Labor to enforce the notification rights of union members;

#### ENHANCED NOTIFICATION RIGHTS

The DRUM Act addresses real problems that have come to the subcommittee's atten-

tion during our hearings or through recent court rulings. For example, the legislation requires unions to periodically notify all members of their Title I rights. Some unions, as incredible as it may sound, have argued that a one-time notification of rights under the LMRDA given decades ago satisfies the current law requirement to "inform its members concerning the provisions of" the Act (29 USC §415).

This issue was the subject of a recent Fourth Circuit case. (*Thomas v. Grand Lodge of Int'l Ass'n of Machinists*, 201 F.3d 517 (4th Cir. 2000)). In *Thomas*, union members sued the International Association of Machinists to require the union to distribute to each member a summary of their rights under Landrum-Griffin. The union claimed that they had fulfilled the notification requirements in 1959 when they distributed the text of the recently-passed law. Incredibly, the district court had agreed with the union leadership despite the fact that most, if not all, of the members were not members in 1959. Fortunately, the Fourth Circuit overruled the district court, and determined that the one-time notification was not sufficient, but stopped short, however, of enumerating what "sufficient notification" entails. My bill clarifies the notification obligation, by requiring the Secretary of Labor to promulgate regulations that provide enhanced guidance to union organizations on how best to inform their members of their LMRDA rights. After all, if union members are not aware that they have rights, they will be unable to exercise them.

#### "REASONABLE QUALIFICATIONS" IN UNION ELECTIONS

An additional line of court cases prompts another provision in DRUM. There is conflicting appeals court precedent on the issue of what constitutes a "reasonable qualification" (29 USC §481 (e)) in order to be eligible to run for elected union office. Earlier this year, the First Circuit ruled against the Department of Labor, after the Department sued a local union over an election rule which barred 96 percent of the local's members from running for office (*Herman v. Springfield Mass. Area, Local 497, American Postal Workers Union*, 201 F.3d (1st Cir. 2000)). The court held as reasonable a requirement that union members attend three of the previous nine union meetings in order to run for office. This court decision contradicts a ruling from the D.C. Circuit in 1987, in which a union's election rule was considered unreasonable primarily because it disqualified a large percentage of union members (*Doyle v. Brock*, 821 F.2d 778 (D.C. Cir. 1987)).

In *Herman*, the Majority all but requested that the Department of Labor adopt a regulation using a specific percentage standard. I believe it is the responsibility of the Congress to enact such a requirement, rather than to require the administration to take on the nearly impossible task of interpreting Congressional intent and balancing that intent with contradictory court opinions. As such, the legislation introduced today lays out a clear standard by which election rules will be judged as reasonable or unreasonable. The legislation simply says that any rule excluding more than half of a union's members from running for office is not reasonable. This bright line will benefit union members, candidates for union office,

and incumbent union leaders equally, because by removing ambiguity, we will enhance union democracy and reduce potential internal strife.

#### CONCLUSION

The workplace of the 21st Century is vastly different from that existing 40 years ago. Workers and employers are working together toward a common goal, rather than continuing the adversarial relationship which characterized the last century. This evolution in the workplace has reduced industrial strife, and has increased productivity, profits, and, most importantly, the satisfaction and pay of workers.

This same collective strategy is key to the effective operation of internal union affairs. The days of well-heeled union bosses, using their members to enrich themselves at the expense of worker advancement are quickly ending. Unions, which provide workers with camaraderie, personal support—both inside and outside the workplace—and a means to improve their lives, are enriched as members achieve true democracy within their labor organizations. Enhancing the ability of rank-and-file members to take a greater responsibility for how their union operates solidifies the positive impact unions have on the workplace and the lives of working men and women.

HONORING IRVING B. HARRIS FOR  
A LIFETIME OF ACHIEVEMENT  
ON HIS 90TH BIRTHDAY

**HON. ROSA L. DeLAURO**

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Ms. DELAURO. Mr. Speaker, it gives me great pleasure to stand today to honor a remarkable individual who has left a lasting mark on our Nation and its children. I am honored to pay tribute to Irving B. Harris as he celebrates his 90th birthday on August 4, 2000.

Irving's leadership and commitment is inspiring. His passion and advocacy have led the fight for policy development on behalf of very young children and families, attention to the physical and mental health of pregnant women and mothers of infants and toddlers, the prevention of violence, the training of a competent infant/family work force, and the building of effective community-based programs. He is as well-respected as a leading voice for children as he is as a corporate leader. After entering the business world following his graduation from Yale University, he served with both the Board of Economic Warfare and the Office of Price Administration during World War II. He has served in executive capacities for several well-known companies, including the Toni Home Permanent Co., and the Pittway Corp.

However, Mr. Harris is best known for his commitment to improving the chances of disadvantaged children across this country. His many contributions and determined advocacy for the well-being and development of infants, toddlers, and their families are legendary. He was instrumental in creating and establishing such well-respected institutions as the Erikson Institute and the Ounce of Prevention Fund,

as well as the highly ambitious Beethoven Project, which has served as models for the development of training and service programs across the country. He helped to establish Zero to Three, a national nonprofit charitable organization whose mission is to strengthen and support families, practitioners and communities to promote the healthy development of babies and toddlers. He was the moving force in the establishment of the Harris Graduate School of Public Policy Studies at the University of Chicago. His vision and leadership have earned him appointments to the National Commission on Children and the Carnegie Corporation of New York's Task Force on Meeting the Needs of Young Children. For his efforts, Irving has been awarded 10 honorary degrees.

He has been, and continues to be, a champion for children and families everywhere. It is with great pride that I rise today to congratulate Irving. I also would like to extend my sincere thanks and appreciation for his many contributions and best wishes for continued health and success. Our Nation's children thank you and wish you a happy birthday.

#### PERSONAL EXPLANATION

### HON. J.D. HAYWORTH

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. HAYWORTH. Mr. Speaker, on Thursday, July 20, 2000, I missed rollcall votes 421, 422, 423, 424, 425, 426, 427, and 428 because I was attending to congressional business in my district. Had I been present, I would have voted "aye" on rollcall vote 421, "no" on rollcall vote 422, "aye" on rollcall vote 423, "no" on rollcall vote 424, "no" on rollcall vote 425, "no" on rollcall vote 426, "aye" on rollcall vote 427, and "aye" on rollcall vote 428.

#### INTRODUCTION OF THE CHRONIC ILLNESS CARE IMPROVEMENT ACT OF 2000

### HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. STARK. Mr. Speaker, in our aging society, it is beginning to dawn on millions of Americans across the country that chronic illnesses are now America's number one health care problem. Yet because our health care system has been designed around meeting the needs of acute, not chronic illness, our system of services for those with Alzheimer's, diabetes, and other major conditions is both fragmented and inadequate.

To be successful, 21st century health care must be reorganized to maximize the intelligent use of those protocols and procedures that can most effectively control and slow the rate of chronic illness progression. This can only be accomplished if treatment for chronic conditions is consciously and carefully integrated across a range of professional providers, caregivers and settings.

This integration of services for chronic illness care is at the heart of the Chronic Illness Care Improvement Act of 2000 that I am introducing today.

It is a major bill, designed to focus debate on the need to provide comprehensive and coordinated care for people with serious and disabling chronic illness. I am introducing this Medicare measure this summer to invite comments, ideas and suggestions for refining this bill so that it can be re-introduced at the beginning of the 107th Congress, with bipartisan sponsorship. The bill I am introducing today is the result of months of consultation and work with numerous senior, illness, and health policy groups. I hope that it will receive the endorsement of many groups in the days to come.

The bill has four titles and is phased in over a number of years. Why? Because we know a lot about the management of chronic illness—but in truth, the comprehensive national program that is so desperately needed will require long range planning and implementation in phases.

Therefore, Title I creates a temporary Commission to study and recommend solutions to the complex issues involved in coordinating and integrating the diversity of healthcare services for the chronically ill.

Title II lays the groundwork for a full, comprehensive care program by establishing the databases and infrastructure we will need to provide high quality care to those with chronic illness.

Title III launches two major prototype chronic disease management programs—one for diabetes and the other for Alzheimer's disease. Once we learn from the experience of these two prototypes, the Act calls for expansion to a high quality national program for management of other serious and disabling chronic illnesses.

Title IV promotes coordination of care for dually eligible beneficiaries by streamlining the processes of obtaining waivers and determining budget neutrality of combined Medicare and Medicaid programs.

#### WHY A PROGRAM TO IMPROVE THE CARE OF CHRONIC ILLNESS IS NEEDED

Do you know someone who has diabetes, high blood pressure or a heart condition? Perhaps someone who is important to you suffers from arthritis, asthma or Alzheimer's disease. All of these problems have one thing in common—they are chronic illnesses. Once these problems begin, they stay with you and many of these problems inevitably progress over time. What most people don't know is that chronic illness is America's highest-cost and fastest growing healthcare problem accounting for 70 percent of our nation's personal healthcare expenditures, 90 percent of all morbidity and 80 percent of all deaths.

Yet while chronic disease is America's number one healthcare problem, care for those with chronic illness is provided by a fragmented healthcare system that was designed to meet the needs of acute episodes of illness. We cannot deliver 21st century healthcare with a system that was designed a half century ago, before angioplasty or bypass surgery for heart disease and before L-dopa for Parkinson's disease.

Medical discoveries like these have transformed many illnesses from rapidly disabling conditions to chronic conditions that people

live with for a long time. But the healthcare system that works for a devastating heart attack does not work for chronic illnesses that need a totally different group of services, including long range planning, prevention, coordination of care, routine monitoring, education, and self-management.

The acute care model is a mismatch for the needs of chronic disease and the result is that people with chronic conditions receive healthcare that responds to crises rather than preventing them. The fact is we know a lot about the natural course of chronic illnesses like diabetes and arthritis. We have learned the all-too-common scenarios that result in complications such as an amputation in the diabetic or a stroke in the person with uncontrolled hypertension. Delaying stroke by 5 years would yield an annual cost savings of 15 billion dollars, yet we continue to shortchange the ounce of prevention that is worth a pound of cure.

The patients know what is wrong with the system—they tell us our healthcare system is disjointed and a nightmare to navigate. They want more information about their condition, more emotional support, and more control of their care. They deserve better communication and integration of care amongst their many healthcare providers who currently function to deliver separate and unrelated services, even though they are providing care to the same person.

But none of this will happen in a medical system that does not reward quality of care for chronic illness. Our healthcare system does not reward preventive care or continuity of care. Neither do we reward early diagnosis, interdisciplinary care, emotional counseling or patient and caregiver education.

The cornerstone of quality healthcare for chronic illness is long-range planning and prevention, yet the Congressional Budget Office currently has no mechanism to measure cost-effectiveness over extended periods of time. Unless we recognize that an upfront investment in the early and middle stages of chronic illness will pay dividends over the long term, we will continue to be caught in the vicious cycle of responding to crises rather than anticipating and preventing them.

There is increasing recognition of the looming problem of providing long-term care to the growing number of senior citizens, but little awareness that better care of chronic illness beginning at the time of diagnosis is the most effective strategy to prevent the progression of disability and loss of independence. Join me in supporting The Chronic Illness Care Improvement Act of 2000 to bring excellence to the care of chronic illness, just as Medicare has already achieved for acute illness. This legislation will put our emphasis where it belongs—on proactive strategies that will prevent complications and disability before they happen.

This is a systems problem that requires a systems solution. Disease management of chronic illness will only succeed if financial, administrative and information systems are developed to support it. Our current healthcare system locks into place fragmentation and duplication of services. We must strive to align financial incentives among healthcare providers to achieve common care, quality and cost objectives. We can improve the quality of care while reducing costs by reducing duplicative and unnecessary services and by preventing complications and loss of independence.

The healthcare challenge of this new century is to design a Medicare system that